

COBRA – UPDATE

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Caveat: This outline is intended to only address the general principles governing COBRA continuation coverage. It is not intended to be a complete discussion of all cases or all regulatory or other guidance regarding COBRA continuation coverage. This outline should not be relied upon as legal advice. No person should take any action based upon the contents of this outline.

I. In General

A. Overview

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (enacted in 1986) amended the Internal Revenue Code of 1954 (which was subsequently amended and renamed the Internal Revenue Code of 1986), as amended (the "Code"), the Employee Retirement Income Security Act ("ERISA"), and the Public Health Service Act ("PHSA") to provide continuation of group health insurance coverage to individuals who, due to certain circumstances, may be left without insurance.¹ Group health plan coverage can be continued for persons who had coverage under a group health plan that is subject to COBRA, if the persons lost health plan coverage² due to certain events and they elect to continue coverage and make timely payments for coverage during the period it may be extended. Once a qualifying event occurs, the employer, or the employee in certain circumstances, must notify the plan administrator who must provide the employee and qualified beneficiaries losing coverage as the result of the qualifying event with a notice of their election rights and an opportunity to elect COBRA continuation coverage. The COBRA continuation coverage may continue for a limited period provided payments are made on a timely basis and the maximum period is not reached or another event ending COBRA coverage does not occur. The only group health plans of employers employing more than the minimum number of employees that can be exempt from COBRA requirements are church plans and Federal government plans.³ Federal government employees are covered by generally similar, but not parallel provisions enacted by the Federal Employees Health Benefits Amendments Act of 1988, 5 U.S.C. 8905a.⁴ COBRA gives qualified beneficiaries the right to elect to continue

¹ House Committee Report Legislative History P.L. 99-272.

² Loss of health plan coverage was further defined in Final Treas. Reg. § 54.4580B-4 Q/A 1(c) (1999) to include not only the total termination of coverage but also any elimination or reduction of coverage in anticipation of an event (e.g., employee terminating his/her spouse's coverage in anticipation of a divorce or legal separation) in which case the reduction or elimination in anticipation of the event is disregarded in determining whether the event caused a loss of coverage. Losing coverage is further defined as to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event and any increase in the premium or contribution that must be paid by a covered employee that results from the occurrence of a qualifying event is a loss of coverage. This interpretation of loss of coverage expands COBRA beyond that contemplated by the Senate Committee Report for P.L. 99-272 which specifically stated that the coverage could be modified by the employer if it was modified for similarly situated beneficiaries for whom a qualifying event had not occurred. Loss of coverage also includes any substantial elimination of coverage occurring within 12 months before or after the date the bankruptcy proceeding commences for a covered employee who retired on or before the date of the substantial elimination of coverage under Treas. Reg. § 54.4980B-4 Q/A 1 (1999).

³ Code § 4980B(d); ERISA § 4(b).

⁴ Treas. Reg. § 54.4980B-2 Q/A 4(d) (1999).

coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA beneficiaries.⁵

B. Effective Dates

Since COBRA was first enacted in 1986, effective for plan years beginning on or after July 1, 1986,⁶ its continuation coverage requirements have been amended on various occasions,⁷ most recently under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").⁸ The Final Regulations were issued in 1999 and 2001 and have different effective dates. The Final Regulations issued in 1999 ("Final Regulations I") apply generally to qualifying events occurring in plan years beginning on and after January 1, 2000. The Final Regulations issued on January 10, 2001 ("Final Regulations II") generally apply to qualifying events occurring on or after January 1, 2001, and to business reorganizations that are effective on or after January 1, 2002. For any period before the effective date of the Final Regulations I, the plan and employer must operate in a good faith compliance with the reasonable interpretation of the requirements of the COBRA statute. For any period prior to the effective date of the Final Regulations I, the IRS will treat operations as in "good faith compliance" if the plan or employer complies with the Proposed Regulations in Prop. Treas. Reg. § 1.162-26 (the A1987 Proposed Regulations") and Prop. Treas. Reg. § 54.4980B-1 (the A1998 Proposed Regulations") for those statutory requirements that are addressed in those regulations as long as those regulations are not inconsistent with any statutory amendments adopted after the date of the Proposed Regulations were issued, during the period when the amendment to the statute was effective, or with any decision of the United States Supreme Court that was released after the Proposed Regulations were issued. An employer should comply with the new Proposed Regulations under § 54.4980B-0, 1, 2, 3, 4, 5, 6, 7, 9 and 10 (the "1999 Proposed Regulations"), while the 1999 Proposed Regulations are not yet effective, compliance with them will still be considered good faith compliance with the reasonable interpretation of the statutory requirements addressed in those regulations until they are finalized. Any actions that are inconsistent with the terms of the 1999 Proposed Regulations are not necessarily indicative of a lack of good faith compliance with the reasonable interpretation of the statutory requirements, but the IRS will determine whether there was good faith compliance with the reasonable interpretation of the statute considering the facts and circumstances of each case.⁹ The Final Regulations II replace and finalize portions of the 1998 and 1999 Proposed Regulations.

⁵ Code § 4980B; ERISA § 602; 42 U.S.C. § 300bb. Treas. Reg. § 54.4980B-3 Q/A 3 (1999) defines similarly situated non-COBRA beneficiaries as the group of covered employees, spouses of covered employees or dependents of covered employees receiving coverage under a group health plan who are receiving that coverage for a reason other than under COBRA continuation coverage rights and who based on all facts and circumstances are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event.

⁶ P.L. 99-272 Single Employer Pension Plan Amendments Act, § 10002(a) special effective date rules applied to collectively bargained plans.

⁷ Changes affecting the COBRA continuation coverage provisions were made under the Omnibus Budget Reconciliation Act of 1986, the Tax Reform Act of 1986, the Technical and Miscellaneous Revenue Act of 1988, the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, the Small Business Job Protection Act of 1996, and the Health Insurance Portability and Accountability Act of 1996.

⁸ P.L. 104-191.

⁹ 64 Fed. Reg. § 5160, 5161 and Treas. Reg. § 54.4980B-1 Q/A 2 (1999).

C. Compliance Overview

COBRA has many technical requirements with which employers must comply. Even if an employer delegates responsibility of COBRA administration to outside administrators, there are certain tasks that the employer should perform. Employers should:

- Review the design and the initial implementation of COBRA compliance procedures including review of all COBRA notices, election forms and description in health plan documents and summary plan descriptions;
- Periodically review and update these procedures based on changes in the law or legal interpretations that affect COBRA compliance;
- Review and comment on COBRA compliance with respect to certain discreet events or transactions (e.g., corporate acquisitions and restructuring, severance or other special arrangements, and correction of COBRA violations);
- Audit any COBRA service providers services for compliance with contractual and legal requirements; and
- Review the calculation of COBRA premiums and procedures for monitoring COBRA premium payments and termination of COBRA coverage.

D. Compliance Using Third Parties to Satisfy COBRA

Employers should remember that even if they delegate the responsibility to perform some of the COBRA obligations, that the employer may still be liable for the excise tax in the event of a violation unless the employer has a legally enforceable written agreement with a third party delegating the responsibility to perform certain COBRA obligations to such third party administrator and the employer requests that such third party provide the coverage in writing and the third party provides coverage under the health plan for a similarly situated beneficiary who has not suffered a qualifying event. However, only the liability for the excise tax is shifted, not liability for providing the coverage.¹⁰

II. Applicability

A. Plans Subject to COBRA

COBRA applies to group health plans maintained by employers who had 20 or more employees on more than 50% of the business days in the prior calendar year, and those sponsored by state and local governments.

1. Definitions

- a. A group health plan is any plan maintained by an employer to provide medical care¹¹ to the employers' employees, former employees, or the

¹⁰ Code § 4980B(e).

¹¹ Medical care includes the diagnosis, cure, medication, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Medical care also includes transportation

families of such employees or former employees and to individuals who have an employment related connection to the employer or employee organization or to their families,¹² whether directly or through insurance,¹³ reimbursement, or otherwise, and regardless of whether provided through an on-site facility or through a cafeteria plan or other flexible benefit arrangement.¹⁴ Flexible benefit programs and cafeteria plans are addressed in the Final Regulations I which indicate that offering the benefits under a cafeteria plan does not cause the benefits to not be a group health plan and the COBRA requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that the qualified beneficiary was actually receiving on the day before the qualifying event.¹⁵

However, the Final Regulations II include limits on the application of COBRA for certain health flexible spending account plans if (1) the benefits provided under the health flexible spending account are excepted benefits under sections 9831 and 9832 of the Code (*i.e.*, reimbursement is limited to less than two times the salary reduction or, if greater, the salary reduction agreement plus \$500, provided other health coverage is available that is subject to HIPAA¹⁶); and (2) the maximum amount the health FSA can require to be paid for a year of COBRA equals or exceeds the maximum benefit available under the health FSA for the year. If the health FSA satisfies (1) and (2), then the health FSA does not need to make COBRA coverage available to the qualified beneficiary who experiences a qualifying event in the year. However, if all of the above are satisfied and if a qualified beneficiary as of the date of the qualifying event can become

primarily for and essential to medical care as described in the preceding sentence. However, medical care does not include anything that is merely beneficial to the general health of an individual such as a vacation. Thus, if an employer maintains a program that furthers general good health, but the program does not relate to the relief or the alleviation of health or medical problems and is generally accessible and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides medical care and so is not a group health plan for purposes of COBRA. Medical care or health care has the same meaning in COBRA as it has in section 213(d) of the Code. Treas. Reg. § 54.4980B-2 Q/A 1 (1999).

Medical benefits provided under the terms of the plan and available to COBRA beneficiaries may include:

- In-patient and out-patient hospital care;
- Physician care;
- Surgery and other major medical benefits;
- Prescription drugs; and
- Any other medical benefits, such as dental and vision care.

¹² Treas. Reg. § 54.4980B-2 Q/A 1(a) (1999).

¹³ Insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of medical care to two (2) or more employees. Prop. Treas. Reg. § 1.162-26 Q/A 7(a) (1987).

¹⁴ Code § 4980B(g)(2); ERISA § 607(1); 42 U.S.C. § 300bb-8(1); Treas. Reg. § 54.4980B-2 Q/A 1 (1999).

¹⁵ Treas. Reg. § 54.4980B-2 Q/A 8 (1999).

¹⁶ ERISA Technical Release 97-01.

entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for the COBRA coverage for the remainder of the plan year then the health FSA must offer COBRA coverage to the qualified beneficiary for the remainder of that plan year.¹⁷ This means that each individual's reimbursement to date of the qualifying event must be compared with their coverage election and then compared to the COBRA premiums due for the remainder of the plan year to determine if COBRA must be offered. In determining the benefit the qualified beneficiary may become entitled to under a health FSA after the qualifying event, the health FSA may deduct from the maximum benefit available any reimbursable claims submitted to the health FSA for the plan year before the date of the qualifying event.¹⁸ To the extent a health FSA is obligated to make COBRA coverage available to a qualified beneficiary, all the general COBRA continuation coverage rules apply in the same way the rules apply to coverage under other group health plans, including how plan limits on coverage apply to a person on COBRA.¹⁹

A group health plan is defined by section 5000(b)(1) of the Code to include "a plan contributed by an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, or others associated or formerly associated with the employer in a business relationship or their families."

- b. A plan "maintained by an employer" is any plan of, or contributed to, directly or indirectly by, an employer. Thus, a group health plan is a "maintained by an employer" regardless of whether the employer contributes to it, if coverage under the plan would not be available at the same cost to an employee in the event that he or she were not employed by the employer. If an employer or employee organization maintains a program that furthers general good health, but does not relate to the relief or alleviation of health or medical problems and it is generally accessible to and used by employees, without regard to their state of health, that program is not considered a program providing health care and consequently is not a group health plan. However, if the employer maintains a drug or alcohol treatment program or clinic, the facility or program is considered as providing health care and it would be a group health plan subject to COBRA.²⁰ Whether or not a benefit is excludable from the employee's income under Code § 132 does not impact whether or not it is a group health plan (e.g., a store providing a discount that can be used on its merchandise which includes drugs or eyeglasses).²¹ The Final Regulations I differ and state that if coverage under the same plan would not be available

¹⁷ Treas. Reg. § 54.4980B-2 Q/A 8 (2001).

¹⁸ Treas. Reg. § 54.4980B-2 Q/A 8(e) (2001).

¹⁹ Treas. Reg. § 54.4980B-2 Q/A 8(b) (2001).

²⁰ Treas. Reg. § 54.4980B-2 Q/A 1(b) (1999).

²¹ Treas. Reg. § 54.4980B-2 Q/A 1(c) (1999).

at the same cost to an individual without the employment related connection, then the coverage still constitutes a group health plan.²²

- c. There has been some confusion regarding whether a small employer's purchase of insurance or reimbursement of employees for the purchase of health insurance constitutes a group health plan subject to COBRA. In one case health insurance purchased by employees and reimbursed by the employer after 30 days of employment, provided the insurance was purchased from a certain insurer constituted a group health plan subject to COBRA.²³ However, other courts have not found that all employer purchased health insurance constitutes welfare benefit plans subject to ERISA.²⁴ The Final Regulations I clarify this issue by addressing whether the plan is maintained by the employer or employee organization. A plan is maintained by the employer if it is contributed to by the employer or if the coverage would not be available at the same cost to an individual but for the individual's employment related connections to the employer or employee organization.²⁵

2. Examples

The following types of group health plans are subject to COBRA:

- Insured and self-insured group health plans;
- HMOs;
- Employee assistance plans that provide benefits beyond just referral services such as counseling sessions²⁶;
- Dental plans;
- Vision plans;
- Retiree health plans;
- Employer reimbursed health insurance policies purchased to bridge to coverage under the Employer's group health plan;²⁷ however, the Final

²² Treas. Reg. § 54.4980B-2 Q/A 1(b) (1999).

²³ *Collins v. Strategic Health Care Management Services, Inc.*, 1992 U.S. Dist. LEXIS 6075, 1992 WL 92099 (N.D. Ill. 1992).

²⁴ *Taggart Corp. v. Life and Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981), *cf. Baker v. Bankers United Life Assurance Company*, 1991 U.S. Dist. LEXIS 8814, 1991 WL 121237 (E.D. La. 1991), *Collins v. Strategic Health Care Management Services, Inc.*, 1992 U.S. Dist. LEXIS 6075, 1992 WL 92099 (N.D. Ill. 1992), *Memorial Hospital System v. Northbrook Life Insurance Company*, 904 F.2d 236 (5th Cir. 1990).

²⁵ Treas. Reg. § 54.4980B-2 Q/A 1(a) (1999).

²⁶ DoL Adv. Ops. 83-35A, 88-04, 91-26A and 92-12A.

²⁷ *Burrill v. Leco Corporation*, 1998 U.S. Dist. LEXIS 8178 (W.D. Mich. 1998).

Regulations II indicate that one or more individual insurance policies in any arrangement that provides health care to two or more employees can constitute a group health plan in certain circumstances. A plan is maintained by the employer or an employee organization if the employer or employee organization contributes directly or indirectly to the plan;²⁸

- Health flexible spending accounts. The provision of medical care in a cafeteria plan or other flexible benefit arrangement constitutes a group health plan;²⁹ and
- Employer discount programs maintained by health care clinics so that the program is utilized exclusively by employees with health or medical needs.³⁰

The group health plans subject to COBRA differ from the group health plans subject to the Health Insurance Portability and Accountability Act of 1996 because certain group health plans providing limited scope benefits are exempted from HIPAA but are still subject to COBRA. HIPAA also applies to any group health plan covering two or more current employees; thus it applies to more group health plans than those subject to COBRA.

The following types of plans are not group health plans subject to COBRA:

- Plans under which substantially all of the coverage provided is for qualified long-term care services as defined in Code § 7702B(c)³¹;
- Amounts contributed by an employer to a medical savings account³²; and
- Plans providing life or accidental death and dismemberment benefits.³³
- On site clinics but only if the medical care provided at the clinic is primary first aid for injuries and illnesses incurred during working hours, the clinic is only available to the employer's current employees, and the employee is not charged.³⁴

²⁸ Treas. Reg. § 54.4980B-2 Q/A 1(a) (2001).

²⁹ COBRA continuation coverage requirements only applied to those medical benefits under the cafeteria plan or other arrangement that a covered employee has actually chosen to receive (if any). Prop. Treas. Reg. § 1.162-26 Q/A 14 (1987); however, see the discussion in II.A.1.a. above regarding the position taken by the 1999 Proposed Regulations and the Final Regulations I for differing positions.

³⁰ Treas. Reg. § 54.4980B-2 Q/A 1(c) (1999).

³¹ Code § 4980B; Treas. Reg. § 54.4980B-2 Q/A 1(e) (1999).

³² Code § 106(b)(5); Treas. Reg. § 54.4980B-2 Q/A 1(f) (1999).

³³ *Jefferson v. Reliance Standard Life Ins. Co.*, 818 F. Supp. 1523 (M.D. Fla. 1993), *rev'd without op., remanded*, 85 F.3d 642 (11th Cir. 1996). Life insurance and accidental death and dismemberment insurance are not covered under COBRA, even if they are offered in conjunction with a plan offering medical care. *Id.*

³⁴ Treas. Reg. § 54.4980B-2 Q/A 1(d) (1999).

- Plans providing disability insurance benefits.³⁵

3. Exceptions

The following group health plans are excepted from COBRA.³⁶

- Small employer plans (as defined in II.B. below)³⁷
- Certain church plans³⁸
- Plans sponsored by the federal government³⁹

4. Retiree Plans

The definition of "group health plans" under the Code, ERISA and the PHSa cover plans that provide medical care to employees or former employees directly or through insurance, reimbursement or otherwise.⁴⁰ Retiree plans can also be clearly covered by the definition of "covered employee" in the regulations.⁴¹

5. Non-Medical Plans

COBRA does not apply to disability income plans.⁴² COBRA does not apply to life insurance or other benefits such as accidental death and dismemberment policies offered in conjunction with a plan offering medical care.⁴³

6. Health Flexible Spending Accounts

A flexible spending account that reimburses health care expenses for employees is covered by COBRA.⁴⁴

³⁵ *Austell v. Raymond James & Associates, Incorporated*, 120 F.3d 32 (4th Cir. 1997).

³⁶ *See* Code § 106(b)(2); Treas. Reg. § 54.4980B-2 Q/A 4(b) (1999).

³⁷ A "small-employer plan" is a group health plan maintained by one or more employers where each of the employers maintaining the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. For purposes of this definition, each employer maintaining the plan shall, in combination with all other entities under common control with that employer, be considered a single employer. Treas. Reg. § 54.4980B-2 Q/A 2 (1999). However, a small employer plan may be subject to COBRA with respect to a qualified beneficiary who experienced a qualifying event when the plan was subject to COBRA. Treas. Reg. § 54.4980B-2 Q/A 4(c) (1999).

³⁸ Church plans must meet the requirements of Code § 414(e) to be a church plan that is exempt from COBRA's requirements.

³⁹ Such plans must meet the requirement of Code § 414(d) and be exempt under 42 U.S.C. § 300bb-1(c). However, similar provisions were enacted for Federally sponsored plans for employees in the Federal Employees Health Benefits Amendments Act of 1988, 5 U.S.C. 8905a.

⁴⁰ Code § 4980B(g)(2); ERISA § 607(1); PHSa § 300bb-8(1).

⁴¹ Treas. Reg. § 54.4980B-3 Q/A 2(b) (1999).

⁴² *Austell v. Raymond James & Associates, Incorporated*, 120 F.3d 32, 1997 U.S. App. LEXIS 18208 (4th Cir. 1997); *Lauder v. First Unum Life Insurance Company*, 55 F. Supp.2d 269 (S.D.N.Y. 1999).

⁴³ *Jefferson v. Reliance Standard Life Insurance Company*, 818 F. Supp. 1523 (M.D. Fla. 1993).

7. Long Term Care and Medical Savings Accounts

Long term care insurance and medical savings accounts are exempted from COBRA.⁴⁵

8. Number of Group Health Plans Maintained

The number of group health plans is determined by the instruments governing the arrangement or arrangements and the operation of the plan or plans.⁴⁶ A multiemployer plan and a non-multiemployer plan are always separate plans.⁴⁷

If the plan's governing instruments do not make it clear whether the benefits are provided under one plan or more than one plan or if there is no governing instruments, then all of the health care benefits (other than qualified long term care benefits under Code § 7702B(c)) that are provided by a partnership, corporation, other entity or trade or business or by an employee organization are one group health plan.⁴⁸

However, if a principal purpose of establishing separate plans is to evade any requirement of the law, then the separate plans are treated as one plan.⁴⁹

If two benefits such as major medical and prescription coverage are treated as one benefit plan, the employer must offer the qualified beneficiary the option to elect both together or neither; however, if the same two benefits were separate plans, the employer would have to permit a qualified beneficiary who had a qualifying event for both plans to elect both, either or no coverage.⁵⁰

B. Employers

1. Small Employer Defined - 20 Employee Application Threshold

a. Non-Multiemployer

COBRA applies to employers (other than employers in a multiemployer plan) with 20 or more employees on at least 50 percent of the typical business days in the prior calendar year.⁵¹ The term "employees" includes

⁴⁴ Treas. Reg. § 54.4980B-2 Q/A 8 (2001).

