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Employee Benefits Bulletin

A review and analysis of recent developments affecting employee benefits

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NEW COBRA REGULATIONS ISSUED

The Internal Revenue Service ("IRS") recently issued final and additional proposed regulations on the COBRA group health plan continuation coverage rules. Highlights include:

- new flexibility for employers in determining which group health plans and separate benefits provided within a plan can be made part of a single or separate COBRA election
- changes in the treatment of health care flexible spending accounts
- elimination of the core coverage election requirement
- additional guidance on when COBRA coverage can be terminated early for failure to pay required premiums or entitlement to coverage under another group health plan or Medicare
- clarification of when COBRA coverage has to be provided if an employee moves to a new geographic area and when information on COBRA coverage has to be provided to health care providers
- allocation of COBRA responsibility in corporate stock and asset transactions
- clarification of the treatment of employer withdrawals from multiple-employer health plans.

Although much of this guidance results in new rules for employers to follow, the new regulations also provide options to employers that can help to simplify their COBRA administration.

COBRA BACKGROUND

COBRA, or the Consolidated Omnibus Reconciliation Act of 1985, amended the Internal Revenue Code and Employee Retirement Income Security Act ("ERISA") to permit covered employees and their beneficiaries to elect to continue their group health plan coverage following an event, such as termination of employment, that would otherwise result in the loss of coverage. Those eligible for COBRA coverage are referred to as "qualified beneficiaries."

A qualified beneficiary's COBRA rights are triggered when there is a loss of group health plan coverage due to a COBRA qualifying event, and the length of coverage is dependent on the qualifying event. Certain qualifying events create COBRA rights for the employee and covered dependents, and others create COBRA rights only for the dependents. Qualifying events include:

- termination of employment for any reason except gross misconduct (18 months)
- a reduction in work hours (18 months)
- death of the employee (36 months)
- divorce or legal separation (36 months)
- a child attaining an age which otherwise would no longer qualify him or her for coverage under the plan (36 months)
- the employee's becoming entitled to Medicare benefits (36 months)
- for those with retiree medical coverage, a Chapter 11 bankruptcy filing by the employer (36 months).

A person can incur more than one qualifying event, and this can result in an increase in the period of COBRA coverage from 18 months to a maximum of 36 months, but only if the second qualifying event provides for 36 months of COBRA coverage. COBRA coverage can be discontinued earlier if the qualified beneficiary does not pay the required premium timely or subsequently becomes covered under either Medicare or another group health

plan that does not have an applicable preexisting condition exclusion.

Failure to comply with COBRA can result in excise taxes being imposed by the IRS and civil damages under ERISA. The IRS initially issued proposed regulations over ten years ago, in 1987. The long-awaited final regulations and additional proposed regulations were issued February 3, 1999.

WHAT'S NEW

Highlights from the new regulations include:

1. **Group Health Plans Maintained.** Under the new proposed regulations, plan sponsors have flexibility in determining the number of group health plans they maintain, and are generally allowed to separate or aggregate group health plan benefits for COBRA purposes. Thus, if a variety of health care benefits are provided to employees, the employer may generally aggregate the benefits into a single group health plan or disaggregate benefits into separate group health plans. Aggregating benefits into a single plan can simplify COBRA administration because, under the new rules, all benefits provided under a plan can be part of an "all or nothing" COBRA election. The determination of whether benefits are provided under a single group health plan or multiple group health plans is based on the governing plan documents.

   Example: ABC Company sponsors a major medical plan, a dental plan, and a vision plan, all of which are maintained under separate plan documents. Accordingly, ABC must offer separate COBRA coverage for each plan. However, if ABC combines all three plans into one plan by adopting a single "wrap around" plan document covering all three benefits, ABC would not have to offer separate COBRA elections for each benefit.

2. **Elimination of Core Coverage Election.** Under the new proposed regulations, group health plans are no longer required to allow participants to elect only core coverage in plans where both core and non-core coverage are provided. This is a significant change from the proposed 1987 regulations.

Qualified beneficiaries may now be required to elect all coverage under the plan if they want to elect COBRA coverage.