⁴⁵ Treas. Reg. § 54.4980B-2 Q/A 1(e) and (f) (1999).

⁴⁶ Treas. Reg. § 54.4980B-2 Q/A 6(a) (2001).

⁴⁷ Treas. Reg. § 54.4980B-2 Q/A 6 (2001).

⁴⁸ Treas. Reg. § 54.4980B-2 Q/A 6(b) (2001).

⁴⁹ Treas. Reg. § 54.4980B-2 Q/A 6(c) (2001).

⁵⁰ Treas. Reg. § 54.4980B-2 Q/A 6(d), Ex. 1 (2001).

⁵¹ Code § 4980B(d)(1); ERISA § 601(b); 42 U.S.C. § 300bb-1(b)(1); Treas. Reg. § 54.4980B-2 Q/A 5 (1999) and Treas. Reg. § 54.4980B-2 Q/A 5(a) and (b) (1999). Church plans are exempted from the provisions in the Code and ERISA and the provisions in the PHSA only apply to plans maintained by a state, any political subdivision of a state or

all full-time and part-time employees, as well as self-employed individuals.⁵² For this purpose, "employees" also includes agents, independent contractors and directors, but these types of individuals are excluded under the Final Regulations I.⁵³ The Final Regulations II indicate that full-time employees are counted as one employee and part-time employees are counted as fractional employees by hours worked by each on a typical business day.⁵⁴ The Final Regulations I counted each individual regardless of the number of hours worked.⁵⁵ All employees of the employer are counted in determining whether the 20 employee threshold is met, including self-employed, full-time and part-time employees under the 1987 Proposed Regulations. However, under the Final Regulations II all of these individuals are not counted in determining whether the 20 employee threshold is satisfied because self employed persons are not counted and part-time employees are counted pro rata based upon the number of hours they work compared to full-time hours worked on a typical business day.⁵⁶ Family relationships among employees does not change whether the individuals are counted as employees.⁵⁷ Agents and independent contractors and corporate directors are all counted as employees if they are covered by the plan under the 1987 Proposed Regulations. However, under the Final Regulations I these individuals are not counted in determining whether the 20 employee threshold is satisfied.⁵⁸ Note there may be additional tax issues that arise from permitting non-employees to participate in a group health plan, depending upon the type of plan funding and how it is offered to the employees and the non-employees.

If an employer ceases to become subject to COBRA because it no longer employs at least 20 employees, it must nevertheless continue to provide

by an agency or instrumentality of a state if the state receives funds under the PHS. Code § 4980B(d); ERISA § 601(b); PHS § 300bb-1(a). See *Martinez v. Dodge Printing Centers, Inc.*, 13 EBC 1348 (D.C. Colo. 1991) and *Silver v. I. Goldberg & Partners, Inc.*, ___ F. Supp. ___, 1994 U.S. Dis. LEXIS 10228 (S.D.N.Y. 1994).

⁵² All full-time and pro rata part-time common law employees of the employer must be counted; however, self-employed individuals, independent contractors and directors are not counted as employees for purposes of determining the 20 employee threshold. Treas. Reg. § 54.4980B-2 Q/A 5(d) (2001). This differs from the 1987 Proposed Regulations. Self employed persons would include partners in a law firm for purposes of determining if COBRA applies. Prop. Treas. Reg. § 1.162-26 Q/A 9(c) (1987).

⁵³ Cf. Treas. Reg. § 54.4980B-2 Q/A 5(d) (2001) with Prop. Treas. Reg. § 1.162-26 Q/A 9(c) (1987).

⁵⁴ Treas. Reg. § 54.4980B-2 Q/A 5(d) and (e) (2001). A Puerto Rican court did not follow this Proposed Regulation and used the one person one employee counting method and required the employer to prove it was entitled to the exception. The court further stated that it will assume that each person on the quarterly payroll records was employed on each business day of the quarter unless there is contrary evidence. *Cotte v. Cooperativa De Ahorro Y Credito Yabucoena*, 1999 U.S. Dist. LEXIS 16811 (D. P.R. 1999).

⁵⁵ Treas. Reg. § 54.4980B-2 Q/A 5(c) (1999).

⁵⁶ Treas. Reg. § 54.4980B-2 Q/A 5(c), (d) and (e) (2001).

⁵⁷ *Jiminez v. Mueblerias Delgado, Inc.*, 2002 U.S. Dist. LEXIS 7126 (D.C.P.R. 2002).

⁵⁸ Treas. Reg. § 54.4980B-2 Q/A 5(c) (1999).

COBRA benefits to qualified beneficiaries whose qualifying events occurred during a year in which the employer was subject to COBRA.⁵⁹

b. Multiemployers

In the case of a multiemployer plan, a small employer plan is a group health plan under which each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year.⁶⁰

If a multiemployer plan ceases to be a small employer plan because it adds an employer that did not normally employ fewer than 20 employees on a typical business day in the preceding calendar year, the multiemployer plan ceases to be excepted from COBRA immediately upon the addition of the new employer; however, if the plan ceases to be a small employer plan because the work force of one of the employers increases, the plan ceases to be exempt from COBRA on the next following January 1.⁶¹

2. Definition of Employer

The employer is defined as a person for whom services are performed and any other person that is a member of the controlled group or affiliated service group that includes the person receiving the services. The employer also includes any "successor" employer as defined above.⁶² The Final Regulations II expand the definition of successor to include the above and any successor if it results from a consolidation, merger or similar restructuring of the employer or if it is a mere continuation of the employer.⁶³ See X. for a further discussion of COBRA in mergers and acquisitions as described in the Final Regulations II. The employer includes all members of the controlled group, the affiliated service group and leased employees providing services to a member of the controlled group.⁶⁴ If an employee ceases to employ at least 20 employees, the employer must continue to provide COBRA to qualified beneficiaries who had qualifying events during a year when the employer was subject to COBRA.⁶⁵

3. Plan Year

The plan year is the year designated as the plan year in the plan documents. If the plan documents do not designate a plan year, then it is determined as follows:

⁵⁹ See Omnibus Budget Reconciliation Act of 1990 and Code § 4980B(d)(1); ERISA § 601(b); PHS § 300bb-1(b)(1) and Treas. Reg. § 54.4980B-2 Q/A 5(g) (1999).

⁶⁰ Treas. Reg. § 54.4980B-2 Q/A 5(a) (1999). See also Treas. Reg. § 54.4980B-2 Q/A 6(f) (2001).

⁶¹ Treas. Reg. § 54.4980B-2 Q/A 5(f) (2001).

⁶² Treas. Reg. § 54.4980B-2 Q/A 2 (2001).

⁶³ Treas. Reg. § 54.4980B-2 Q/A 2 (2001).

⁶⁴ Code § 414(b), (c), (m), (o), and (t)(2); ERISA § 607(4); Treas. Reg. § 54.4980B-2 Q/A 2(b) (2001).

⁶⁵ Code § 4980B(d)(1); ERISA § 601(b); 42 U.S.C. § 300bb-1(b)(1); Treas. Reg. § 54.4980B-2 Q/A 5(g) (1999).

- a. the plan year is the deductible or limit year used under the plan;
- b. if the plan does not impose limits or deductibles on an annual basis, then the policy year;
- c. if the plan does not impose limits or deductibles on an annual basis and either is not insured or does not have a policy renewal on an annual basis, then the plan year is the employer's tax year.⁶⁶

4. Multiple Employer Welfare Associations

The statutory provision is unclear if it applies to a multiple employer groups covered by one plan⁶⁷ (which would make the entire plan subject to COBRA even if some employers did not have 20 employees) or if it only applies to the employer with 20 or more employees in the group. See II.B.2.b. above for a discussion of the Final Regulations II provisions on multiemployers and the small group exemption; however, this does not address multiple employer welfare associations.⁶⁸

In a recent case a group of related entities provided health benefits through one health plan. The entities had some common owners but not sufficient commonality of ownership to constitute a controlled group that covered all of the entities. Thus, the health plan was a multiple employer welfare association. The common owner sold one of the entities and the new owner terminated the employee in question two days after acquiring the clinic, but while the health benefits were still provided out of the MEWA. Only oral representations that coverage could be continued were provided. The former employee sued the former owner. The former owner had obtained the group policy in his own name. While the defendant argued that each clinic must be considered separately for COBRA purposes, the district court determined that they should be considered a single employer by relying on 29 U.S.C. § 1002(40)(B).⁶⁹

5. Multiemployer Plans

The sponsor of a multiemployer plan is considered to be the joint board of trustees operating the plan and the plan.⁷⁰ The joint board of trustees operating the plan and the plan are responsible for COBRA coverage requirements, not the employer.⁷¹ The excise tax is imposed on the plan for any violations.⁷² A multiemployer plan is a plan to which more than one employer is required to contribute, that is maintained

⁶⁶ Treas. Reg. § 54.4980B-2 Q/A 7 (1999).

⁶⁷ Code § 4980B(e)(1).

⁶⁸ See Treas. Reg. § 54.4980B-2 Q/A 5 (2001); *Johnson v. Reserve Life Ins. Co.*, 765 F. Supp. 1478 (C.D. Cal. 1991).

⁶⁹ *McDowell v. Krawchinson*, 125 F.3d 954 (6th Cir. 1997), 21 EBC 1689, see footnote 8.

⁷⁰ Code § 4980B(c)(4)(B)(i).

⁷¹ *In Matter of Appletree Markets, Inc.*, 19 F.3d 969 (5th Cir. 1994).

⁷² Treas. Reg. § 54.4980B-2 Q/A 10 (1999).

pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer and provided it satisfies other requirements in regulations issued by the Secretary of Labor.⁷³ Whether a multiemployer plan is subject to COBRA can be determined based on which employers are contributing to the multiemployer plan on the day on which the qualifying event occurs based upon the work force of those employers contributing to the plan in the prior calendar year.⁷⁴ If one employer contributing fails the less than 20 employee test, the entire multiemployer plan fails.⁷⁵

C. Covered Employees

COBRA protects covered employees or their covered dependents who would lose group health plan coverage as the result of a qualifying event by giving these protected persons the right to elect to continue coverage. A covered employee is any individual who is or was provided coverage under a group health plan by virtue of having been an employee who performed services for the employer maintaining the plan or by virtue of membership in the employee organization maintaining the plan, including the following persons if their relationship makes them eligible for coverage: self employed individuals, independent contractors and their employees and dependents and directors.⁷⁶ However, only employees provided coverage are covered employees.⁷⁷ An individual who is merely *eligible* for coverage under a group health plan is not a covered employee if the individual is not and has not actually been covered under the plan. The reason for an individual's lack of actual coverage is not relevant. However, in situations where an individual is not covered (because he/she was denied or not offered coverage under circumstances in which the denial or failure to offer coverage constituted a violation of applicable law (e.g., in violation of HIPAA or the Americans with Disabilities Act), then that employee or former employee will be considered to have had the coverage that was wrongfully denied or not offered.⁷⁸ A former employee is not a covered employee if there was no coverage at his qualifying event even if the employer could have reinstated the coverage by paying the past due premiums for the plan.⁷⁹ In a case where the employer missed a number of premium payments before filing bankruptcy, the bankruptcy stay did not alter the prior coverage termination and neither the employer nor the participants had any rights under COBRA because the failure to pay the premiums terminated the plan's coverage.⁸⁰

Agents, independent contractors, and directors can also be employees if they are (or were) actually covered under a group health plan by virtue of their relationship to an employer

⁷³ Treas. Reg. § 54.4980B-2 Q/A 3 (2001).

⁷⁴ Treas. Reg. § 54.4980B-2 Q/A 5(f) (2001).

⁷⁵ Treas. Reg. § 54.4980B-2 Q/A 5(f) (2001).

⁷⁶ Treas. Reg. § 54.4980B-3 Q/A 2 (1999).

⁷⁷ Treas. Reg. § 54.4980B-3 Q/A 2(a) and (b) (1999); *Walker v. Doctors Hospital of Hyde Park*, 110 F. Supp.2d 704 (N.D. Ill. 2000).

⁷⁸ Treas. Reg. § 54.4980B-3 Q/A 2(b) (1999).

⁷⁹ *Martinez v. District 119J National Union of Hospital and Health Care Employees, AFS CME, AFL-CIO*, 2003 U.S. Dist. LEXIS 15605 (D. N.J. 2003).

⁸⁰ *In re Management Limited Partnership*, 2003 Bank. LEXIS 1659 (Bankr. C.D. Ill. 2003).

maintaining the plan and if that plan or some other group health plan maintained by the employer covers one or more common-law employees of the employer.⁸¹

III. Qualifying for COBRA Continuation Coverage

A. Qualified Beneficiaries

Individuals entitled to elect and receive COBRA continuation coverage are called "qualified beneficiaries." Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee.⁸² The Final Regulations I expanded the definition of qualified beneficiary to include any individual who on the day before the qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee or the spouse or dependent child of a coverage employee or any child who is born to or placed for adoption with a covered employee during the COBRA continuation coverage period.⁸³

In order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before a qualifying event that causes a loss of coverage.⁸⁴ The Final Regulations I clarified that the reason for the individual's lack of coverage is not relevant for purposes of determining if the individual is a qualified beneficiary, unless the reason is the individual was denied or not offered coverage was in violation of applicable laws (e.g., HIPAA or the Americans with Disabilities Act). If the individual was not covered because they previously were denied or not offered coverage due in violation of the law, then the individual is treated as having had the coverage that was wrongfully denied.⁸⁵ However, a child who is born to the covered employee, who is placed for adoption with the covered employee or who is adopted by a covered employee during a period of COBRA continuation coverage is also a qualified beneficiary.⁸⁶ In order for a child to be defined as placed for adoption requires the assumption and retention by the covered employee of a legal obligation for partial or total support and when this obligation ends so does the placement for adoption.⁸⁷

A covered employee can be a qualified beneficiary only in connection with a qualifying event that is a reduction in hours or termination of the covered employee's employment or the bankruptcy of the employer.⁸⁸

An individual is not a qualified beneficiary under any of the following circumstances:

⁸¹ Treas. Reg. § 54.4980B-3 Q/A 2(a) (1999).

⁸² Treas. Reg. § 54.4980B-3 Q/A 1(a) (1999).

⁸³ Treas. Reg. § 54.4980B-3 Q/A 1(a) (1999).

⁸⁴ Treas. Reg. § 54.4980B-3 Q/A 1(a)(3) (1999).

⁸⁵ Treas. Reg. § 54.4980B-3 Q/A 1(a)(3) (1999).

⁸⁶ Code § 4980B(g)(1), ERISA § 607(3), and 42 U.S.C. § 300bb-8(3). This new statutory provision was added by HIPAA and became effective on January 1, 1997; Treas. Reg. § 54.4980B-3 Q/A 1(a)(ii) (1999).

⁸⁷ Treas. Reg. § 54.4980B-3 Q/A 1(g) (1999).

⁸⁸ Treas. Reg. § 54.4980B-3 Q/A 1(d) (1999).

- An individual stops being a qualified beneficiary at the end of the election period if they do not elect COBRA during such period.⁸⁹
- The 1987 proposed regulations attempt to define who is and who is not a qualified beneficiary with the following: "On the day before the qualifying event, the individual is covered under the group health plan by reason of another individual's election of COBRA continuation coverage and is not already a qualified beneficiary by reason of a prior qualifying event or is entitled to Medicare benefits under Title XVIII of the Social Security Act."⁹⁰ This previously referred to a dependent who is born while the former employee was on COBRA before the enactment of HIPAA which made dependents born to persons on COBRA qualified beneficiaries.
- The individual is not a qualified beneficiary if on the day before the qualifying event the individual is covered under the group health plan by virtue of another person's COBRA coverage and that individual is not already a qualified beneficiary by reason of the prior qualifying event. (For example, if a covered employee and spouse lose coverage due to a reduction in hours and only the covered employee elects COBRA initially. At the next open enrollment the covered employee adds the spouse who previously declined COBRA coverage. The spouse is now covered by virtue of the covered employee's COBRA election, but the spouse will not be a qualified beneficiary after declining COBRA coverage.)⁹¹
- The individual is first entitled to Medicare benefits after electing COBRA coverage; thus terminating his COBRA coverage.⁹²
- The individual's status as a covered employee is attributable to a period in which the individual was a non-resident alien who received no earned income from the individual's employer that constituted income from sources within the United States. Accordingly, the spouse or dependent child of that individual would not be considered a qualified beneficiary by virtue of the relationship to the individual.⁹³
- An individual who was only a covered employee when they were a nonresident alien with no U.S. source income is not a qualified beneficiary.⁹⁴
- An individual who marries a qualified beneficiary after the date of the qualifying event and any newborn or adopted child (other than one born to or placed for adoption with a covered employee) are not qualified beneficiaries by virtue of the marriage, birth or placement for adoption or by virtue of the individual's status as a dependent of a qualified beneficiary, even if they become covered under the plan.⁹⁵

⁸⁹ Treas. Reg. § 54.4980B-3 Q/A 1(f) (1999).

⁹⁰ Prop. Treas. Reg. § 1.162-26 Q/A 15(b) (1987).

⁹¹ Treas. Reg. § 54.4980B-3 Q/A 1(c); see also examples 1-5 (1999).

⁹² Code § 4980B(f)(2)(B)(v); ERISA § 602(2)(A)(v); 42 U.S.C. § 300bb-2(2)(A)(ii).

⁹³ Code § 4980B(g)(1)(C); Treas. Reg. § 54.4980B-3 Q/A 1(e) (1999).

⁹⁴ Treas. Reg. § 54.4980B-3 Q/A 1(e) (1999).

⁹⁵ Treas. Reg. § 54.4980B-3 Q/A 1(b) (1999).

B. Qualifying Event

COBRA continuation coverage is available upon loss of coverage due to a qualifying event.⁹⁶ "Qualifying events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage while the plan is subject to COBRA.⁹⁷ Losing coverage means to cease to be covered under the plan under the same terms and conditions as were in effect immediately before the qualifying event, including any increase in premium or contribution that must be paid by a covered employee that results in one of the events listed in III.B.1. through 3. below.⁹⁸ If the qualifying event is the bankruptcy of the employer, then a loss of coverage occurs if there is any substantial elimination of coverage under the plan occurring within 12 months before or after the bankruptcy proceeding began for a covered employee who retired on or before the date of the substantial elimination of group health plan coverage or for any spouse or dependent child of such covered employee if on the day before the bankruptcy qualifying event, the spouse or dependent child is a beneficiary under the plan.⁹⁹ If coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event caused a loss in coverage.¹⁰⁰ The qualifying event must occur while the plan is subject to COBRA.¹⁰¹ One court indicated that if a qualifying event occurs before the plan is subject to COBRA, a second qualifying event occurring within 18 months of the date the plan became subject to COBRA could trigger COBRA for such qualified beneficiary. However, the facts presented did not have the second qualifying event occurring within 18 months, thus no COBRA obligation existed.¹⁰² A plan, at its discretion, may provide longer periods of continuation coverage. If there is a loss of coverage in anticipation of a qualifying event (e.g., an employee terminates his spouse's coverage in anticipation of a divorce or legal separation), the plan must disregard the reduction or elimination of coverage in anticipation of the event in determining whether the event caused the loss of coverage.¹⁰³ A loss of coverage seven months after the qualifying event of termination of employment was not a qualifying event because it did not trigger the loss of coverage.¹⁰⁴

⁹⁶ If loss of coverage does not immediately follow the qualifying event, the plan can elect to treat the loss of coverage as the qualifying event. In that case, the applicable period of coverage runs from the cessation of regular coverage as evidenced by the giving of the notice based upon the date coverage is lost rather than measured from the date of the original qualifying event. Code § 4980B(f)(8); ERISA § 607(5). A loss of coverage for any reason that is not one of the defined qualifying events does not result in COBRA entitlement.

⁹⁷ Treas. Reg. § 54.4980B-4 Q/A 1 (1999).

⁹⁸ Treas. Reg. § 54.4980B-4 Q/A 1(c) (1999).

⁹⁹ Treas. Reg. § 54.4980B-4 Q/A 1(c) (1999).

¹⁰⁰ Treas. Reg. § 54.4980B-4 Q/A 1(c) (1999); See also VI, A, 2, c, i with respect to divorce as a qualifying event.

¹⁰¹ Treas. Reg. § 54.4980B-4 Q/A 1(d) (1999).

¹⁰² *Fritz v. Health and Welfare Department of the Construction and General Laborers*, District Council of Chicago and Vicinity, 2001 U.S. Dist. LEXIS 25173 (D.N.D. Ill. 2001).

¹⁰³ Treas. Reg. § 54.4980B-4 Q/A 1(c) (1999); See also VI, A, 2, c, i with respect to divorce as a qualifying event.

¹⁰⁴ *Wilcox v. National Distributors, Inc.*, 2001 U.S. Dist. LEXIS 11413 (D.Me. 2001).

1. For Employees

The types of qualifying events for employees are:

- Voluntary or involuntary termination¹⁰⁵ other than by reason of gross misconduct¹⁰⁶;
- Reduction in hours, including a strike or walkout,¹⁰⁷ this includes any decrease in the hours the employee is required to work or actually works as long as the decrease is not accompanied by an immediate termination of employment¹⁰⁸; and
- Notifying the employer that the employee will not return to work from a Family and Medical Leave Act leave of absence.¹⁰⁹

The following have been held by courts to *not* constitute qualifying events:

- Medical leave of absence¹¹⁰;
- Failure to pay health care premiums¹¹¹; and
- Commencement of a Family and Medical Leave Act leave of absence.¹¹²

While the statute lists entitlement to Medicare as a qualifying event the Medicare Secondary Payer provisions¹¹³ prohibit a group health plan from discriminating or

¹⁰⁵ A termination that required the participant to take an action to continue coverage rather than automatically continuing coverage is still a qualifying event because the retiring employee was required to take any action to continue coverage. *Mansfield v. Chicago Park District Group Plan*, 997 F. Supp. 1053 (N.D. Ill. 1998) and *Fenner v. Favorite Brands International, Inc.*, 25 F. Supp.2d 870, 1998 U.S. Dist. LEXIS 17922 (N.D. Ill. 1998); Treas. Reg. § 54.4980B-4 Q/A 2 (1999) clarifies that facts surrounding a termination are irrelevant unless they are facts constituting gross misconduct; *Frank v. Ameritech Corporation*, 1999 U.S. Dist. LEXIS 17236 (N.D. Ill. 1999) further states that the voluntary v. involuntary nature of the employment termination does not effect the COBRA obligation.

¹⁰⁶ A termination of a flight attendant for throwing an apple and yelling a racial epithet at another employee in front of passengers was gross misconduct. *Nebraska v. Continental Airlines*, 2001 U.S. Dist. LEXIS 20784 (S.D. Tex. 2001).

¹⁰⁷ Treas. Reg. § 54.4980B-4 Q/A 1(b)(2) (1999); *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1993); *Communications Workers of America v. Nynex Corp.*, 898 F.2d 887 (2d Cir. 1990).

¹⁰⁸ Treas. Reg. § 54.4980B-4 Q/A 1(a) (1999).

¹⁰⁹ IRS Notice 94-103 Q/A 1, IRB 1994-51.

¹¹⁰ *Shade v. Panhandle Motor Serv. Corp.*, No. 95-1129, 1996 U.S. App. LEXIS 16703 (4th Cir. 1996). Likewise, the termination of coverage of an employee on medical leave for failure to pay her share of the premium does not constitute a qualifying event giving the employee COBRA rights. *Aguilera v. Landmark Hotel-Metairie*, 1992 WL 396842 (E.D. La. 1992). Note this decision predates the Family and Medical Leave Act of 1993 and the issuance of IRS Notice 94-103, I.R.B. 1994-51.

¹¹¹ *Aguilera v. Landmark Hotel-Metairie*, Civ. A. No. 92-1815, 1992 WL 396842 (E.D. La. 1992), 16 EBC 1466.

¹¹² IRS Notice 94-103 Q/A 1, IRB 1994-51; Treas. Reg. § 54.4980B-10 Q/A 1(a) (2001).

¹¹³ Code § 5000(b)(1) and 42 U.S.C. § 1395y(b).

denying coverage based upon (1) the employee's or spouse's eligibility for Medicare based upon attaining age 65 if the employer had at least 20 employees on each working day in each of 20 calendar weeks in the current calendar year or preceding year, (2) an individual becoming disabled if the plan is maintained by an employer that employed at least 100 employees on 50% or more of its regular business days during the prior calendar year or (3) an individual's diagnosis with end-stage renal disease for the first 30 months following Medicare entitlement or when the individual first would have been entitled if he/she had applied for benefits. Thus coverage cannot generally be terminated by the employer as the result of the employee becoming entitled to Medicare. An individual who ceased to be an employee covered by a union plan when he became the owner-operator of the funeral home and ineligible for the union plan since he was not an employee did not have a qualifying event and was not entitled to a COBRA notice.¹¹⁴

2. For Spouses

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;
- Death of the covered employee¹¹⁵;
- Divorce or legal separation from covered employee¹¹⁶; and
- Commencement of the covered employee's entitlement to Medicare coverage (assuming the covered employee voluntarily elects to drop group health plan coverage in favor of Medicare coverage resulting in the covered employee's dependents losing coverage).

3. For Dependent Children

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

- Loss of dependent children status under the plan rules.¹¹⁷

¹¹⁴ *Williams v. Teamsters Local Union No. 727*, 2003 U.S. Dist. LEXIS 18906 (N.D. Ill. 2003).

¹¹⁵ See Treas. Reg. § 54.4980B-4 Q/A 1(g) Ex. 4 (1999) showing that death of the covered employee gives rise to COBRA for the covered spouse and dependent children of the covered employee.

¹¹⁶ A foreign divorce decree that was set aside as null and void in the U.S. was a qualifying event and thus there was a COBRA obligation. The notice requirement was triggered by the employee's notice to the employer that he was divorced. The mere fact the divorce decree was set aside in New York did not mean it was not valid in some jurisdiction. *Phillips v. Saratoga Harness Racing, Inc.*, 240 F.3d 174, 2001 U.S. App. LEXIS 2426 (2d Cir. 2001).

¹¹⁷ Code § 4980B(f)(3)(E); ERISA § 603(5); 42 U.S.C. § 300bb-3(5).

The qualifying event for a child born to or placed for adoption with a qualified beneficiary during a period of COBRA coverage is the event that gave rise to the COBRA coverage period during which the child was born or placed for adoption and if a second qualifying event occurs before the child's birth or placement, it too applies to the child.¹¹⁸

4. Special Multiemployer Plan Rules

Cessation of contributions to a multiemployer plan by an employer alone is not a qualifying event even though it may cause current employees to lose coverage; however, if that cessation coincides with a qualifying event (such as a reduction in hours due to a strike) it would constitute a qualifying event.¹¹⁹ If an employer stops contributing to a multiemployer plan, the multiemployer plan generally must make COBRA coverage available to a qualified beneficiary who was receiving coverage under that plan on the day prior to the cessation of contributions and who is or whose qualifying event occurred in connection with a covered employee whose last employment prior to the qualifying event was with the employer who stopped contributing.¹²⁰ If the employer who stopped contributing to the multiemployer plan established one or more group health plans (or starts contributing to another multiemployer plan providing group health benefits) covering a significant number of the employer's employees covered by the former under the prior multiemployer plan, then the plan established by the employer must make COBRA coverage available to any qualified beneficiary who was covered under the multiemployer plan on the day before the contributions ceased and who is or whose qualifying event occurred in connection with a covered employee whose last employment prior to the qualifying event was with the employer.¹²¹ The Final Regulations II do not define or give any example of what constitutes a "significant number."

5. Timing of Coverage Termination

The mere fact that coverage termination occurs at a later date does not negate the occurrence of the qualifying event, but instead it delays the occurrence of the qualifying event until the loss of coverage is effective.¹²² The statutory provision indicates that the plan may provide that the COBRA coverage will commence at the later loss of coverage and the notification period will commence at the same time.¹²³ The Final Regulations II follow the statute by providing that the maximum coverage period is only extended by the delay in the loss of coverage if the plan provides for the extension of the required periods to be measured from the loss of coverage, provided both of the following:

¹¹⁸ Treas. Reg. § 54.4980B-4 Q/A 1(f) (1999).

¹¹⁹ Treas. Reg. § 54.4980B-9 Q/A 9 (2001).

¹²⁰ Treas. Reg. § 54.4980B-9 Q/A 10 (2001).

¹²¹ Treas. Reg. § 54.4980B-9 Q/A 10 (2001) which differs from the holding *In re Appletree Markets, Inc.*, 19 F.3d 969 (5th Cir. 1994).

¹²² Treas. Reg. § 54.4980B-4 Q/A 1(g) Ex. 1 (1999).

¹²³ Code § 4980B(f)(8).

- a. the 30-day notice period (during which the employer is required to notify the plan administrator of the occurrence of certain qualifying events) begins on the date of the loss of coverage rather than on the qualifying event; and
- b. the end of the maximum coverage period is measured from the loss of coverage rather than the date of the qualifying event.¹²⁴

The delay in the loss of coverage is found in an additional example to arise when retirees not offered COBRA because they were provided identical retiree coverage at retirement and the retiree coverage is subsequently eliminated, with the delay triggering COBRA rights for all retirees who were not provided with such rights at their retirement due to the existence of the identical retiree plan.¹²⁵

If coverage does not terminate on the date the qualifying event occurs, the plan may provide that the COBRA notification period and the maximum COBRA coverage period measured from the date of the loss of coverage. Both periods must be measured from the same date.¹²⁶

C. Denying COBRA Coverage

An employer may deny COBRA coverage to an employee who is terminated for gross misconduct.¹²⁷ Neither the statute nor the regulations define "gross misconduct." However, it is clear that job incompetence or poor judgment alone will not constitute gross misconduct for COBRA purposes.¹²⁸ However, where the company clearly defined eight standards the violations of which could result in immediate discharge, an employee's violation of such standards constituted gross misconduct where each employee's violations were reviewed separately and distinguished between the obligation of a managerial employee versus non-managerial employee and applied different standards to each.¹²⁹

In one case, the Western District of Texas found that a termination for cash handling irregularities, invoice irregularities, and the failure to improve the performance of one of the employer's stores constituted gross misconduct. The court defined gross misconduct as the "substantial deviation from the high standards and obligations of a managerial employee that would indicate that said employee cannot be entrusted with his management duties without danger to the employer."¹³⁰

In another case, a court found that a security guard was terminated for gross misconduct where he had deserted his post and was found asleep at his home when he was the only

¹²⁴ Treas. Reg. § 54.4980B-7 Q/A 4(b) (2001).

¹²⁵ Treas. Reg. § 54.4980B-4 Q/A 1(g) Ex. 5 (1999).

¹²⁶ Code § 4980B(f)(8); ERISA § 607(5). No similar provision is found in the PHS Act.

¹²⁷ Code § 4980B(f)(3)(B); ERISA § 603(2); 42 U.S.C. § 300bb-3(2).

¹²⁸ *MLSNA v. Unitel Comm., Inc.*, 91 F.3d 876 (7th Cir. 1996); *Paris v. F. Korbel & Bros., Inc.*, 751 F. Supp. 834 (N.D. Cal. 1990).

¹²⁹ *Bryant v. Food Lion, Inc.*, 2000 U.S. Dist. LEXIS 8049 (D. S.C. 2000) (*aff'd* No. 00-1894, available on LEXIS, April 30, 2001, 2001 U.S. App. LEXIS 7913, 4th Cir. 2001) (4th Cir. 2001 unpublished).

¹³⁰ *Avina v. Texas Pig Stands, Inc.*, No. SA-88-CA-13, 1991 U.S. Dist. LEXIS 13957 (W.D. Tex. Feb. 1, 1991).

*guard scheduled to be on duty. He had also falsified the duty log to show that a second guard was also on duty for the purpose of collecting a second unearned paycheck; and failed to inform the employer of the circumstances of his termination by his earlier employer, which circumstances would have disqualified him from working for the successor. The court defined gross misconduct as "conduct evincing such willful or wanton disregard of an employer's interest as is found in deliberate violations or disregard of standards of behavior which the employer has the right to expect of his employee, or in carelessness or negligence of such a degree or occurrence as to manifest equal culpability, wrongful intent, or evil design, or to show an intention and substantial disregard of the employer's interest or the employee's duties and obligations to his employer."*¹³¹

*A school teacher arrested for sexual assault and other crimes allegedly committed with an 18 year old former student in his home was denied COBRA. However, the charges were dismissed eight months later. The court found there was no difference between denying COBRA upon conviction and denying COBRA in this case based upon an arrest.*¹³²

A state supreme court judge convicted of two felony counts on illegally obtaining narcotics by using his staff members' names to obtain prescriptions and who was impeached and removed from office was found to have been discharged for "gross misconduct" under the PHSA's COBRA provisions.¹³³

A flight attendant's throwing an apple and yelling a racial epithet at another employee in front of passengers was fired and denied COBRA correctly for gross misconduct.¹³⁴

A felonious assault on a co-worker outside of the workplace that caused the hospitalization of the co-worker for five days was found to be gross misconduct. The other employees knew the co-worker and the assaulter. The assaulter was in a supervisory position prior to the incident. The impact of the assault on the other co-workers and the ability of the supervisor to supervise was called into question by his actions. The nexus of the act constituting gross misconduct, felonious assault on a co-worker and failure to respond to his employer's request that he obtain help in controlling his angry outbursts in the workplace was sufficiently close to impact his ability to perform his obligations to the employer so that the incident constituted gross misconduct.¹³⁵

At least one court has held that it is not sufficient that the employer has a good faith belief that the employee engaged in gross misconduct. The employer must have evidence that the employee actually engaged in gross misconduct, *i.e.*, the gross misconduct determination must be based on facts.¹³⁶ However, breach of a company confidence was not gross

¹³¹ *Adkins v. United Int'l Investigative Serv., Inc.*, No. C 91-0087 BAC, 1992 U.S. Dist. LEXIS 4719 (N.D. Cal. 1992).

¹³² *McKnight v. School District of Philadelphia*, 2001 U.S. Dist. LEXIS 4751 (E.D. Pa. 2001).

¹³³ *Larsen v. Senate of Pennsylvania*, 154 F.3d 82 (3d Cir. 1998).

¹³⁴ *Nakisa v. Continental Airlines*, 2001 U.S. Dist. LEXIS 20784 (S.D. Tx. 2001).

¹³⁵ *Zickafoose v. UB Services Incorporated*, 23 F. Supp.2d 652, 1998 U.S. Dist. LEXIS 17482 (S.D. W. Va. 1998).

¹³⁶ *Kariotis v. Navistar Int'l Transp. Corp.*, 131 F.3d 672, 1997 WL 757448 (7th Cir. 1997).

misconduct.¹³⁷ At least one court has required a trial to determine whether the gross misconduct was the reason for the termination when the alleged acts occurred two years prior to termination.¹³⁸ If the employer had grounds to terminate the employee for gross misconduct, but permitted the employee to resign, it may not deny COBRA.¹³⁹ Failure to include onion powder in the days batches of ravioli may be negligent, but is not gross misconduct.¹⁴⁰

Several cases have held that the employer's refusal to provide COBRA on the basis of gross misconduct will be judged on the information available to the employer at the time and if the employer acted in good faith the decision will stand.¹⁴¹

If there is a possibility that the company may utilize this exception to COBRA coverage, the company should first establish a procedure to determine when an employee is terminated for gross misconduct. This procedure is important because the ramifications of improper denial are significant. A careful review of the current judicial positions on what constitutes gross misconduct should also be reviewed before denying COBRA coverage based upon the gross misconduct exception. Accordingly, a company should err on the side of providing COBRA coverage. The gross misconduct exceptions have been granted sparingly by the courts.

A court may grant a preliminary injunction preventing the employer from denying COBRA coverage to the former employee if the court finds that the former employee is likely to succeed on the merits.¹⁴²

Just because an employer has grounds for terminating an employee for gross misconduct does not permit the employer to deny COBRA rights if the employee is allowed to resign in order to avoid being terminated.¹⁴³

D. Coverage That Constitutes COBRA Continuation Coverage

1. Type of Coverage

The COBRA coverage offered must be the group health plan coverage that is offered to similarly situated non-COBRA beneficiaries.¹⁴⁴ If the coverage under the plan is modified for similarly situated non-COBRA beneficiaries then the coverage available to the qualified beneficiaries is modified in the same way.¹⁴⁵ If the

¹³⁷ *Paris v. F. Korbel & Brothers, Inc.*, 751 F. Supp. 834 (N.D. Col. 1980), 12 EBC 2489.

¹³⁸ *Cotte v. Cooperativa De Ahorro Y Credito Yabucoena*, 1999 U.S. Dist. LEXIS 18984 (D. P.R. 1999).

¹³⁹ *Conery v. Bath Associates*, 803 F. Supp. 1388 (N.D. Ind. 1992); *MLSNA v. Unitel Comm., Inc.*, 825 F. Supp. 862 (N.D. Ill. 1993).

¹⁴⁰ *Lloynd v. Hanover Foods Corporation*, 1999 U.S. Dist. LEXIS 18519 (D. Del. 1999).

¹⁴¹ *Burke v. American Stores Employee Benefit Plan*, 818 F. Supp. 1131 (N.D. Ill. 1993); *but see Kariotis v. Navistar Int'l Transp. Corp.*, 131 F.3d 672, 1997 WL 757448 (7th Cir. 1997); *and see MLSNA v. Unitel Comm., Inc., id.*

¹⁴² *Cabral v. The Olsten Corp.*, 843 F. Supp. 701 (M.D. Fla. 1994).

¹⁴³ *Mlsna v. Unitel Comm., Inc. v. Mlsna*, 91 F.3d 876 (7th Cir. 1996); *Conery v. Bath Assoc.*, 803 F. Supp. 1383 (N.D. Ind. 1992).

¹⁴⁴ Treas. Reg. § 54.4980B-5 Q/A 1(a) (2001).

¹⁴⁵ Treas. Reg. § 54.4980B-5 Q/A 1(a) (2001); *Besing v. America West Holdings Corp., Inc.*, 2000 U.S. App.

continuation coverage offered to qualified beneficiaries differs in any way from that available to "similarly situated non-COBRA beneficiaries," it does not constitute COBRA coverage and any change or elimination of coverage in anticipation of a qualifying event is ignored for purposes of determining whether the coverage qualifies as COBRA continuation coverage.¹⁴⁶ The term similarly situated non-COBRA beneficiaries was added by the Final Regulations I which also continues to use "similarly situated active employees."¹⁴⁷ A similarly situated non-COBRA beneficiary is a person receiving coverage under the plan for a reason other than COBRA (e.g., as a dependent of a covered employee or a child covered pursuant to a qualified medical child support order) and who considering all of the facts and circumstances is most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event. For any child born to or placed with a covered employee while that individual is covered under COBRA, the coverage must be the same coverage offered to dependent children of active employees in the benefits offered to active employees at the time of birth or placement for adoption.¹⁴⁸

2. Deductibles

The deductibles for qualified beneficiaries must generally be the same as those for similarly situated non-COBRA beneficiaries. If the COBRA coverage begins before the end of a period under the plan for accumulating amounts toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward the deductibles before the COBRA coverage began as if the qualifying event had not occurred.¹⁴⁹ The deductible carryover rule applies for each individual covered under the plan if the plan accumulates deductibles on an individual basis.¹⁵⁰ If the plan computes deductibles on a family basis, the remaining deductible for the family at the beginning of COBRA coverage depends on the members of the family electing COBRA coverage and only the expenses of the family members receiving COBRA coverage need to be considered. If the qualifying event results in more than one family unit, the family deductible may be computed separately for each resulting family unit based on the members of each unit. These rules apply regardless of whether the plan provides the family deductible as an alternative to the individual deductibles or an additional requirement.¹⁵¹ Other types of deductibles must be computed in a manner that is consistent with the principles described above.¹⁵² Any deductibles computed based upon a percentage of the covered employee's compensation, provided the covered employee remains employed during the COBRA coverage period, permit the plan to choose whether to apply the deductible

LEXIS 31222 (10th Cir. 2000).

¹⁴⁶ Treas. Reg. § 54.4980B-5 Q/A 1(a) (2001).

¹⁴⁷ Cf. Treas. Reg. § 54.4980B-3 Q/A 3 (1999) for similarly situated non-COBRA beneficiaries and Treas. Reg. § 54.4980B-8 Q/A 2(c) (1999) referring to similarly situated active employees.

¹⁴⁸ Treas. Reg. § 54.4980B-5 Q/A 1(b) (1999).