Example: In its group health plan, DEF Company provides a basic medical coverage program and a prescription drug program. Under the 1987 proposed regulations, DEF had to permit separate elections for the basic medical coverage, which was core coverage, and for the prescription drug program, which was non-core coverage. However, under the new regulations, DEF may require qualified beneficiaries to elect either (1) both basic medical and prescription drug coverage or (2) nothing.

3. **COBRA and Health Flexible Spending Accounts ("FSAs").** Under the 1987 proposed regulations, a health FSA component of a section 125 cafeteria plan had to offer COBRA coverage. However, the new proposed rules generally limit the obligation to offer COBRA coverage for health FSAs to the plan year in which the qualifying event occurs. Further, COBRA coverage ordinarily does not have to be offered at all under a health FSA if, as of the date of the qualifying event, the amount the qualified beneficiary can become entitled to receive during the remainder of the plan year does not exceed the maximum amount the employer can require to be paid for COBRA coverage under the health FSA for the remainder of the year.

   Example: An employer maintains a group health plan providing major medical benefits and a health FSA, and the plan year for both plans is the calendar year. Employee B elects to have $100 per month (or $1,200 per year) contributed to her health FSA account for the year 2000 and then terminates her employment on May 31, 2000, having submitted $300 in reimbursable expenses as of that date. The maximum amount B can be required to pay for COBRA continuation coverage for the remaining seven months of the year under the health FSA is $714 ($700 x 102%). However, the maximum benefit B could become entitled to for the remainder of 2000 is $900 ($1,200 annual election less $300 claims submitted). Because the maximum benefit ($900) is greater than the maximum COBRA

premium ($714), B would be entitled to continue her health FSA for the remainder of 2000 under the new proposed regulations.

Example: Assume the same facts as the preceding example except that, as of the date of the qualifying event, employee B has submitted $800 in reimbursable expenses. The employer could offer B COBRA continuation coverage but would not be obligated to do so because the maximum benefit B could become entitled to for the remainder of the plan year is $400 ($1,200 annual election less $800 claims submitted), which is less than the maximum COBRA premium that could be charged for coverage for that period ($714).

4. **COBRA Responsibility Involving the Sale of a Business.** The 1987 proposed regulations provided little guidance on the allocation of COBRA responsibility in corporate transactions, such as the stock sale of a wholly owned subsidiary or the sale of substantially all of the assets of a company or a division thereof. Under the new proposed regulations, the buyer and seller are given the right to determine by contract which entity will assume the COBRA liability for former employees of the seller even if the contract imposes liability on the party that would otherwise have this obligation under the law. If there is no contractual agreement or the buyer defaults on its contractual obligation to provide COBRA coverage, the seller is responsible for providing COBRA continuation coverage irrespective of whether the transaction is a stock or assets sale. However, if the seller terminates all of its group health plans, the buyer ordinarily becomes responsible for providing COBRA continuation coverage for existing qualified beneficiaries.

   Comment: Although the new proposed regulations permit the buyer and seller to allocate COBRA responsibility, most buyers can be expected to try to avoid assuming this liability unless they are buying a division with its own group health plan. The IRS continues to impose successor employer concepts requiring the buyer to provide COBRA coverage when the seller fails to do so. Moreover, it is still unclear under what circumstances a seller can avoid offering COBRA coverage to its former employees

who, immediately after a transaction, are rehired by the buyer and covered by its group health plan.

5. **Early Termination of COBRA Coverage.** A qualified beneficiary may have his or her COBRA continuation coverage terminated early in certain cases, such as failure to pay the premium timely, for cause, becoming covered under another group health plan or Medicare, or termination of all of an employer's group health plans. The regulations provide a number of new rules on the timely payment issue. Payment is considered made on the date it is sent, a qualified beneficiary must be given a reasonable period of time (30 days is deemed reasonable) to correct insignificant payment shortfalls after being notified by the employer, and payments must be accepted from persons other than the qualified beneficiary. To terminate coverage early based on cause, the same rules must also apply to similarly situated active employees (the regulations provide an example of submitting a fraudulent claim as constituting cause). For coverage under another group health plan or Medicare, there must be actual coverage beginning after the date of COBRA coverage. Merely being eligible for other coverage but not enrolling is insufficient to terminate COBRA coverage early. Similarly, the existence of other coverage at the time of a qualifying event, as opposed to becoming entitled to such coverage after that time, is not grounds for denial of COBRA coverage. This latter rule adopts the Supreme Court's ruling in *Geissel v. Moore Medical Corporation*, reported in the July 1998 edition of the *Employee Benefits Bulletin.*