¹⁴⁹ Treas. Reg. § 54.4980B-5 Q/A 2(a) (1999).

¹⁵⁰ Treas. Reg. § 54.4980B-5 Q/A 2(b) (1999).

¹⁵¹ Treas. Reg. § 54.4980B-5 Q/A 2(b) and (c) (1999).

¹⁵² Treas. Reg. § 54.4980B-5 Q/A 2(d) (1999).

by treating the employee's compensation as continuing without change for the entire COBRA coverage period, or to apply the deductible using the employee's actual compensation.¹⁵³ If the plan computes the deductible as a percentage of compensation, for periods of COBRA coverage in which the employee is not employed, the plan must compute the deductible by treating the employee's compensation as continuing for the duration of the COBRA coverage either at the level used to compute the deductible immediately before the COBRA coverage began or at the level that was used to compute the deductible immediately before the employee's employment was terminated.¹⁵⁴

3. Plan Limits

Plan limits are treated in the same way that deductibles are treated both with respect to limits on plan benefits (both annual and lifetime limits on days or dollar amount of reimbursements) and limits on out-of-pocket expenses, deductibles and copayments.¹⁵⁵

4. Changes in Coverage Elections by the Qualified Beneficiary

Qualified beneficiaries only must be given an opportunity to continue the coverage he or she was receiving immediately before the qualifying event, even if that coverage ceases to be of value to the qualified beneficiary (e.g., moving out of an HMO service area). Qualified beneficiaries only must be allowed to change coverage from the coverage they had:

- a. If the qualified beneficiary participated in a region specific HMO and moved out of the HMO's service area and the plan permits active employees to change their election in such situations. In this case the same options offered to similarly situated non-COBRA beneficiaries must be offered to the COBRA qualified beneficiary. This alternate coverage must be available no later than the date of the qualified beneficiary's relocation, or, if later, the first day of the month following the month in which the qualified beneficiary requests the alternate coverage.¹⁵⁶ However, if the only other coverage offered is not available in the area to which the qualified beneficiary relocated, then the employer is not required to make any other coverage available to the relocating qualified beneficiary.¹⁵⁷
- b. If the employer or employee organization makes an open enrollment available to similarly situated active employees who have not experienced a qualifying event, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. For this purpose an open enrollment period is a period during

¹⁵³ Treas. Reg. § 54.4980B-5 Q/A 2(e) (1999).

¹⁵⁴ Treas. Reg. § 54.4980B-5 Q/A 2(e) (1999).

¹⁵⁵ Treas. Reg. § 54.4980B-5 Q/A 3 (1999).

¹⁵⁶ Treas. Reg. § 54.4980B-5 Q/A 4(b) (2001).

¹⁵⁷ Treas. Reg. § 54.4980B-5 Q/A 4(a) (1999) and (b) (2001).

which an employee covered by the plan can select another group health plan's coverage or another benefit package or to add or eliminate coverage of family members.¹⁵⁸

However, the plan must give the qualified beneficiary the same rights as similarly situated active employees and if similarly situated active employees are permitted to change the coverage they are receiving, then the plan must also allow each qualified beneficiary to change the coverage received on the same terms as similarly situated active employees.¹⁵⁹

5. Adding New Family Members to COBRA Coverage

Because the special enrollment rules under Code section 9801 (HIPAA special enrollment periods) permit active employees to add new family members through special enrollment periods upon the loss of other group health plan coverage or the addition of a new spouse or new dependent via marriage, birth, adoption or placement for adoption of the requirements of the plan and/or section 9801 are satisfied, a qualified beneficiary receiving COBRA coverage (one who timely elected and timely paid for coverage) has the same right to enroll family members under the special enrollment rules as if the qualified beneficiary was an employee. However, neither a qualified beneficiary who is not receiving COBRA coverage nor a former qualified beneficiary has any special enrollment rights.¹⁶⁰ The plan may charge a higher COBRA premium if the addition of new family members results in a higher premium.¹⁶¹

IV. Notification Requirements

The COBRA statute requires that employers provide two COBRA notifications to employees and eligible beneficiaries. On May 28, 2003, the U.S. Department of Labor ("DoL") issued proposed regulations on the timing, content and types of COBRA notifications it believes are required.¹⁶² The proposed regulations, when finalized, are to be effective for the first day of the first plan year on or after January 1, 2004.¹⁶³

A. Types of Required Notice

1. Initial General Notice

Sometimes referred to as the "COBRA announcement," the initial general notice simply informs the employee, spouse, and any dependent children of the availability of continuation coverage if a qualifying event occurs. The COBRA announcement provides notice of the rights and obligations of COBRA coverage. A company

¹⁵⁸ Treas. Reg. § 54.4980B-5 Q/A 4(c) (1999).

¹⁵⁹ Treas. Reg. § 54.4980B-8 Q/A 2(c) (1999).

¹⁶⁰ Treas. Reg. § 54.4980B-5 Q/A 5(a) and (b) (1999).

¹⁶¹ Treas. Reg. § 54.4980B-5 Q/A 5(c) (1999).

¹⁶² 68 F.R. 31832 (2003).

¹⁶³ 68 F.R. 31832, 31834 (2003).

should develop a standardized procedure to ensure that all notifications are provided in a timely and proper manner. The initial notice must be provided within 90 days of the later of the date the individual's coverage commenced or the first date the plan became subject to COBRA.¹⁶⁴ The initial notice must be delivered in a manner consistent with the requirements for delivery of summary plan descriptions.¹⁶⁵ If an employee and their spouse's coverage commences on the same date and their last known address is the same in the plan's records, then one initial notice may be addressed to both at their one address.¹⁶⁶ However, if the employee and his spouse's coverage do not commence on the same date, then a separate notice must be sent to the spouse, unless the spouse's coverage commenced before the notice was required (e.g., if the spouse's coverage commenced when the plan was not subject to COBRA due to the employer having less than 20 employees).¹⁶⁷ The initial notice requirement may be satisfied by including the content requirements, excepting the reference to the summary plan description, in the summary plan description.¹⁶⁸

The content of the notice is also specified by the proposed regulation. The proposed regulation includes a sample model notice that includes areas that must be completed. A checklist of the proposed regulations content requirements for the initial notice is attached as Exhibit A.¹⁶⁹

COBRA information must also 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.¹⁷⁰ The initial notice must be provided to both the covered employee and to the covered spouse.¹⁷¹ An initial notice that notified the employee and spouse to notify the employer within 60 days of a divorce protected the employer when the employee and spouse failed to provide notice within the 60 day period.¹⁷² If the spouse is not enrolled in the health plan as a dependent, the spouse need not be provided the notice.¹⁷³ An initial model notice was issued by the DoL as ERISA Tech. Rel. 86-2. However, the initial model notice must be updated to make it consistent with current law. The Technical Release also provided that good faith compliance would be found if the notice were furnished by first-class mail to the covered employee's last known address. Other methods of delivery have

¹⁶⁴ Prop. DoL Reg. § 2590.606-1(b) (2003).

¹⁶⁵ Prop. DoL Reg. § 2590.606-1(f) (2003).

¹⁶⁶ Prop. DoL Reg. § 2590.606-1(d) (2003).

¹⁶⁷ *Id.*

¹⁶⁸ Prop. DoL. Reg. § 2590.606-1(e) (2003).

¹⁶⁹ See also Prop. DoL Reg. § 2590.606-1(c)(2003).

¹⁷⁰ Plan administrators must automatically furnish the SPD booklet 90 days after a person becomes a participant or beneficiary begins receiving benefits or within 120 days after the plan is subject to the reporting and disclosure divisions of the law.

¹⁷¹ Code § 4980B(f)(6); ERISA § 606(1); 42 U.S.C. § 300bb-6(1); DoL Adv. Op. 94-17A; See also *Nichols v. Carpenter Health and Welfare Trust Fund for California* 19 F.3d 1440 (9th Cir. 1994).

¹⁷² *Johnson v. Northwest Airlines, Inc.*, 2001 U.S. Dist. LEXIS 2160 (N.D. Ca. 2001).

¹⁷³ DoL Adv. Op. 94-17A.

resulted in different results in court.¹⁷⁴ The DoL issued a new model notice on May 28, 2003, and indicated at that time that continued use of the model notice contained in ERISA Tech. Rel. 86-2 after May 28, 2003, was no longer good faith compliance.¹⁷⁵

2. Qualifying Event Notice

Event notice is essentially notification that continuation coverage is available, explanation of the current coverage and the continuation coverage options, and a statement of the premium due. Specific notice requirements are triggered for employers, qualified beneficiaries, and plan administrators when a qualifying event occurs.

a. Employers

Employers generally must notify plan administrators within 30 days after an employee's death, termination, reduced hours of work, or entitlement to Medicare or the date of loss of coverage related to such event, if coverage is not lost on the date of the qualifying event.¹⁷⁶ A notice and election form that did not explain what constituted a "Qualifying Event" to explain how and when the election must be made was found to be insufficiently clear to put the individual on notice of her rights and did not fulfill the plan administrator's obligation to give her notice. Since the notice was deficient, the employer remains liable for the qualified beneficiaries' medical costs.¹⁷⁷

This notice's content must have sufficient information for the plan administrator to determine the plan, the covered employee, the qualifying event and the date of the qualifying event.¹⁷⁸ However, multiemployer plans may provide for a longer period of time and, in multiemployer plans, the employer's obligation to notify the plan administrator of an employee's termination or reduction in hours, may be delegated to the plan administrator if the plan provides that the determination of the occurrence will be made by the plan administrators.¹⁷⁹ An employee whose dental coverage was continued for seven months following termination of employment did not have a qualifying event because the qualifying event did not trigger a loss of coverage and because the court reasoned that even if it was not correct, the qualified beneficiary did not show any harm from the delay of the notice after the qualifying event.¹⁸⁰

¹⁷⁴ See *Dehner v. Kansas City Southern Industries, Inc.*, 713 F. Supp. 1397 (D. Kan. 1989); *Stanton v. Larry Fowler Trucking, Inc.*, 52 F.3d 723 (8th Cir. 1995); and *Martin v. Marriott Corp.*, 15 EBC 1217 (D.D.C. 1992).

¹⁷⁵ 68 F.R. 31832, 31834 (2003).

¹⁷⁶ Code § 4980B(f)(6); ERISA § 606; 42 U.S.C. § 300bb-6; Prop. DoL Reg. § 2590.606-2 (2003).

¹⁷⁷ *Emilien v. Stull Technologies Corp.*, 70 Fed. Appx. 635, 2003 U.S. App. LEXIS 14515 (3d Cir. 2003).

¹⁷⁸ Prop. DoL Reg. § 2590.606-2(c) (2003).

¹⁷⁹ Code § 4980B(f)(6); ERISA § 606; 42 U.S.C. § 300bb-6; Prop. DoL Reg. § 2590.606-2(b)(2) and (d) (2003).

¹⁸⁰ *Wilcox v. National Distributors, Inc.*, 2001 U.S. Dist. LEXIS 11413 (D. Me. 2001).

An employer's failure to notify the qualified beneficiaries of their right to independently elect COBRA coverage, the amount of the premium for the individual coverage and when the 60-day election period began and ended resulted in the employer failing to fulfill its fiduciary obligation to the qualified beneficiaries.¹⁸¹ An employer should develop standard procedures for issuing COBRA notices. Failure to have evidence of standard procedures for issuing notices or evidence the notice was given can result in the employer failing to prove it provided the notice.¹⁸² An employer's good faith efforts to send the COBRA notice and election via certified mail was sufficient event though it was returned undelivered to the corporation. However, the Fifth Circuit states in footnote 2, "It is worth noting that this whole episode could have been avoided had Sprint taken the added precaution of mailing Degruise his COBRA notification by ordinary first class mail at the same time it sent the notice by certified mail. Sprint was not required to do this but it would have been a good practice."¹⁸³ A qualified beneficiary need not exhaust its administrative remedies in appeals in a COBRA claim for failure to notify of the COBRA election rights.¹⁸⁴ An employer's failure to provide notice is not negated by the qualified beneficiary's inability to show how they would have paid for the coverage.¹⁸⁵

b. Qualified Beneficiaries

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.¹⁸⁶ The DoL's proposed regulations require plans to have reasonable procedures for the qualified beneficiary or covered employee to furnish this notice. In order for the procedures to be reasonable they must:

- (i) be described in the plan's summary plan description;
- (ii) specify the individual or entity designated to receive such notices;
- (iii) specify the means by which the notice may be given;

¹⁸¹ *Smith v. Rogers Galvanizing Co.*, 128 F.3d 1380 (10th Cir. 1997) and 148 F.3d 1196 (10th Cir. 1998) approving district courts reopening case for issue of calculation of damages. See also 64 F.R. 5160, 5164 noting that the U.S. Department of Labor advised the IRS and Treasury that to the extent a fiduciary subjects the plan to liability for the COBRA excise tax on account of his/her imprudent actions, the plan fiduciary may be held personally liable under Title I of ERISA for the amount of tax.

¹⁸² *Daneshvar v. Graphic Technology, Inc.*, 40 F. Supp.2d 1225 (Dis. Kansas 1998); *Ramos v. SEIU Local 74 Welfare Fund*, 2002 U.S. Dist. LEXIS 5849 (S.D. N.Y. 2002); *Gibbs v. A. Finkl & Sons Company*, 2002 U.S. Dist LEXIS 3066 (N.D. Ill. 2002). Cf. footnote 221.

¹⁸³ *Degruise v. Sprint Corporation*, 279 F.3d 333 (5th Cir. 2002).

¹⁸⁴ *Thompson v. Origin Technology In Business, Inc.*, 2001 U.S. Dist. LEXIS 12609 (2001).

¹⁸⁵ *Chenoweth v. Wal-Mart Stores, Inc.*, 159 F. Supp. 2d. 1032 (S.D. Oh 2001).

¹⁸⁶ Code § 4980B(f)(6)(C); ERISA § 606(a)(4)(B); 42 U.S.C. § 300bb-6(3); Prop. Treas. Reg. § 1.162-26 Q/A 33 (1987); Treas. Reg. § 54.4980B-6 Q/A 2(a) (1999); Prop. DoL Reg. § 2590.606-3 (2003).

- (iv) describe the information that the plan deems necessary in order to provide continuation coverage; and
- (v) describe the time requirements for providing the notice, the contents of what must be in the notice and who may provide the notice.¹⁸⁷

If a plan has not established reasonable procedures for the covered employee or qualified beneficiary to provide the notice, such notice is deemed to have been provided when a written or oral communication identifying a specific qualifying event is made in a way reasonably calculated to bring it to the attention of (1) the organizational unit that customarily handles employer benefit matters for a single employee plan or any officer of the employer for a single employer plan; (2) for plans with more than one unaffiliated employer contributing or which are maintained by employee organizations, to the joint board, association, committee or similar group administering the plan or to the person or organizational unit to which benefit claims are sent; or (3) for plans where benefits are provided or administered by an insurance company, insurance service or similar organization regulated by state insurance laws, to the person or organizational unit handling claims or to any officer of the insurance company, insurance service or similar organization.¹⁸⁸

Written notification is not necessarily required; oral notice may be sufficient.¹⁸⁹ If this notice is not sent to the plan administrator within 60 days after the later of (1) the date of the qualifying event or (2) the date that the qualified beneficiary would lose coverage on account of the qualifying event, the group health plan does not have to offer COBRA continuation coverage to the qualified beneficiary.¹⁹⁰ If more than one qualified beneficiary would lose coverage as the result of a divorce or legal separation, a timely notice of the divorce or legal separation that is provided by the covered employee or any one of the qualified beneficiaries or a representative of either is sufficient to preserve the election rights of all qualified beneficiaries.¹⁹¹

Disabled beneficiaries must notify plan administrators of Social Security disability determinations within 60 days of the determination and prior to the expiration of the 18-month period of COBRA coverage; these

¹⁸⁷ Prop. DoL Reg. § 2590.606-3(b) through (e) (2003).

¹⁸⁸ Prop. DoL Reg. § 2590.606-3(b)(4) (2003).

¹⁸⁹ *Lawrence v. Jackson Mack Sales, Inc.*, 837 F. Supp. 771 (S.D. Miss. 1992), *aff'd without op.*, 42 F.3d 642 (5th Cir. 1994); *Swint v. Protective Life Ins. Co.*, 779 F. Supp. 532 (S.D. Ala. 1991); *Heebner v. Nationwide Mutual Insurance Company*, 2003 U.S. Dist. LEXIS 19569 (E.D. Pa. 2003).

¹⁹⁰ Treas. Reg. § 54.4980B-6 Q/A 2(a) (1999).

¹⁹¹ Treas. Reg. § 54.4980B-6 Q/A 2(b) (1999), *cf.* DoL Adv. Op. 99-14A which requires a separate notice to each qualified beneficiary unless the notice clearly identifies all qualified beneficiaries and clearly describes the separate and independent right each has to elect COBRA; Prop. DoL Reg. § 2590.606-3(e) (2003).

beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.¹⁹² Any of the persons who are qualified beneficiaries with the disabled qualified beneficiary by reason of the same qualifying event the covered employee or the person acting as representative of a covered employee or qualified beneficiary may notify the plan administrator of the disability determination.¹⁹³

c. Plan Administrators

i. Notice of Occurrence of Qualifying Event

When the plan administrator receives notice that a qualifying event has occurred, notice must be provided to the covered employee, spouse, and/or dependent child within 14 days of the plan administrator's receipt of notice of the qualifying event.¹⁹⁴ This notice may be sent at the same time and even in the same envelope as the Certificate of Coverage required under HIPAA.

Courts are split on whether an administrator who is also an employer has 14 or 44 days to notify a beneficiary. A recent case questioned whether DoL's opinion letter was correct when the employer and plan administrator knew of the employee's spouse's medical conditions and that delay in providing the notice caused the spouse to miss treatments.¹⁹⁵ However, the Department of Labor has expressed its opinion that the statute gives an employer/administrator 44 days to notify a qualified beneficiary and also provided for 44 days in such situation in its proposed regulation.¹⁹⁶ Failure to separately notify the spouse of COBRA election rights even though it did not prevent the spouse from electing COBRA resulted in the employer being subject to the \$100 per day penalty.¹⁹⁷ The U.S. Department of Labor previously had taken the position where there is more than one qualified beneficiary from a qualifying event, that each qualified beneficiary has a separate right to receive a written election form permitting him to exercise his COBRA rights. However, in its proposed regulations, the DoL provided modified rules when more than one qualified beneficiary exists with respect to a single qualifying

¹⁹² Code § 4980B(f)(6)(C); ERISA § 606(3); 42 U.S.C. § 300bb-6(3); Prop. DoL Reg. § 2590.606-3(c)(2) (2003).

¹⁹³ Treas. Reg. § 54.4980B-7 Q/A 5(c) and (d) (1999); Prop. DoL Reg. § 2590.606-3(e) (2003).

¹⁹⁴ Code § 4980B(f)(6); ERISA § 606(a); 42 U.S.C. § 300bb-6.

¹⁹⁵ *Anderson v. Royal Crest Dairy*, 281 F. Supp.2d 1242, 2003 U.S. Dist. LEXIS 6773 (D. Col. 2003).

¹⁹⁶ *Goodman v. Commercial Labor Services, Inc.*, 2000 U.S. Dist. LEXIS 1324 (N.D.N.Y. 2000); *Roberts v. Nat'l Health Corp.*, No. 8:96-193-20, 1997 U.S. Dist. LEXIS 5964 (D.S.C. April 25, 1997); U.S. Department of Labor Pension and Welfare Benefits Program, Susan G. Lahne, Acting Chief, Division of Coverage, letter to Pieter J. Doerr dated April 11, 1995, 1995 ERISA LEXIS 18; *Carner v. MGS-576 5th Avenue, Inc.*, 997 F. Supp. 629 (S.D.N.Y. 1997); Prop. DoL Reg. § 2590.606-4(b)(2) (2003).

¹⁹⁷ *Underwood v. Fluor Daniel, Inc.*, No. 95-3036, 1997 U.S. App. LEXIS 1410 (4th Cir. 1997).

event. The notice of COBRA election rights must generally be furnished to each qualified beneficiary except (i) if the plans most recent information shows the plan's last known address for an employee and spouse is the same, a single election notice may be provided to both if it is addressed to both, and (2) if each qualified beneficiary who is a dependent child has the same address as the covered employee or covered employee's spouse, then one election form may be sent to the covered employee or covered employee's spouse for all dependents.¹⁹⁸ This requirement can be met by sending one notice and election via first-class mail where more than one qualified beneficiary resides at the same address provided, that the mailing either includes a separate election notice for each qualified beneficiary, or if a single notice is sent it must clearly identify the qualified beneficiaries covered by the notice and the independent right each has to elect COBRA coverage.¹⁹⁹ The notice may be sent in the same way summary plan descriptions are provided.²⁰⁰

The election notice now must contain specific information. A checklist of the information that must be included is attached as Exhibit B.²⁰¹ The proposed DoL regulations included a model election notice with a number of provisions that must be completed by the plan; however, the model notice is not designed to be used when bankruptcy is the qualifying event.²⁰² One court has upheld an oral notice given during an exit interview as a timely notice of COBRA rights;²⁰³ however, a written notice can be documented as to delivery and sufficiency to preserve the record of the notice.

ii. Notice of Unavailability of COBRA

The proposed DoL regulations also included other notice requirements for the plan administrator. Under the proposed DoL regulations, the plan administrator must provide a notice of unavailability of continuation coverage if the plan administrator receives notice of a qualifying event for a covered employee or qualified beneficiary under Prop. DoL Reg. § 2590.606-3 and the plan administrator determined the individual is not entitled to continuation coverage. This notice must include an explanation of why the individual is not entitled to elect continuation coverage or

¹⁹⁸ Prop. DoL Reg. § 2590.606-4(e) (2003).

¹⁹⁹ DoL Adv. Op. 99-14A; Prop. DoL Reg. § 2590.606-4(e) (2003).

²⁰⁰ Prop. DoL Reg. § 2590.606-4(f) (2003).

²⁰¹ Prop. DoL Reg. § 2590.606-4(b) (2003); however, the District Court in Puerto Rico does not require the notice to contain as much information as the proposed regulation. *See Gotay v. Becton Dickinson Caribe, Ltd.*, 2003 U.S. Dist. LEXIS 6147 (D.P.R. 2003).

²⁰² 68 F.R. 31832, 31833 fn. 11 (2003).

²⁰³ *Heebner v. Nationwide Mutual Insurance Company*, 2003 U.S. Dist. LEXIS 19569 (E.D. Pa. 2003).

have a disability or second qualifying event extension of continuation coverage, and the notice must be furnished within 14 days after the plan administrator receives notice of the qualifying event from the covered employee or qualified beneficiary.²⁰⁴

Some courts have refused to impose the \$100 per day penalty when the proper notice was not sent but the medical expenses were less than the COBRA premiums so there was no damage.²⁰⁵ Some courts have also refused to impose the penalty when the company can prove the notice was sent to the last known address and returned to the company since the statute only requires sending the notice, not the qualified beneficiary's receipt of the notice.²⁰⁶ However, an employer may not rely on its COBRA notification procedures as a defense when it knows there are deficiencies in the process and particularly not when the qualified beneficiary notifies the employer of the fact he had not received the notice.²⁰⁷ The content of COBRA notices is as important as the timing of the notice when a plan told a qualified beneficiary that her coverage terminated, but did not tell her that her dependent may have separate rights to elect, the court permitted the action to proceed and denied summary judgment. The qualified beneficiary remitted payment to the wrong carrier and the court indicated it was not the qualified beneficiary's obligation to discover to whom the premium should be paid, but it was the obligation of the ERISA fiduciaries administering the plan to tender payment to the proper plan provider.²⁰⁸

If an administrator fails to provide timely notice, a court may find it reasonable to assume that the beneficiary would have elected COBRA continuation coverage had he properly been informed of his right to do so and thus deem the beneficiary to have made an election.²⁰⁹

Some courts have held that as a matter of law, an employer cannot be held liable for any failure on the part of the plan administrator to give notification of COBRA rights or to provide continuation of coverage, as long as the employer satisfied its obligations of providing notice to the plan administrator (see Part a above).²¹⁰

²⁰⁴ Prop. DoL Reg. § 2590.606-4(c) (2003).

²⁰⁵ *Moller v. State Personnel Bd.*, No. 95-16620, 1996 U.S. App. LEXIS 34005 (9th Cir. 1996).

²⁰⁶ *Degruipe v. Sprint Corporation*, 1999 U.S. Dist. LEXIS 10729 (E.D. La. 1999).

²⁰⁷ *Wooderson v. American Airlines, Inc.*, 2001 U.S. Dist. LEXIS 3721 (N.D. Tex. 2001).

²⁰⁸ *Fink v. Dakotacare*, 2003 U.S. App. LEXIS 6167 (8th Cir. 2003).

²⁰⁹ *Swint v. Protective Life Ins. Co.*, 779 F. Supp. 532 (S.D. Ala. 1991).

²¹⁰ *Barley v. Superior Chevrolet Automotive Co.*, No. 96-2119-EEO, 1997 U.S. Dist. LEXIS 4510 (D. Kan., March 21, 1997).

At least one court has questioned the adequacy of the notice where the notice did not clearly tell the qualified beneficiaries what they must do in the 60-day election period or that they must pay for the initial COBRA premium within 45 days of making the election.²¹¹ The sufficiency of the contents of the notice have caused other cases to not be dismissed on a motion to dismiss.²¹²

In one case, the undisputed evidence established that Plaintiff was terminated on December 19, 1994, and that on December 20, 1994, the employer's plan administrator received notice in writing of Plaintiff's termination. Thus, as proper notice was sent by the employer to the plan administrator within 30 days of Plaintiff's termination, it became the responsibility of the plan administrator to notify Plaintiff of her COBRA rights.²¹³ However, failure to maintain proof of notice procedures and proof of issuance of the notice can lead to trials on whether the notice was sent.²¹⁴

3. Termination Notice

The plan administrator is not required to provide termination notice of the COBRA coverage expiration date prior to the effective date of any final DoL regulation on COBRA notices, but is required to provide a Certificate of Creditable Coverage under the Health Insurance Portability and Accountability Act of 1996. One court indicated in a situation involving an ERISA plan that the plan's failure to give notice of the termination of COBRA coupled with the plan's continued acceptance of premiums after the COBRA period expired were sufficient facts to go to trial when coupled with incorrect communications regarding the way in which to obtain conversion coverage.²¹⁵ However, another court noted in dicta that a qualified beneficiary, covered under COBRA under the PHSA, who received the appropriate initial COBRA rights notice and who continued paying COBRA premiums beyond the expiration of her maximum COBRA coverage period, might be able to make a claim based upon detrimental reliance on the city's acceptance of her premiums after the expiration of her 18-month period of COBRA coverage.²¹⁶

While the COBRA statute does not require a COBRA termination notice, the DoL added a termination notice requirement in its proposed regulation, possibly in response to the divergent court opinions on notification requirements. The proposed regulations require the plan administrator to provide each qualified beneficiary (the rules regarding notice to multiple qualified beneficiaries in IV, A.2c above apply) notice of any termination of continuation coverage that will occur earlier than the end of the maximum period of COBRA coverage. This notice must include the

²¹¹ *Goodman v. Commercial Labor Services, Inc.*, 2000 U.S. Dist. LEXIS 1324 (N.D.N.Y. 2000).

²¹² *Haydt v. Loikits*, 2000 U.S. Dist. LEXIS 18202 (E.D. Pa. 2000).

²¹³ *Barley v. Superior Chevrolet Automotive Co.*, 1997 U.S. Dist. LEXIS 4510.

²¹⁴ *Matuska v. Hinckley Township*, 56 F.2d 906 (N.D. Ohio 1999).

²¹⁵ *Wright v. Anthem Life Ins. Co. of Indiana*, 2000 U.S. Dist. LEXIS 8899 (N.D. Miss. 2000).

²¹⁶ *Bigelow v. United Healthcare of Mississippi, Inc.*, 213 F.3d 254 (5th Cir. 2000).

reason coverage terminated early, the date of the termination of continuation coverage and any rights the qualified beneficiary might have to elect alternative or individual coverage, such as conversion rights. This termination notice is to be furnished as soon as practicable following “the administrator’s determination that continuation coverage shall terminate.”²¹⁷ Since this notice is to be provided as soon as practicable following the determination that coverage “shall” terminate, it must be provided each time a qualified beneficiary is delinquent in submitting the COBRA premium before the grace period expires.

B. Sending Notice

Notice must be provided to both the covered employee and his covered spouse at the time of commencement of participation in the covered plan.²¹⁸ Notice to the covered employee is not necessarily deemed to be notice to the spouse or to dependent children living with the covered employee. However, notice to a spouse is deemed to be notice to all qualified beneficiaries who live with the spouse.²¹⁹ In addition, some courts have held that a single notice sent to a household containing more than one beneficiary is reasonably calculated to inform all qualified beneficiaries living at that address of their COBRA rights if the notice allows all beneficiaries to elect coverage.²²⁰ However, the Internal Revenue Service in audits of COBRA compliance requires the plan administrator to show a separate notice sent to the spouse in order to avoid the penalty.

The statute is silent on the manner in which notice of COBRA eligibility must be communicated. Courts that have considered the issue, however, have determined that a good faith attempt to comply with a reasonable interpretation of the provision is sufficient.²²¹ Methods of notification which are reasonably calculated to reach the employee or beneficiary are considered to conform to the standard of good faith compliance with the statute.²²² An employer may generally comply with the notice provisions by sending notice by first-class mail to the last known address of an employee.²²³ The notice period may be measured either from the date of the qualifying event or of the loss of coverage, if later, provided that both the notice period and the period for extension of coverage are measured from the same date.²²⁴ Administrators should follow an established procedure in sending these notices to

²¹⁷ Prop. DoL Reg. § 2590.606-4(d) (2003).

²¹⁸ Code § 4980B(f)(6); ERISA § 606(a)(1); 42 U.S.C. § 300bb-6(1).

²¹⁹ Code § 4980B(f)(6); ERISA § 606; 42 U.S.C. § 300bb-6.

²²⁰ *Conery v. Bath Assoc.*, 803 F. Supp. 1388 (N.D. Ind. 1992); *Jachim v. KUTV, Inc.*, 783 F. Supp. 1328 (D. Utah 1992).

²²¹ *Lawrence v. Jackson Mack Sales, Inc.*, 837 F. Supp. 771 (S.D. Miss. 1992), *aff'd without op.*, 42 F.3d 642 (5th Cir. 1994); *Conery v. Bath Assoc.*, 803 F. Supp. 1388 (N.D. Ind. 1992); *Phillips v. Riverside*, 796 F. Supp. 403 (E.D. Ark. 1992); *Jachim v. KUTV, Inc.*, 783 F. Supp. 1328 (D. Utah 1992); *Truesdale v. Pacific Holding Co.*, 778 F. Supp. 77 (D.D.C. 1991); *Dehner v. Kansas City Southern Indus., Inc.*, 713 F. Supp. 1397 (D. Kan. 1989).

²²² *Lawrence v. Jackson Mack Sales, Inc.*, 837 F. Supp. 771 (S.D. Miss. 1992), *aff'd without op.*, 42 F.3d 642 (5th Cir. 1994).

²²³ *Lawrence v. Jackson Mack Sales, Inc.*, 837 F. Supp. 771 (S.D. Miss. 1992), *aff'd without op.*, 42 F.3d 642 (5th Cir. 1994); *Conery v. Bath Assoc.*, 803 F. Supp. 1388 (N.D. Ind. 1992); *Jachim v. KUTV, Inc.*, 783 F. Supp. 1328 (D. Utah 1992).

²²⁴ Code § 4980B(f)(8); ERISA § 607(5).

individuals. Establishing standard procedures for delivery of COBRA notices and keeping records that the procedures were followed can save the administrator by proving that the COBRA notice was sent.²²⁵ An employer cannot rely on its COBRA notification procedures when it knows there are deficiencies in the process and the qualified beneficiary made repeated calls requesting the notice and election forms.²²⁶

*In one case, Plaintiff argued that Defendant had failed to notify her of her COBRA rights subsequent to termination. Although Defendant stated that it mailed her a COBRA letter, Plaintiff argued that she never received it. Plaintiff further argued that because Defendant could not produce a copy of the letter, Defendant could not prove that it gave Plaintiff adequate notice. The court disagreed with Plaintiff. Although Plaintiff complained that she never received the COBRA notice, Defendant presented evidence showing that it followed an established procedure in notifying Plaintiff. As part of this established procedure, Defendant was able to produce a COBRA report that was stamped with the date that the COBRA letter was mailed to Plaintiff.*²²⁷

V. The Qualified Beneficiary's Acceptance/Election of Coverage

A. The Election Period – Non Trade Adjustment Act Eligible Individuals

The plan must give the qualified beneficiary a minimum of 60 days to accept coverage or lose all rights to benefits.²²⁸ In other words, an employer cannot force a terminated employee to make a decision on the day he or she leaves the company.²²⁹ The mere fact the notice contains an incorrect response due date when it explains the 60-day election period does not forgive the qualified beneficiaries' late response on the election.²³⁰

The 60-day election period begins on the later of the day the qualified beneficiary receives the notice of COBRA election rights or the date the qualified beneficiary would lose coverage as the result of the qualifying event.²³¹

The 60-day period is a minimum requirement. The period may be longer if the plan so provides or if the qualified beneficiaries are misled as to the length of the period. The period may also be tolled during any time when the qualified beneficiary is incapable of acting and has no legal representative to act on his or her behalf.²³²

²²⁵ *Maloney v. R. R. Donnelley & Sons Company*, 1999 U.S. Dist. LEXIS 1120 (N.D. Ill. 1999).

²²⁶ *Wooderson v. American Airlines, Inc.*, 2001 U.S. Dist. LEXIS 3721 (N.D. Tex. 2001).

²²⁷ *Roberts v. National Health Corp.*, No. 8:96-193-20, 1997 U.S. Dist. LEXIS 5964 (D.S.C. April 25, 1997); *Arina v. Texas Pig Stands, Inc.*, No. SA-88-CA-13, 1991 U.S. Dist. LEXIS 13957 (W.D. Tex. Feb. 1, 1991).

²²⁸ Code § 4980B(f)(2)(B) and (5)(A)(ii); ERISA §§ 602(2), 605(1)(B); 42 U.S.C. §§ 300bb-2(2), 300bb-5(1)(B); Treas. Reg. § 54.4980B-6 Q/A 1(a) (1999).

²²⁹ *Conery v. Bath Associates*, 803 F. Supp. 1388 (N.D. Ind. 1992); *Powell v. Bob Downes Chrysler-Plymouth, Inc.*, 763 F. Supp. 1023 (E.D. Mo. 1991).

²³⁰ *Deering v. O.K. Industries, Inc.*, 2001 U.S. App. LEXIS 8923 (8th Cir. 2001).

²³¹ Code § 4980B(f)(8); ERISA § 607(5); Treas. Reg. § 54.4980B-6 Q/A 1(a) (1999).

²³² *Branch v. G. Bernd Co.*, 955 F.2d 1574 (11th Cir. 1992); *Meadows v. Cagle's, Inc.*, 954 F.2d 686 (11th Cir. 1992).

Regardless of when during the election period the election is made, the beneficiary's coverage relates back to the date of the qualifying event.²³³ If coverage is provided under an indemnity or reimbursement arrangement, the employer or employee organization can provide for coverage during the election period or if the plan permits retroactive reinstatement can terminate the qualified beneficiary's coverage and then reinstate him/her when the coverage is elected. Any claims incurred during the election period do not have to be paid before the election is made.²³⁴ The coverage extension, subject to retroactive revocation, is not a free extension of coverage, but it is conditioned on the employee making the election and paying the applicable premium.²³⁵ The Final Regulations I place new requirements on plans and their administrators in the event a health care provider contacts them to confirm coverage during the election period. In the event of such an inquiry regarding a qualified beneficiary's coverage during the election period, the plan must give a complete response about the qualified beneficiary's rights, such as, if the plan provides coverage during the election period subject to retroactive revocation, if COBRA is not elected, then the inquiring health care provider must be told the qualified beneficiary has COBRA coverage, but that it is subject to retroactive revocation if the election is not timely made and the coverage is not paid for in a timely manner. If the plan cancels coverage and retroactively reinstates upon receipt of the election, the provider must be told that the qualified beneficiary does not currently have coverage, but that coverage could be retroactively reinstated if the election is timely made and the payment for the coverage is received in a timely manner.²³⁶ If a health plan provides health services (an HMO or a walk-in clinic), the plan can require the qualified beneficiary who has not yet made the COBRA election to either:

1. elect and pay for the coverage; or
2. pay the reasonable and customary charge for the plan's services as long as the qualified beneficiary will be reimbursed for the services he/she paid for within 30 days after the COBRA election; or
3. provide continued coverage and treat the qualified beneficiary's use of the facilities as a constructive election in which case the qualified beneficiary must pay any applicable charge for the coverage; but only if the qualified beneficiary is informed that use of the facility is a constructive election of COBRA before he uses the facility.²³⁷

An election is considered made on the date that it is sent to the employer or plan administrator.²³⁸ Coverage continues from the date of the qualifying event even if the

²³³ Treas. Reg. § 54.4980B-6 Q/A 3(a) (1999).

²³⁴ Treas. Reg. § 54.4980B-6 Q/A 3(b) (2001).

²³⁵ *Goletto v. W. H. Braum, Inc.*, 2001 U.S. App. LEXIS 1367 (10th Cir. 2001).

²³⁶ Treas. Reg. § 54.4980B-6 Q/A 3(b) (2001) which follows *Communications Workers of America v. NYNEX Corp.*, 898 F.2d 887 (2d Cir. 1989).

²³⁷ Treas. Reg. § 54.4980B-6 Q/A 3(c) (1999).

²³⁸ Treas. Reg. § 54.4980B-6 Q/A 1(b) (1999); however, in *Wilczynski v. Kemper National Insurance Companies*, 1999 U.S. App. LEXIS 10796 (7th Cir. 1999), the qualified beneficiaries' mailing of the election was insufficient to make the election when the COBRA administrator never received the election and the qualified beneficiary knew it was not received on the due date for the election.

beneficiary makes an election *after* incurring medical expenses during the election period.²³⁹ "The whole purpose of COBRA is to prevent gaps in health care coverage."²⁴⁰

An employer and an employee organization may not withhold anything to which a qualified beneficiary is otherwise entitled (by law or by agreement) in order to compel payment for COBRA coverage or to coerce the qualified beneficiary to give up rights to COBRA coverage. Any withholding is a failure to comply with COBRA coverage requirements. Any purported waiver obtained by withholding of anything as described above is an invalid waiver.²⁴¹

A qualified beneficiary who, during this election period, voluntarily waives COBRA continuation coverage, can revoke the waiver at any time before the end of the election period. However, if a waiver of COBRA continuation coverage is revoked, coverage need not be provided retroactively. Waivers and revocations of waivers are considered made on the date they are sent to the employer, employee organization or plan administrator.²⁴²

A qualified beneficiary who elects coverage but fails to pay the premiums cannot recover the difference between her medical costs and the premiums she owed because COBRA does not require a free initial extension of COBRA.²⁴³ A qualified beneficiary who fails to elect COBRA coverage voluntarily forfeits all rights to COBRA by not electing coverage.²⁴⁴

B. The Election Period – Trade Adjustment Act Eligible Individuals

1. The Federal Trade Act of 2002 (the "FTA") extended trade adjustment assistance ("TAA") through September 30, 2007, provided a Federal income tax credit for health insurance for persons who lose their jobs as the result of shifts in imports or exports because of a company's shift in production overseas or who are age fifty-five (55) or older and are receiving pension benefits from the Pension Benefit Guaranty Corporation ("PBGC").
2. The FTA also provided an expanded COBRA coverage election period for TAA eligible individuals and eligible alternative TAA recipients. The individuals eligible for such expanded election rights are defined as:

An eligible individual is an individual who is receiving TAA assistance or who is 55 or older and is a PBGC benefit recipient.

- (a) **Eligible TAA recipient** (as defined in IRC §35(c)(2) with respect to any month) is any individual who is:

²³⁹ *Branch v. g. Bernd Co.*, 955 F.2d 1574 (11th Cir. 1992) and Treas. Reg. § 54.4980B-6 Q/A 3 and 5 (1999).

²⁴⁰ *Kyle v. Stewart Title Co.*, 788 F. Supp. 321 (S.D. Tex. 1992) (citing *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990)).

²⁴¹ Treas. Reg. § 54.4980B-6 Q/A 5 (1999).

²⁴² Treas. Reg. § 54.4980B-6 Q/A 4 (1999).

²⁴³ *Goletto v. W. H. Braum, Inc.*, 2001 U.S. App. LEXIS 1367 (10th Cir. 2001).

²⁴⁴ *Roberts v. Union Pacific Railroad Company*, 2001 U.S. App. LEXIS 17990 (9th Cir. 2001).