6. **Limitation on the Geographical Scope of COBRA Coverage.** If a qualified beneficiary receiving COBRA coverage moves outside of the geographical area where coverage is offered under a region-specific plan, such as an HMO or point-of-service plan, the employer is obligated to continue providing COBRA coverage under certain circumstances. If employees in the area where the qualified beneficiary is moving are provided with health coverage, the same coverage must be offered as an alternative to the qualified beneficiary. If the employer does not provide any coverage that is available in the area where the qualified beneficiary

is moving, the employer does not have to make alternate coverage available to the qualified beneficiary.

7. **Responses to Health Care Providers Regarding Coverage.** The final regulations require group health plans to respond to a health care provider's inquiries into the status of a qualified beneficiary during the COBRA election period. This means that the plan must make a full response to all inquiries regarding the qualified beneficiary's right to coverage under the plan during the election period. If the qualified beneficiary has not elected coverage under the plan, the provider must be informed that the qualified beneficiary is eligible to make a COBRA election and is covered by the plan once the election is made. The provider may be informed that, if the election is not made timely, any coverage remaining in effect during the election period is subject to retroactive cancellation.

8. **The Small Employer Exception.** COBRA does not apply to a plan sponsored by an employer with fewer than 20 employees on at least 50% of its typical business days during the prior year. The total number of employees is determined on a common control basis and includes full-time and part-time employees and employees not covered under the plan. However, each part-time employee only has to be counted as a fraction of a full-time employee. Although self-employed persons, directors, and independent contractors are not included for purposes of this rule, they are entitled to COBRA coverage if the employer otherwise employs more than 20 employees. Employers with fewer than 20 employees can still be subject to COBRA if they participate in a multiple-employer plan under which another employer has more than 20 employees. Also, an employer cannot terminate COBRA coverage for existing qualified beneficiaries if the employer subsequently has fewer than 20 employees.

   Example: AB Company maintains two group health plans. One plan covers 100 rank and file employees and the other plan covers 15 executive employees. Since AB has more than 20 employees, both plans are subject to COBRA.

employer trust funds, investment managers and other plan fiduciaries.

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Example: During 1998, YZ Company employed 22 employees on at least 50% of its business days. Accordingly, qualified beneficiaries who incur a qualifying event during 1999 are entitled to COBRA coverage. Their COBRA rights would not be adversely affected if YZ typically employed less than 20 employees in 1999 or in 2000.

EFFECTIVE DATE AND PLANNING OPPORTUNITIES

The final regulations are effective for qualifying events which occur on or after January 1, 2000. Prior to that date, a good-faith compliance standard applies. For matters covered by the new proposed regulations, a good-faith standard also applies. Although complying with the proposed regulations will constitute good-faith compliance for IRS purposes, the proposed regulations are not binding in ERISA litigation with qualified beneficiaries.

To ensure compliance with the new regulations, employers should review their COBRA procedures, COBRA notices, and group health plans and summary plan descriptions, including health FSA plan documents and SPDs. Employers should also consider implementing new options permitted under the new rules that could help alleviate some of the complexities in COBRA administration. For example, many employers will want to take this opportunity to consider consolidating their group health plan benefits into one plan by adopting a wrap-around plan document. In addition to streamlining the COBRA notice and election process, this could also help to ensure that the plan document complies with ERISA requirements and contains eligibility requirements that are consistent with the employer's intent.

For more information on the new regulations, please contact the author of this article, Mark Bogart (312/6097878), any other member of the firm's Employee Benefits Group, or any Vedder Price attorney with whom you have worked. The names and telephone numbers of the Employee Benefits Group members are listed at the end of this Bulletin.

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