1. receiving for any day of such month a trade readjustment allowance under Chapter 2 of Title 11 of Trade Act of 1974, OR
2. Who would be eligible to receive such allowance if §231 of the Trade Act of 1974 were applied without regard to (a)(3)(B) of such section OR
 - a. Trade Act of 1974, §231-worker can receive trade readjustment allowance if the worker is covered by a certification, and the worker applies for the allowance for any week of unemployment which being more than 670 days after the date that the petition that resulted in certification was filed if:
 - i. The worker's total or partial separation occurred within certain specified times (Trade Act of 1974, §231(a)(1)(A)-(C));
 - ii. The worker had at least 26 weeks of employment with wages of \$30 or more a week, within the 52 weeks preceding the total/partial separation (weeks of employment further defined in Trade Act of 1974, §231(a)(2));
 - iii. The worker was entitled to, or would be entitled to unemployment insurance for a week within the benefit period in which the total/partial separation took place, and does not have an unexpired waiting period applicable to him for any such unemployment insurance (Trade Act of 1974 §231(a)(3), excluding Trade Act of 1974, §231(a)(3)(B));
 - iv. The worker would not be disqualified for extended compensation payable under the 1970 Federal State Extended Compensation Act of 1970 by reason of work acceptance and job search requirement of Trade Act of 1974, §202(a)(3) of such act (Trade Act of 1974, §231(a)(4)); AND
 - v. Such worker is either enrolled in, or completed, a training program approved by the Secretary of Labor, or has received a written statement saying that it is not feasible or appropriate to approve a training program. (Trade Act of 1974, §231(a)(5)).

(b) **Eligible Alternative TAA recipient**-with respect to any month any individual who:

1. is a worker described in §246(a)(3)(B) of the Trade of 1974 and who is participating in the program established under §246(a)(1) of the Trade Act of 1974; and
 - a. 1974 Trade Act §246(a)(3)(B)-a worker who:
 - i. is the group that the Secretary has certified as eligible for the alternative trade adjustment assistance program (basically a program allowing trade adjustment assistance for older workers);
 - ii. obtains reemployment not more than 26 weeks after the date of separation from the adversely affected employment;
 - iii. is at least fifty years of age;
 - iv. earns not more than \$50,000 a year in wages from reemployment;
 - v. is employed on a full-time basis as that term is defined by state law in the state where the worker is employed; and
 - vi. does not return from the employment from which the worker was separated.
2. receiving benefit for such month under §246(a)(2) OR an eligible PBGC recipient-55 or older and receiving benefit paid by PBGC.

(c) Qualifying family member:

- i. Spouse; and
 - ii. dependent under §151(c) of the Code.
3. The TAA-eligible individuals are provided with a second COBRA election period for a TAA related loss of coverage which is the loss of coverage associated with the TAA-eligible individual's separation from employment then gave rise to his status as a TAA-eligible individual.²⁴⁵ The second COBRA election period for TAA-eligible individuals is only for those eligible individuals who had not previously elected COBRA coverage. The second COBRA election period is available if the individual is receiving trade adjustment assistance, the individual lost coverage due to a job loss that resulted in eligibility for trade adjustment assistance, and the individual failed to elect COBRA coverage during the COBRA election period described in V.A. above that was triggered by a job loss; however the TAA-eligible individual must make the COBRA election within the new 60 day election period

²⁴⁵ Code § 4980B(f)(5)(C)(iv)(IV).

and no later than 6 months after the TAA-related loss of coverage.²⁴⁶ The new election period for TAA-eligible individuals begins on the first day of the month in which the worker begins receiving trade adjustment assistance.²⁴⁷ The coverage available to the TAA-eligible individuals does not reach back to their original COBRA election period, if earlier, but only begins on the first day of the 60 day election period for TAA-eligible individuals.²⁴⁸

4. Any TAA-eligible individual who elects COBRA coverage is treated as not having a break in coverage for the period that begins on the date of the TAA-related loss of coverage and ending on the first day of the 60 day election period for the TAA-eligible individual.²⁴⁹
5. The FTA did not expressly provide for how the maximum period of COBRA coverage is to be measured. Presumably it would be measured from commencement of coverage on the first day of the TAA-eligible individual election period.

C. Who Elects COBRA Coverage

Each qualified beneficiary (including children born to or placed for adoption during the COBRA period) must be offered the opportunity to make an independent COBRA election.²⁵⁰ If the plan permits similarly situated active employees who have not had a qualifying event to select between different benefit options during open enrollment, then each qualified beneficiary must be given the opportunity to make a similar independent election during an open enrollment period.²⁵¹ If there are multiple qualified beneficiaries, except as otherwise specified in the election, the election by one qualified beneficiary will be deemed to be an election for all other qualified beneficiaries who would otherwise lose coverage.²⁵² The Final Regulations I modify this slightly by only binding the other qualified beneficiaries by an election of a qualified beneficiary who is either the covered employee or the spouse of the covered employee with respect to all other qualified beneficiaries or with respect to that qualifying event.²⁵³

1. Child's Election

A parent or legal guardian can make the election on behalf of a minor child.²⁵⁴ However, a decision to reject benefits will not be binding on the other qualified beneficiaries who are entitled to make their own COBRA elections.²⁵⁵

²⁴⁶ Code § 4980B(f)(5)(C)(i).

²⁴⁷ *Id.*

²⁴⁸ Code § 4980B(f)(5)(C)(ii).

²⁴⁹ Code § 4980B(f)(5)(C)(iii).

²⁵⁰ Treas. Reg. § 54.4980B-6 Q/A 6 (1999).

²⁵¹ Treas. Reg. § 54.4980B-6 Q/A 6 (1999).

²⁵² Code § 4980B(f)(5)(B); ERISA § 605(2); 42 U.S.C. § 300bb-5(2).

²⁵³ Treas. Reg. § 54.4980B-6 Q/A 6 (1999).

²⁵⁴ Treas. Reg. § 54.4980B-6 Q/A 6 (1999).

²⁵⁵ Treas. Reg. § 54.4980B-6 Q/A 6 (1999).

2. Incapacitation or Death

If a qualified beneficiary is incapacitated or dies, the legal representative of the qualified beneficiary, the qualified beneficiary's estate or the qualified beneficiary's spouse may make the election for the qualified beneficiary.²⁵⁶ The examples demonstrate that while an individual may make an election on behalf of his/her spouse, he/she cannot decline coverage on behalf of his/her spouse.²⁵⁷

D. Paying for Coverage

Once COBRA coverage is chosen, the qualified beneficiary may be required to pay for the coverage, even if the employer subsidizes all or some of the coverage for active employees and their dependents.²⁵⁸ A health care tax credit was enacted that permits health plan administrators to register with the Central Contractor Registration to be able to obtain Health Coverage Tax Credits ("HCTC") to obtain payments and obtain early payments. See the attached materials issued by the IRS in Exhibit C.

1. The Cost

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. COBRA beneficiaries are made subject to the rules of the plan and therefore must satisfy all cost requirements relating to deductibles, catastrophic, and other benefit limits. Any amounts accumulated toward such limits during the applicable period for accumulating such amounts prior to the qualifying event must be credited toward such limits under the COBRA coverage.²⁵⁹

Beneficiaries may be required to pay the entire premium for coverage. The premium cannot exceed 102% of the cost to the plan for similarly situated individuals who have not incurred a qualifying event, provided the individual is not on a disability extension.²⁶⁰ Premiums reflect the total cost of group health care coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus 2% for administrative cost. The applicable premium for each determination period must be computed and fixed before the 12-month determination period begins. The determination period is any 12-month period selected by the plan and applied consistently from year to year for any benefit package. It is not a period selected for each qualified beneficiary.²⁶¹ A plan may increase the COBRA premium during a determination period only in three situations.

²⁵⁶ Treas. Reg. § 54.4980B-6 Q/A 6 (1999).

²⁵⁷ Treas. Reg. § 54.4980B-6 Q/A 6, Ex. 1 (1999).

²⁵⁸ *Charles v. Des Plaines Publishing Co., Inc.*, 1991 U.S. Dist. LEXIS 7806 (N.D. Ill. 1991).

²⁵⁹ Treas. Reg. § 54.4980B-5 Q/A 2 and 3 (1999).

²⁶⁰ Code § 4980B(f)(2)(C)(i); ERISA § 602(3)(A); 42 U.S.C. § 300bb-2(3)(A); Treas. Reg. § 54.4980B-8 Q/A 1(a) (1999).

²⁶¹ Treas. Reg. § 54.4980B-8 Q/A 2(a) (1999).

- a. If the plan previously charged less than the maximum amount permitted for COBRA and the increased amount does not exceed the maximum permissible premium;
- b. The increase occurs during a disability extension and the increased amount that must be paid does not exceed the maximum amount permitted; or
- c. A qualified beneficiary changes the coverage being received.²⁶²

However, if a plan permits similarly situated active employees to change benefits, then the qualified beneficiaries must have the same right to change benefits. If a qualified beneficiary makes a change to a higher cost benefit package, then the applicable premium may not exceed the applicable premium (102% or 150% as applicable) for that higher cost coverage. If a qualified beneficiary changes coverage to a lower cost benefit package, then the maximum amount that may be changed is the applicable premium calculated for that lower cost benefit package.²⁶³

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months because they became disabled for Social Security purposes within 60 days of the qualifying event, the premium for those additional 11 months may be increased to 150% of the plan's total cost for coverage.²⁶⁴ If the disabled individual suffered a second qualifying event during the first 18 months of continuation coverage, the coverage period would be extended to 36 months and the premium limited to 102% of the applicable premium for the full 36 months of COBRA continuation coverage.²⁶⁵ If the disabled individual suffered a second qualifying event during the 19th through the 29th months of coverage, the maximum COBRA period is extended to 36 months and the premium for the 19th through the 36th months may be increased to 150% of the applicable premium.²⁶⁶ The 1998 Proposed and Temporary Treasury Regulations did not address the extent to which a plan can charge 150% of the applicable premium to a non-disabled qualified beneficiary who is a family member of the disabled qualified beneficiary causing the disability extension. The Final Regulations I clarify that in the event a second qualifying event occurs in the 19th to the 29th month extending coverage to 36 months, the

²⁶² Treas. Reg. § 54.4980B-8 Q/A 2(b) (1999).

²⁶³ Treas. Reg. § 54.4980B-8 Q/A 2(c) (1999).

²⁶⁴ Code § 4980B(f)(4)(B); ERISA § 604(2); 42 U.S.C. § 300bb-4(2)(B); Prop. Treas. Reg. § 54.4980B-1(a)(4) (1998); Treas. Reg. § 54.4980B-8 Q/A 1(b) (1999). Where the disabled qualified beneficiary is entitled to a 36-month maximum coverage period only because a second qualifying event occurred during the disability extension, the plan may require payment of 150% of the applicable premium until the end of the 36-month maximum coverage period. Treas. Reg. § 54.4980B-8 Q/A 1(b) (1999).

HIPAA added provisions to the Internal Revenue Code, in § 9802(b), that generally prohibit discrimination in premiums on the basis of health status, including on the basis of disability. The 1999 Proposed and 1999 Final Regulations clarify that a plan that requires a disabled qualified beneficiary entitled to the disability extension to pay 150% of the applicable premiums does not for that reason fail to comply with the nondiscrimination requirements of Code § 9802(b); Treas. Reg. § 54.4980B-8 Q/A 1(c) (1999).

²⁶⁵ Treas. Reg. § 54.4980B-8 Q/A 1(b) (1999).

²⁶⁶ Treas. Reg. § 54.4980B-8 Q/A 1(b) (1999).

150% premium may be charged for the entire 19th to 36th month period as long as the disabled qualified beneficiary is included in that coverage.²⁶⁷

Premiums due may be increased if the cost to the plan increases but generally must be fixed in advance of each twelve-month premium cycle.²⁶⁸

The IRS released Revenue Ruling 96-8, addressing the appropriate premium to charge a person electing COBRA continuation coverage in several fact situations, when the health plan provides for only two tiers of coverage, employee only and family.

- a. The first situation involves an employee and a spouse who both lost coverage under the employer's health plan. In this situation, Revenue Ruling 96-8 indicates that since both the employee and spouse will be receiving coverage and the plan offers employee only or family coverage (for covering the employee and one or more dependents), the premium for the family level of coverage is the appropriate premium to charge the employee and the spouse for COBRA coverage.
- b. In the second situation the employee does not lose coverage as the result of the qualifying event, but the spouse loses coverage. In this case the health plan may not charge the spouse the family rate of coverage. The plan instead must charge the spouse the employee only premium for the COBRA coverage because only one person is covered by the COBRA coverage. This rule applies even though an insurer may charge the plan sponsor the family rate for the COBRA coverage for that person.²⁶⁹

The IRS has begun auditing COBRA issues, and in fact, issued a COBRA audit guide that can be obtained through a Freedom of Information Act request. The IRS has stated in recent months that the audits have discovered compliance problems in both the initial COBRA notification and the notification following a qualifying event. Since no tax return is filed that covers the excise tax for COBRA violations the IRS has taken the position that there is no statute of limitations on past violations. The audit initiative in this area, the IRS's position that no prior years are closed for COBRA violations, and the potential liability for former participants' medical claims for violations makes this area particularly dangerous for employers who are not in compliance.

2. Making Payments

The initial premium payment must be made within 45 days after the date of the COBRA election of the qualifying beneficiary.²⁷⁰ The payment may be applied by the plan to the first period after coverage was lost.²⁷¹ Payment generally must cover

²⁶⁷ Treas. Reg. § 54.4980B-8 Q/A 1(b) and Examples 1 and 2 (1999).

²⁶⁸ Treas. Reg. § 54.4980B-8 Q/A 2(a) (1999).

²⁶⁹ Rev. Rul. 96-8, 1996-1 C.B. 286.

²⁷⁰ Treas. Reg. § 54.4980B-8 Q/A 5(c) (1999).

²⁷¹ Treas. Reg. § 54.4980B-8 Q/A 4 (1999); however, where the election was not offered as required and was

the period of coverage from the date of COBRA election *retroactive to* the date of loss of coverage due to the qualifying event. In other words, COBRA coverage begins immediately upon the qualifying event even though the first premium is not due until later.²⁷² However, if COBRA coverage is first waived and then elected so that coverage is only effective after the waiver revocation, the first payment is not applied to the period for which the coverage was waived.²⁷³

Premiums for successive periods of coverage are due on the dates stated in the plan with a minimum 30-day grace period for payments. The date for measuring the 30-day grace period may not be prior to the first date of the period of coverage.²⁷⁴ Plans must permit premiums to be paid in monthly installments.²⁷⁵

For example, the due date for the month of January could not be prior to January 1, and coverage for January could not be canceled if payment is made by January 31.

Premiums for the rest of the COBRA period must be made within 30 days after the 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. The plan must allow qualified beneficiaries to pay premiums on a monthly basis if they ask to pay monthly.²⁷⁶ A company may automatically and retroactively terminate benefits for failure to make timely payments and oral or informal communications may not alter the written terms of the plan.²⁷⁷ "Timely payment" is refined in the Final Regulations I to include not only the general rule of payments made within 30 days after the first day of the period, but to also include payments made to the plan by a later date if either --

- a. under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage; or
- b. under the terms of an arrangement between the employer or employee organization and the insurance company or health maintenance organization or other entity providing plan benefits, the employer or employee organization is allowed until a later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.²⁷⁸

only offered near the end of the 18-month maximum coverage period, the employer cannot require the qualified beneficiary to pay for the premiums for the full 18-month prior period, but the qualified beneficiary only must pay for the coverage she wants because it required her to pay more for the coverage (for 18 months instead of seven) than other beneficiaries seeking seven months of coverage would pay and the notice did not mention any option to pay for less than 18 months of coverage. *Popovits v. Circuit City Stores, Inc.*, 185 F.3d 726 (7th Cir. 1999).

²⁷² *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990); *Kytle v. Stewart Title Co.*, 788 F. Supp. 321 (S.D. Tex. 1992).

²⁷³ Treas. Reg. § 54.4980B-8 Q/A 4 (1999).

²⁷⁴ Code § 4980B(f)(2)(C); ERISA § 602(3); 42 U.S.C. § 300bb-2(3); Treas. Reg. § 54.4980B-8 Q/A 5 (1999).

²⁷⁵ Treas. Reg. § 54.4980B-8 Q/A 3 (1999).

²⁷⁶ Treas. Reg. § 54.4980B-8 Q/A 3 and 5 (1999).

²⁷⁷ *Homan v. T.W. Garner Food Co.*, No. 95-1936, 1996 U.S. App. LEXIS 24847 (4th Cir. 1996).

²⁷⁸ Treas. Reg. § 54.4980B-8 Q/A 5(a) (1999).

The Final Regulations I establish the disclosures that must be made to health care providers inquiring regarding a qualified beneficiary's coverage by requiring full disclosure, such as the individual currently has coverage, however that coverage may be retroactively revoked to December 31st if payment of the premium is not received by January 31st.²⁷⁹

3. Payment of Amounts Less Than the Full Premium

If timely payment is made to the plan in an amount that is not significantly less than the amount due for the COBRA premium, the Final Regulations I require this payment to be deemed to satisfy the plan's requirements, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a period of at least 30 days for payment of the deficiency to be made.²⁸⁰ An amount is not significantly less if it is no greater than the lesser of \$50.00 or 10% of the amount the plan requires to be paid.²⁸¹

4. Timing of Payment

Payment is considered made to the plan on the date it is sent to the plan.²⁸²

E. Claims Procedures

1. In General

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims.²⁸³ Claims procedures are to be included in the SPD booklet.²⁸⁴ Qualified beneficiaries may be charged up to \$.25 per page for copies of the complete plan document. Qualified beneficiaries should submit a written claim for benefits to whomever is designated as the Plan Administrator.

2. Denial of Claims

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.

The qualified beneficiary has 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless:

²⁷⁹ Treas. Reg. § 54.4980B-8 Q/A 5(c) (1999).

²⁸⁰ Treas. Reg. § 54.4980B-8 Q/A 5(d) (2001).

²⁸¹ Treas. Reg. § 54.4980B-8 Q/A 5(d) (2001).

²⁸² Treas. Reg. § 54.4980B-8 Q/A 5(e) (1999).

²⁸³ ERISA § 503.

²⁸⁴ DoL Reg. § 2560.503-1.

- The plan provides for a special hearing; or
- The decision must be made by a group which meets only on a periodic basis.²⁸⁵

Participants must exhaust administrative remedies in the plan to appeal denials of COBRA coverage, unless the futility exception to the exhaustion of administrative remedies applies.²⁸⁶ However, one court has held that a qualified beneficiary need not exhaust his administrative remedies in a COBRA claim for failure to notify the individual of this COBRA election rights.²⁸⁷

VI. Length of Coverage

COBRA continuation coverage begins on the date that coverage would have otherwise been lost by reason of a qualifying event and can end when any of the events described below occur.

Some plans allow beneficiaries to convert group health care coverage to an individual health insurance policy. If this option is available from the plan under COBRA, it must be offered to the qualified beneficiary within 180 days before COBRA coverage ends.²⁸⁸ The premium is generally not a group rate. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the maximum period of entitlement.

A. Last Day of Maximum Coverage

1. Coverage Duration

Coverage may end when the last day of the maximum coverage period is reached.²⁸⁹ Coverage may end earlier if any of the following occur:

- the first day timely payment is not made to the plan for the qualified beneficiary's coverage;
- the day on which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;
- the date after the election that the qualified beneficiary first becomes covered under another group health plan that does not apply an exclusion or limitation to a preexisting condition of the qualified beneficiary or the date such exclusion or limitation is satisfied by virtue of HIPAA's credits for prior coverage; or

²⁸⁵ DoL Reg. § 2560.503-1. Note B Proposed Regulations issued in 1998 would change the claims procedure requirements for health plans.

²⁸⁶ *Wylczynski v. Lumberman's Mutual Cas. Co.*, 93 F.3d 397 (7th Cir. 1996).

²⁸⁷ *Thompson v. Origin Technology in Business, Inc.*, 2001 U.S. Dist. LEXIS 12609 (2001).

²⁸⁸ Code § 4980B(f)(2)(E); ERISA § 602(5); 42 U.S.C. § 300bb-2(5).

²⁸⁹ Code § 4980B(f)(2)(B); ERISA § 602(2)(D)(i); 42 U.S.C. § 300bb-2(2); Treas. Reg. § 54.4980B-7 Q/A 1(a)(1) (1999). See VI.A.2. for the maximum periods.

- d. the date after the election that the qualified beneficiary first becomes covered (entitled) to Medicare.²⁹⁰

The maximum coverage period for newborns, adopted children, or children placed for adoption is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event and not from the date of the birth, adoption or placement for adoption.²⁹¹ A plan may terminate a qualified beneficiary's coverage on the same basis the plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, e.g., fraudulent claims, falsifying or forging prescriptions. However, termination for failure to make payment may only occur as described in V.C.2., 3. and 4.²⁹²

2. Maximum Period

COBRA establishes minimum required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA.²⁹³ Under COBRA, an individual may be entitled to up to 18 months, 29 months, or 36 months of continuation coverage depending upon which qualifying event(s) gave rise to the COBRA coverage. The COBRA coverage maximum periods can be cut short by the occurrence of the events described in VI.B., C., D., and E. below.

a. Eighteen Months

If an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan generally is only required to make COBRA continuation coverage available to that individual for 18 months.²⁹⁴

b. Twenty-Nine Months

If an individual or a covered family member of an individual, who has been terminated or whose hours have been reduced, is disabled within 60 days of the qualifying event or the date coverage ends (if the election under Code § 4980B(f)(8) is made by the employer) (as determined under the Social Security Act) and satisfies the applicable notice requirements by notifying the employer during the initial 18-month period of COBRA coverage, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months.²⁹⁵ Failure to notify the employer during the first 18 months

²⁹⁰ Code § 4980B(f)(2)(B)(i); Treas. Reg. § 54.4980B-7 Q/A 1(a) and Q/A 2 (1999).

²⁹¹ Treas. Reg. § 54.4980B-7 Q/A 4(a) (2001).

²⁹² Treas. Reg. § 54.4980B-7 Q/A 1(b) and (c) (1999).

²⁹³ Treas. Reg. § 54.4980B-7 Q/A 4 (1999).

²⁹⁴ Code § 4980B(f)(2)(B)(i)(I); ERISA § 602(2)(A)(i); 42 U.S.C. § 300bb-2(2)(A)(i).

²⁹⁵ Code § 4980B(f)(2)(B)(i) and (C); ERISA §§ 602(2)(A) and (3); 42 U.S.C. §§ 300bb-2(2)(A) and (3); Treas. Reg. § 54.4980B-7 Q/A 5 (1999).

of COBRA coverage of the Social Security Administration's disability determination results in loss of the extension.²⁹⁶

The disability extension applies if a qualified beneficiary in the family of the covered employee or the covered employee is disabled at the time of the termination of employment or reduction in hours or if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage.²⁹⁷ The disability extension applies independently to each qualified beneficiary entitled to COBRA coverage by reason of the same qualifying event.²⁹⁸

If the qualified beneficiary is a child born to or placed for adoption with the covered employee during the COBRA period, the 60-day period for the occurrence of the disability is measured from the date of birth or placement for adoption.²⁹⁹ The notice requirement is satisfied if any of the qualified beneficiaries provide the plan administrator with notice of the disability within 60 days after the disability determination is issued and before the end of the 18-month maximum COBRA period.³⁰⁰

If the disabled qualified beneficiary is later determined to no longer be disabled, then the plan may terminate the COBRA coverage of an affected qualified beneficiary before the end of the disability extension.³⁰¹

Also, if the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members who are qualified beneficiaries are also entitled to the 29 months disability extension.³⁰²

If a second qualifying event (such as Medicare entitlement) occurs during this 29-month period, the beneficiary becomes eligible for up to 36 months of coverage measured from the original event -- the termination of employment or reduction in hours. However, the second qualifying event cannot be a reduction of hours or a termination of employment. The extension only applies to the individuals who were qualified beneficiaries under the plan with respect to the first qualifying event and who are still qualified beneficiaries at the second qualifying event.³⁰³

²⁹⁶ *Marsh v. Omaha Printing Co.*, 218 F.3d 854 (8th Cir. 2000).

²⁹⁷ Code § 4980B(f)(2)(B)(i); ERISA § 602(2)(A); Treas. Reg. § 54.4980B-7 Q/A 4 and Q/A 5 (1999).

²⁹⁸ Treas. Reg. § 54.4980B-7 Q/A 5(a) and (c) (1999 and 2001, respectively).

²⁹⁹ Treas. Reg. § 54.4980B-7 Q/A 5(c) (2001).

³⁰⁰ Treas. Reg. § 54.4980B-7 Q/A 5(d) (1999).

³⁰¹ Treas. Reg. § 54.4980B-7 Q/A 4(c) and Q/A 5(a) (2001).

³⁰² Code § 4980B(f)(2)(B)(i); ERISA § 602(2)(A); Treas. Reg. § 54.4980B-7 Q/A 6 (1999).

³⁰³ Code § 4980B(f)(2)(B)(i); ERISA § 602(2)(A); Treas. Reg. § 54.4980B-7 Q/A 6 (1999).

c. Thirty-Six Months

Certain qualifying events, or a second qualifying event during the initial period of 18 or 29 months of COBRA coverage, may permit a beneficiary to receive a maximum of 36 months coverage.

i. Qualifying Events

A spouse or dependent child is entitled to 36 months of COBRA continuation coverage if one of the following qualifying events occurs:

- The covered employee is entitled to Medicare.³⁰⁴ If a covered employee becomes entitled to Medicare before experiencing a qualifying event, the 1999 Proposed Regulations indicate that the maximum coverage period ends on the later of:
 - (1) 36 months after the date the covered employee became entitled to Medicare; or
 - (2) 18 months (or 29 months if there is a disability extension) after the covered employee's employment terminates or his hours are reduced³⁰⁵;
- Divorce or legal separation³⁰⁶; or
- Death of the covered employee.

In addition, the dependent child may receive a maximum of 36 months of coverage if he loses "dependent child" status under the plan (e.g., reaching the maximum age for coverage as a dependent child).³⁰⁷

ii. Multiple Qualifying Events

If a second or additional qualifying event occurs during the initial 18-month continuation coverage period or during the extended 29-month period for a disabled qualified beneficiary, the period will be

³⁰⁴ Treas. Reg. § 54.4980B-7 Q/A 3(b) (1999) clarifies that entitlement to Medicare means actual coverage under either Part A or B of Medicare and this occurs on the effective date of enrollment in either Part A or B.

³⁰⁵ Treas. Reg. § 54.4980B-7 Q/A 4(d) (2001).

³⁰⁶ Rev. Rul. 2002-88, 2002-52 I.R.B. 995, clarified that when the qualifying event is divorce and the loss of coverage was in anticipation of the divorce, the coverage must be made available as of the date of divorce. There is no requirement to make the coverage effective as of the date coverage was lost in anticipation of the divorce.

³⁰⁷ Code § 4980B(f)(2)(B)(i)(II); ERISA § 602(2)(A)(ii); 42 U.S.C. § 300bb-2(2)(A)(ii); Treas. Reg. § 54.4980B-7 Q/A 6(b) (2001).

extended to 36 months from the date of the earlier qualifying event.³⁰⁸ Termination of employment or reduction in hours is not a second qualifying event that extends coverage to 36 months. The bankruptcy of the employer also cannot be a second qualifying event.³⁰⁹

d. Bankruptcy of the Employer for Retired Covered Employees

If the qualifying event is the bankruptcy of the employer, the maximum coverage period for a qualified beneficiary who is the retired covered employee ends on such person's death. The maximum coverage period for a qualified beneficiary who is the spouse, surviving spouse or dependent of the retired covered employee ends on the earlier of --

- i. the date of the qualified beneficiary's death; or
- ii. the date that is 36 months after the death of the retired covered employee.³¹⁰

B. Unpaid Premiums

A company may automatically and retroactively terminate benefits for failure of timely payment of premiums.³¹¹ However, qualified beneficiaries must receive a minimum grace period of 30 days, regardless of any shorter period contained in the plan for active employees.³¹² Payment by a later date is also considered timely if, under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage during the period, or if the employer is allowed until a later date to transmit payment to the insurer.³¹³ The Final Regulations I introduced a new concept of a payment in an "amount not significantly less than the amount the plan requires" as being deemed timely payment and requires the plan to permit the qualified beneficiary an additional grace period of at least 30 days after the notice is provided to make the additional payment and to provide the qualified beneficiary with a notice of the deficiency.³¹⁴ Payment is considered to be made on the date it is sent to the Plan.³¹⁵ An amount is "not significantly less" if it is greater than the lesser of \$50.00 or 10% of the amount the plan requires to be paid.³¹⁶

³⁰⁸ Code § 4980B(f)(2)(B)(i)(II); ERISA § 602(2)(A)(ii); 42 U.S.C. § 300bb-2(2)(A)(ii).

³⁰⁹ Treas. Reg. § 54.4980B-7 Q/A 6(b) (1999); Treas. Reg. § 54.4980B-7 Q/A 6(b) (2001); *Accord, Burgess v. Adams Tool & Engineering, Inc.*, 908 F. Supp. 473 (W.D. Mich. 1995); *Contra, Gibbs v. Anchorage School District*, 1995 U.S. LEXIS 6290 (D. Ark. 1995).

³¹⁰ Treas. Reg. § 54.4980B-7 Q/A 4(e) (2001).

³¹¹ *Homan v. T.W. Garner Food Co.*, No. 95-1936, 1996 U.S. App. LEXIS 24847 (4th Cir. Sept. 10, 1996).

³¹² Code § 4980B(f)(2)(B)(iii); ERISA § 602(2)(C); 42 U.S.C. § 300bb-2(2)(C); Treas. Reg. § 54.4980B-8 Q/A 5(a) (1999).

³¹³ Treas. Reg. § 54.4980B-8 Q/A 5(a) (1999).

³¹⁴ Treas. Reg. § 54.4980B-8 Q/A 5(d) (1999).

³¹⁵ Treas. Reg. § 54.4980B-8 Q/A 5(e) (1999).

³¹⁶ Treas. Reg. § 54.4980B-8 Q/A 5(d) (2001).

C. Cessation of Health Plan

COBRA continuation coverage may end when the employer ceases to maintain any group health plan.³¹⁷ Note the "employer" that must cease to maintain any group health plan means the employer including all members of the controlled group and affiliated service group.³¹⁸

D. Other Coverage

COBRA continuation coverage may be terminated if coverage is obtained with another employer group health plan (actual coverage not merely eligibility for coverage) that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary and that first becomes effective after the COBRA election is made, provided the other group health plan is not maintained by the employer or employee organization maintaining the plan under which the COBRA coverage must be available.³¹⁹

The Fifth Circuit has held that an employer may cancel continuation coverage regardless of when the employee obtained replacement insurance.³²⁰ However, other circuits have been split over the issue of whether a person is disqualified from receiving continuation of benefits only if he procures other coverage *after* he has chosen to secure COBRA insurance (focusing on the statutory language "first becomes covered after the qualifying event"), or if the COBRA coverage may only be terminated if there is no gap in the other coverage (focusing on the statutory language "does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary"). While the Eighth and Eleventh Circuits have also held that a person is disqualified from receiving continuation benefits if he has other coverage regardless of when he procured the other coverage,³²¹ the Tenth and Seventh Circuits have held that continuation benefits may be terminated only if the beneficiary obtains other insurance *after* the date of election.³²² The Supreme Court accepted a case considering this dispute for review and decided in the *Geissal* case whether the "gap theory" or the "first in time theory" should govern whether COBRA coverage may be terminated. The Court in *Geissal* decided that the "gap theory" had no statutory basis. The Court in *Geissal* decided that only coverage that first begins after the qualified beneficiary makes the COBRA election may terminate the COBRA coverage. Preexisting coverage or coverage that first commenced prior to the election of the COBRA coverage does not terminate COBRA coverage.

³¹⁷ Code § 4980B(f)(2)(B)(ii); ERISA § 602(2)(B); 42 U.S.C. § 300bb-2(2)(B).

³¹⁸ Code § 414(t)(2).

³¹⁹ Code § 4980B(f)(2)(B)(iv)(I); ERISA § 602(2)(D)(i); 42 U.S.C. § 300bb-2(2)(D)(i); Treas. Reg. § 54.4980B-7 Q/A 2 (1999).

³²⁰ *Brock v. Primedica*, 904 F.2d 295 (5th Cir. 1990).

³²¹ *Geissal v. Moore Med. Corp.*, 118 S. Ct. 1869, 141 L.Ed2d 64 (June 8, 1998) rev'g 114 F.3d 1458 (8th Cir. 1997) (U.S. Sup. Ct., No. 97-689, review granted January 23, 1998); *National Cos. Health Benefit Plan v. St. Joseph's Hosp., Inc.*, 929 F.2d 1558 (11th Cir. 1991).

³²² *Lutheran Hosp., Inc. v. Business Men's Assurance Co. of Am.*, 51 F.3d 1308 (7th Cir. 1995); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990).

If the other group health plan whose coverage arose after the election limits or excludes coverage for any pre-existing condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. However, if, under HIPAA, those limits or exclusions would not apply to (or would be satisfied by the coverage of a subsequent plan) an individual receiving COBRA continuation coverage, then the plan providing the COBRA continuation coverage can stop making the COBRA continuation coverage available to that individual as long as the individual does not have a preexisting condition that is covered by an exclusion or limitation in the subsequent group health plan coverage.³²³

E. Medicare Entitlement

COBRA continuation coverage ends when a beneficiary is entitled to Medicare benefits.³²⁴ Entitled means actually covered (*i.e.*, the effective date of enrollment) by Medicare for either Part A or Part B benefits, not mere eligibility.³²⁵

F. Summary Plan Descriptions

A summary plan description's description of COBRA coverage and its duration should be carefully reviewed. A summary plan description's COBRA description that was broader than the statutory provision or the provision in the plan bound the plan to provide additional coverage.³²⁶

VII. Effect of Failure to Comply With COBRA

A. Statutory Penalties

There are significant penalties for failure to meet COBRA requirements. While there are some allowances for failures which are due to a reasonable cause and are immediately corrected, an employer can be penalized \$110 per day per participant under ERISA section 502(c)(1).

The U.S. Department of Labor has indicated to the IRS and Treasury Department that to the extent a plan fiduciary subjects a plan to liability for the COBRA excise taxes on account of his or her imprudent actions, the plan fiduciary may be held liable under Title I of ERISA for the amount of the tax.³²⁷

B. Tax Penalties

Failure to comply with any of the continuation coverage requirements will result in the imposition of an excise tax under Code § 4980B. For a single employer plan that is not a

³²³ Code § 4980B(f)(2)(B)(iv); ERISA § 602(2)(D); 42 U.S.C. § 300bb-2(2)(D); Treas. Reg. § 54.4980B-7 Q/A 3 (1999).

³²⁴ Code § 4980B(f)(2)(B)(i)(V); ERISA § 602(2)(D); 42 U.S.C. § 300bb-2(2)(D).

³²⁵ Treas. Reg. § 54.4980B-7 Q/A 3(b) (1999).

³²⁶ *Fallov v. Piccadilly Cafeterias, Inc.*, 1998 U.S. App. LEXIS 10719 (5th Cir. 1998).

³²⁷ 64 F.R. 5160, 5164 fn. 4.

governmental plan, the maximum liability for excise taxes is the lesser of \$500,000 or 10% of the total amount paid or incurred by the employer during the preceding taxable year for the group health plan.³²⁸ It is also a violation of COBRA for a group health plan to reduce its coverage for pediatric vaccines to a level below that covered by the plan on May 1, 1993.³²⁹ It is unclear how the pediatric vaccine provision applies to plans resulting from mergers, acquisitions and spinoffs.

Because no tax return is filed reporting the COBRA excise tax for violations, no statute of limitation is tolled or begins to run, thus the Internal Revenue Service has taken the position that no statute of limitation exists on COBRA violations for purposes of assessing the excise tax.

In the case of a person providing benefits under the plan or for administering or providing benefits under the plan and whose act or failure to act caused (in whole or in part the failure), such person may be subject to a tax of up to \$2,000,000 for failures for a taxable year for all plans.³³⁰

C. ERISA Penalties Imposed

ERISA section 502(c)(1) imposes a \$110 per day penalty for failure to provide the required notice to the qualified beneficiary at his last known mailing address. However, courts vary regarding whether the penalty is assessed in a notice failure.

1. ERISA Plans

Where an employer did not fail to provide the COBRA notice in bad faith and gave the qualified beneficiary the full 60 days to elect COBRA after the delinquent notice and the delinquency did not harm the qualified beneficiary, no penalty was imposed.³³¹ Individuals who fail to request the penalty and have no harm have been denied the penalty in some cases.³³² The 11th Circuit held that only participants may recover the penalty for failure to provide notice.³³³ Individuals who suffer no harm from the failure to receive the COBRA notice have been held in some courts to not be entitled to any damages or recovery.³³⁴ Individuals who were not prejudiced by the failure to provide the COBRA notice were awarded only modest penalties because there was no showing the employer acted in bad faith and caused him prejudice.³³⁵ However, one court found the failure to provide the COBRA notice information on the plan and conversion options on a timely basis to be a breach of

³²⁸ Code § 4980B(b).

³²⁹ Code § 4980B(f)(1), this will not apply to governmental plans.

³³⁰ Code § 4980B(c)(4)(C) and § 4980B(e)(1) (2003).

³³¹ *Kerkhof v. MCI Worldcom, Inc.*, 282 F.3d 44 (1st Cir. 2002).

³³² *Boucher v. Williams*, 1998 U.S. Dist. LEXIS 6623 (D.C. Maine May 6, 1998).

³³³ *Wright v. Hanna Steel Corporation*, 2001 U.S. App. LEXIS 22878 (11th Cir. 2001).

³³⁴ *Partridge v. HIP of Greater New York*, 2000 U.S. Dist. LEXIS 8714 (S.D.N.Y. 2000); *Kerkhof v. MCI Worldcom, Inc.*, 2000 U.S. Dist. LEXIS 12334 (Me. 2000).

³³⁵ *Veneziano v. Long Island Pipe Fabrication & Supply*, 2003 U.S. App. LEXIS 21735 (3d Cir. 2003).

fiduciary duty.³³⁶ Evidence of a reliable system of COBRA notification that is regularly followed with records that the notice was sent has sufficed to overcome claims that the notice was not received.³³⁷ In one case a plaintiff sued for the statutory penalty after he was made whole under the coverage, the court found the offending party to be the plaintiff's counsel for prosecuting a case that did not have a reasonable basis and ordered the plaintiff's counsel to pay a portion of the defendant's attorney's fees and costs.³³⁸ Where the COBRA notice was not provided to a former employee on a disability leave with health problems and also withheld providing her a summary plan description, the court imposed the maximum statutory penalties for failure to provide notice.³³⁹

2. Governmental Plans

No similar penalty is provided in the PHSa. At least one court has refused to interpret 42 U.S.C. § 300bb-7 reference to "appropriate equitable relief" to apply penalties similar to those in the Code and ERISA.³⁴⁰ Another court held that the PHSa provisions regarding COBRA do not provide for any fines or attorney fees; thus none are available.³⁴¹ The Third Circuit has held that when the failure to provide the COBRA notice by a governmental plan caused no harm, there is no equitable relief for the notice violation.³⁴²

D. Restoration of Person Entitled to COBRA

A plan may correct its failure to comply with COBRA's requirements for any qualified beneficiary by retroactively correcting the deficiency to the extent possible and placing the qualified beneficiary in a financial position which is as good as such beneficiary would have been in had the failure not occurred.³⁴³ However, the restitution of the person to the position he would have been in if there had been no violation does not entitle the person to monetary damages. Equitable relief for a COBRA qualified beneficiary who is deceased does not entitle the beneficiary to compensatory damages.³⁴⁴ Similarly, compensatory, extra contractual and punitive damages were all rejected and only restoring the participant to the

³³⁶ *Carner v. MGS*, 992 F. Supp. 340 (S.D.N.Y. 1998).

³³⁷ *Southern Maryland Hospital Center, Dadger v. Corley*, 1998 U.S. Dist. LEXIS 7393 (D. Md. 1998) and *Shafir v. Association of Reform Zionists of America*, 1998 U.S. Dist. LEXIS 3879 (S.D.N.Y. 1998); *Gotay v. Becton Dickinson Caribe LTD*, 2003 U.S. Dist. LEXIS 6147 (D.C. P.R. 2003); notice sent via certified mail even if returned is sufficient, *Holmes v. Scarlet Oaks Retirement Community*, 277 F. Supp.2d 829 (S.D. Ohio 2003); and notice sent by third party sufficient, *Swift v. Lake Park High School District 108*, 2003 U.S. Dist. LEXIS 18684 (N.D. Ill. 2003).

³³⁸ *Moreno v. St. Francis Hospital & Health Center*, 2002 U.S. Dist. LEXIS 1672 (N.D. Ill. E. Div. 2002).

³³⁹ *Brown v. Aventis Pharmaceuticals, Inc.*, 2003 U.S. App. LEXIS 18557 (8th Cir. 2003).

³⁴⁰ *Brett v. Jefferson County, Georgia*, 123 F.3d 1429 (11th Cir. 1997).

³⁴¹ *Thomas v. Town of Hammonton*, 2003 U.S. App. LEXIS, 24431 (3d Cir. 2003).

³⁴² *Thomas v. Town of Hammonton*, 2003 U.S. App. LEXIS 24431 (3d Cir. 2003).

³⁴³ Code § 4980B(g)(4). Note: no comparable provision is found in ERISA or the PHSa.

³⁴⁴ In *Geissal v. Moore Medical Corp.*, 2001 U.S. Dist. LEXIS 5389 (E.D. Mo. 2001), the court found Ms. Geissal was not entitled to receive restitution when the beneficiary had died. If he were alive he could have received the benefits, but since he was deceased he could not receive the plan's benefits; thus, he was left without a remedy.

place they would have been in with COBRA coverage were permitted in another action.³⁴⁵ Compensatory damages were also rejected by other courts.³⁴⁶

Participants in ERISA plans also may sue for benefits under ERISA § 502(a) to obtain their COBRA rights and benefits under the plan which will permit the participant to receive the benefits they would have been entitled to receive under COBRA under the plan. An employer's failure to remit COBRA premiums to the insurer on a timely basis resulting in loss of coverage for the qualified beneficiary was actionable and resulted in the employer being forced to pay the qualified beneficiary's medical expenses net of the COBRA premiums.³⁴⁷

COBRA rights do not give the plan participant or his estate the right to receive amounts another plan paid as primary payer when it should have been secondary payer under the coordination of benefits provisions if the plan which did not provide COBRA had paid primary. The estate does not have the right to recover those amounts either under a claim for equitable relief under ERISA section 502(a)(3) or as a claim for benefits under ERISA section 502(a)(1)(B).³⁴⁸

For persons pursuing COBRA rights under the PHS, ERISA's preemption provision does not apply and state law based causes of action may proceed.³⁴⁹

E. Limitation on Actions

The COBRA statute does not contain a statute of limitation which limits when an action must be brought by a participant for a violation of his COBRA rights. At least one court has determined that the five year statute of limitations for actions under § 510 of ERISA and the ten year statute of limitations held applicable to suits under § 502 of ERISA do not apply, but that the most analogous statute of limitations is a two year statute for state actions against insurance producers, limited insurance representatives and registered firms and that statute should apply.³⁵⁰ The District Court in South Carolina determined that the statute of limitations on an action for failure to give notice of election rights was one year borrowed from a state statute for a penalty claim.³⁵¹ Similarly, the District Court in West Virginia likened a failure to provide the COBRA notice action to an unfair insurance practices action under West Virginia State law and used that law's one year statute of limitations.³⁵² A District Court in Louisiana used the same statute of limitation used for an ERISA section 502

³⁴⁵ *Vargas v. Child Development Council of Franklin County, Inc.*, 269 F. Supp.2d 954 (S.D. Ohio 2003).

³⁴⁶ *Torres-Negron v. Ramallo Bros. Printing, Inc.*, 203 F. Supp.2d 120 (D.P.R. 2002).

³⁴⁷ *McFadden v. R&R Engine Machine Co.*, 102 F. Supp. 458 (N.D. Ohio 2000).

³⁴⁸ *Geissal v. Moore Medical Corporation*, 338 F.3d 926 (8th Cir. 2003); rehearing en banc denied, 2003 U.S. App. LEXIS 18967 (8th Cir. Sept. 12, 2003).

³⁴⁹ *Radici v. Associated Insurance Companies, Blue Cross/Blue Shield of Indiana*, 217 F.3d 737 (9th Cir. 2000).

³⁵⁰ *Carter v. General Electric*, No. 98C50239, 2000 U.S. Dist. LEXIS 3875 (N.D. Ill. 2000) citing *Dail v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62 (7th Cir. 1996).

³⁵¹ *Bryant v. Food Lion, Inc.*, 2000 U.S. Dist. LEXIS 8049 (D. S.C. 2000).

³⁵² *Harvey v. Mingo Logan Coal Company*, 274 F. Supp.2d 791 (S.D. W.Va. 2003).

claim as the statute for the COBRA claim.³⁵³ The District Court in Vermont found the statute of limitations for economic damages, six years, was most analogous.³⁵⁴

F. Pleadings

The Plan is required to provide the COBRA coverage. An aggrieved party should sue the plan or a plan fiduciary for a failure to provide COBRA coverage to recover reimbursement for medical expenses not his employer who is not the plan administrator.³⁵⁵ Similarly, a COBRA claim cannot be brought against the individual's former supervisor or the corporate entities that are parents to the individual's employer.³⁵⁶ Failure to allege that the plaintiff is a participant or beneficiary in the group health plan results in dismissal of the complaint.³⁵⁷

VIII. Coordination With Other Benefits

A. FMLA

The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions that 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. The taking of an FMLA leave is not a qualifying event.³⁵⁸ 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 intent not to return to work.³⁵⁹ However, if the employer eliminates all group health plan coverage for the class of employees to which they employee would have returned before the end of the FMLA leave, there is no qualifying event.³⁶⁰

If the employee on FMLA leave permits his coverage to lapse during the leave, it does not effect the determination of whether a set of circumstances constitute a qualifying event.³⁶¹ If a state or local law requires coverage under a group health plan be maintained during a leave of absence for longer than that required under FMLA, this does not effect the plan's COBRA obligations.³⁶² COBRA coverage cannot be conditioned on the employees payment of premiums for the coverage during the FMLA leave.³⁶³

³⁵³ *Stewart v. Project Consulting Services, Inc.*, 2001 U.S. Dist. LEXIS 13680 (E.D. La. 2001).

³⁵⁴ *Mattson v. Farrell Distributing Corp.*, 163 F. Supp. 2d 411 (D.C. 14 2001).

³⁵⁵ *Cheney v. Comcast Cable Communications, Inc.*, 2003 U.S. Dist. LEXIS 12232 (E.D. PA. 2003).

³⁵⁶ *Bishop v. ABN-AMRO Services Co., Inc.*, 2003 U.S. Dist. LEXIS 12368 (N.D. Ill. 2003).

³⁵⁷ *Lakin v. Gary Skaletsky, M.D.*, 2003 U.S. Dist. LEXIS 15449 (N.D. Ill. 2003).

³⁵⁸ Treas. Reg. § 54.4980B-10 Q/A 1 (2001) and IRS Notice 94-103, I.R.B. 1994-51.

³⁵⁹ IRS Notice 94-103, IRB 1994-51; Treas. Reg. § 54.4980B-10 Q/A 1 and 2 (2001).

³⁶⁰ Treas. Reg. § 54.4980B-10 Q/A 1 (2001).

³⁶¹ Treas. Reg. § 54.4980B-10 Q/A 3 (2001).

³⁶² Treas. Reg. § 54.4980B-10 Q/A 4 (2001).

³⁶³ Treas. Reg. § 54.4980B-10 Q/A 5 (2001).

B. Medicare

Merely because an employee retires at or after age 65 does not mean that COBRA can be ignored. Entitlement to Medicare is not the same as eligibility for Medicare. Under COBRA, only entitlement counts. Although a 65-year old individual is eligible for Medicare, attainment of age 65 does not mean that someone is "entitled" to or covered by Medicare. To be entitled to Medicare due to age, an individual must take some affirmative act either to commence Social Security Income payments or to actually elect and pay for Medicare benefits. The timing of when someone becomes entitled to Medicare is a key to the liability question. If a person becomes entitled to Medicare before a COBRA election, that Medicare entitlement would not disqualify him from electing COBRA. Only post-COBRA election Medicare entitlement will clearly allow a plan to terminate COBRA coverage. **Note:** Medicare entitlement does not permit termination of COBRA coverage if the qualifying event was the Chapter 11 bankruptcy of the employer.

C. Military Leave and USERRA

1. Pre-USERRA

When the Persian Gulf War commenced, many employers suddenly were faced with how should the group health plan treat reservists called to active duty. The Internal Revenue Service provided guidance by issuing Notice 90-58 which addressed two alternatives.

- a. The employer may voluntarily continue with no increase in employee contributions for premiums. The amounts paid for the premium would continue to be excludable from gross income. The employer need not offer COBRA if the employer pays the premium in full.
- b. If the employer did not voluntarily maintain coverage for the COBRA coverage period and the group health plan is subject to COBRA, a qualifying event did occur for COBRA purposes and the reservist, the reservist's spouse and the dependent children (if covered under the plan) must be provided with a COBRA election.
- c. The military health coverage (CHAMPUS) does not affect the employer's obligation to offer COBRA and coverage under military health coverage does not terminate COBRA coverage.

2. Uniformed Services Employment and Reemployment Rights Act of 1994

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that a group health plan must provide a person on military leave the right to elect to continue coverage. The maximum period of coverage that must be offered under USERRA is the lesser of 18 months beginning on the date the person's military absence begins or until the day after the date on which the person fails to apply for a return to a position of employment (under section 4312(e) of USERRA). An employer cannot require an individual on a USERRA leave to pay more than 102% of the full premium determined using the COBRA premium guidance. However, if an individual is gone less than 31 days, the employee may

only be required to pay the employee's share of the premium. If a person on military service has their health care coverage terminated, an exclusion or waiting period may not be imposed in connection with the reinstatement of the coverage on reemployment. This prohibition on applications of preexisting condition exclusions and waiting periods on the employment applies to both the employee and any dependent who is covered when the employee's coverage is reinstated upon return. The prohibition on preexisting condition exclusions and waiting periods will not apply to any injury or illness that is determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during performance of service in uniformed services.³⁶⁴

USERRA does not state that the coverage it mandates replaces COBRA or addresses its coordination with COBRA. However, the Final Regulations I indicate that if health care is provided to a qualified beneficiary after a qualifying event without regard to COBRA coverage (as the result of state law or USERRA) or industry practice or a severance agreement, such alternative coverage does not extend the maximum coverage period. However, if the alternative coverage does not satisfy all of COBRA's requirements or if the amount the group health plan requires the individual to pay is greater than the amount paid by similarly situated non-COBRA beneficiaries for coverage that the qualified beneficiary can elect to receive under COBRA, then the plan covering the qualified beneficiary before the qualifying event must offer the qualified beneficiary the opportunity to elect COBRA coverage.³⁶⁵ If the individual elects alternative coverage over COBRA coverage, then at the expiration of the alternative coverage, the plan does not need to offer COBRA.³⁶⁶

If the individual who receives the alternative coverage is a covered employee and that individual's spouse or dependent child would lose that alternative coverage as the result of a qualifying event (e.g., divorce or death), then the spouse or dependent child must be given the opportunity to elect to continue the alternative coverage with a maximum coverage period lasting 36 months from the date of that qualifying event.³⁶⁷ If the alternative coverage does not provide the 36-month duration, then presumably this is provided through COBRA coverage.

3. Conversion Coverage

No group health plan is required to provide conversion coverage. However, if a group health plan chooses to provide conversion coverage, it must notify the qualified beneficiary of his/her option to enroll in the conversion coverage within the 180-day period ending on the expiration of the maximum coverage period for the qualified beneficiary, if that option is otherwise generally available to similarly situated non-COBRA beneficiaries. If the option is not otherwise generally available, then it need not be offered to qualified beneficiaries.³⁶⁸

³⁶⁴ USERRA §§ 4312(e), 4316 and 4317.

³⁶⁵ Treas. Reg. § 54.4980B-7 Q/A 7(a) and (b) (1999).

³⁶⁶ Treas. Reg. § 54.4980B-7 Q/A 7(c) (1999).

³⁶⁷ Treas. Reg. § 54.4980B-7 Q/A 7(c) (1999).

³⁶⁸ Treas. Reg. § 54.4980B-7 Q/A 8 (1999).

D. Interaction of COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

In an effort to provide employers guidance that they can give to employees regarding the interaction of COBRA and HIPAA, the Internal Revenue Service issued Notice 98-12. This is an optional notice employers may provide to persons considering whether to elect COBRA to assist them in understanding the interaction of COBRA with HIPAA.

E. COBRA, Rehires and Group Health Plan Disclosures

One court has held that a group health plan's failure to disclose the interaction of COBRA for rehires with the preexisting condition exclusion in the group health plan is a breach of fiduciary duty for which a participant may seek appropriate equitable relief.³⁶⁹

IX. COBRA in Mergers and Acquisitions

A. General Concepts and New Definitions

The 1999 Proposed Treasury Regulations and Final Regulations II added new provisions regarding business reorganizations and employer withdrawals from multiemployer plans that build on the provision contained in the original 1987 Proposed Regulations regarding successor liability. A business reorganization is either a stock sale in which the stock of one organization is sold or transferred so that that corporation becomes a different employer or a member of a different controlled group of corporations.³⁷⁰

1. Asset Sale

An asset sale is defined in the Final Regulations II as a sale of "substantial assets" such as a plant or division or substantially all of the assets of the trade or business.³⁷¹

2. Stock Sale

A stock sale is a transfer of stock in a corporation that causes the corporation to become a member of a different controlled group or to separate it from its previous controlled group.³⁷² The general rules for a controlled group determination under Code § 414(b) and (c) and Treas. Reg. § 1.414(b) and (c) and Treas. Reg. § 1.414(b)-1, 1.414(c)-1 - 5 applied to determine whether or not businesses are in a controlled group.³⁷³

³⁶⁹ *Bowerman v. Wal-Mart Stores, Inc.*, 226 F.3d 574 (7th Cir. 2000).

³⁷⁰ Treas. Reg. § 54.4980B-9 Q/A 1(a) and (b) (2001).

³⁷¹ Treas. Reg. § 54.4980B-9 Q/A 1(c) (2001).

³⁷² Treas. Reg. § 54.4980B-9 Q/A 1(b) (2001).

³⁷³ Treas. Reg. § 54.4980B-9 Q/A 1(d) (2001).

3. **Buying Group, Selling Group, Acquired Organization**

The Final Regulations II finalized several other concepts that were introduced in the 1999 Proposed Treasury Regulations such as selling group, acquired organization and buying group. In the case of a stock sale, the selling group is the controlled group of corporations or groups of trades or businesses under common control from which the corporation ceases to be a member as the result of a stock sale. For a stock sale the acquired organization is a corporation that ceases to be the member of the selling group as the result of the stock sale. For a stock sale, the buying group is the controlled group of corporations or a group of controlled trades or businesses which adds the acquired organization as a member of its controlled group as the result of the stock sale. However, if the acquired organization does not become a member of another controlled group, the buying group is the acquired organization.³⁷⁴

In the case of an asset sale, the selling group is the controlled group or group of trades or businesses under common control that includes the corporation or a trade or business that is selling the assets. In an asset sale, the buying group is the controlled group of corporations or group of trades or businesses under common control that includes the corporation or trade or business that is buying the assets.³⁷⁵ The asset sale rules also apply to purchases of assets out of bankruptcy.³⁷⁶

4. **M&A Qualified Beneficiary**

The most important defined term added as the result of the new COBRA mergers and acquisitions proposed regulations is the defined term "M&A qualified beneficiary." An M&A qualified beneficiary is defined only slightly differently in the event of an asset sale or a stock sale. An M&A qualified beneficiary for an asset sale is an individual who is a qualified beneficiary whose qualifying event occurred either prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was associated with the assets being sold.³⁷⁷

An M&A qualified beneficiary for a stock sale is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.³⁷⁸ If a qualified beneficiary has experienced more than one qualifying event with respect to his current right to COBRA coverage, then the individual is an M&A qualified beneficiary if the events referred to in the definition of an M&A qualifying beneficiary was the first qualifying event. However, since the qualifying events referred to in the M&A qualified beneficiary definition include qualifying events

³⁷⁴ Treas. Reg. § 54.4980B-9 Q/A 2 (2001).

³⁷⁵ Treas. Reg. § 54.4980B-9 Q/A 3 (2001).

³⁷⁶ Treas. Reg. § 54.4980B-9 Q/A 8(c) (2001).

³⁷⁷ Treas. Reg. § 54.4980B-9 Q/A 4(a) (2001).

³⁷⁸ Treas. Reg. § 54.4980B-9 Q/A 4(b) (2001).

that occurred prior to the sale as well as those in connection with the sale, this includes anyone who was once employed in relation to the assets sold or by the acquired corporation as well as those who had a qualifying event as the result of the transfer.³⁷⁹

B. Does a Business Reorganization Always Result in a Qualifying Event?

1. Stock Sale - General Rule

The Final Regulations II clarify that a qualifying event will not always necessarily result from a business reorganization. In the event of a stock sale in which a covered employee was employed by the acquired organization both before the sale and who continues to be employed by the acquired organization after the sale and for that covered employee's spouse and dependent children, the sale does not constitute a qualifying event because there is no termination of employment as the result of the sale. The sale is not a qualifying event with respect to the covered employee, the covered employee's spouse or dependents regardless of whether they are provided with group health plan coverage after the sale, and the sale does not cause these individuals to become qualified beneficiaries.³⁸⁰

2. Asset Sale - General Rule

However, in the case of an asset sale, a covered employee whose employment immediately before the sale was associated with the purchased assets and for that individual's covered spouse and dependent children who were covered under the group health plan of the selling group immediately before the sale will have a qualifying event, unless the buying group is a successor employer and the covered employee is employed by the buying group immediately after the sale.³⁸¹

3. Asset Sale - Buyer is Successor

The buying group is a successor employer if the sale involved substantial assets and the selling group ceases to provide any group health plan to any employee in connection with the sale and the buying group continues the business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is treated as a successor employer to the selling group in connection with the asset sale. As a successor employer the group health plan maintained by the buying group has the obligation to provide COBRA continuation coverage to the M&A qualified beneficiaries with respect to that asset sale. This obligation begins on the later of two dates and continues as long as the buying group continues to maintain a group health plan. The obligation begins at the later of either the date the seller group ceases to provide any group health plan to any employee or the date of the asset sale. To determine whether the selling group ceased to provide any group health plan to any employee in connection with the asset sale must be determined based on all the relevant facts and circumstances.

³⁷⁹ Treas. Reg. § 54.4980B-9 Q/A 4(c) (2001).

³⁸⁰ Treas. Reg. § 54.4980B-9 Q/A 5 (2001).

³⁸¹ Treas. Reg. § 54.4980B-9 Q/A 6(a)(1) (2001).

Since the definition of M&A qualified beneficiary for an asset sale includes individuals who were employed with respect to those assets who had a qualifying event before the sale, this may extend to individuals who had COBRA coverage under the selling group's plan well in advance of the sale and who have not yet exhausted their COBRA coverage. This means that entities engaged in asset sales should consider requesting employment records and coverage records for all individuals who were employed or who had coverage terminate within 36 months prior to the asset sale.³⁸²

In the event of an asset sale, the asset sale will not be a qualifying event if either (1) the covered employee whose is employed immediately before the sale was associated with the purchased assets and that covered employee or the spouse or dependent child of the covered employee does not lose coverage under the group health plan of the selling group after the sale, or (2) the purchaser is a successor employer.³⁸³ In this instance, loss of coverage is defined under the Final Regulations I which indicates that there may not be a change in the premium or in the benefits for the duration of the maximum COBRA coverage period or the reduction will be a loss of coverage. This might occur in situations in which the seller continues the plan for the individuals employed with respect to the assets sold and those employees following the sale continue in that same plan under the same terms.³⁸⁴

If the covered employee and their spouse or dependents cease to be covered by the seller's plan under the same terms and conditions, then the covered employee and the spouse and dependents would experience a termination of employment with the selling group as the result of the asset sale regardless of whether the covered employee is employed by the buying group or whether coverage is offered under the buyer's plan. This means that the covered employee and spouse and children would lose coverage under the selling group plan and would be M&A qualified beneficiaries in connection with the sale.³⁸⁵ This could occur subsequent to closing of the sale.

C. Contractual Allocation of COBRA Responsibility

The Final Regulations II permit a selling group and a buying group to allocate COBRA obligations in the purchase agreement. However, in the event a party is assigned the COBRA responsibility under the agreement and it fails to perform, the party who has the obligation under Treas. Reg. § 54.4980B-9 Q/A 8 to make the COBRA available to the M&A qualified beneficiaries will continue to have the obligation for transactions taking effect on and after January 1, 2002.³⁸⁶ This means that the agreement will need to continue to include indemnification provisions in the event they allocate COBRA responsibility and one of the parties fails to provide the COBRA coverage to the M&A qualified beneficiaries

³⁸² Treas. Reg. § 54.4980B-9 Q/A 6(a)(1) and 8(c) (2001).

³⁸³ Treas. Reg. § 54.4980B-9 Q/A 6(a) (2001).

³⁸⁴ Treas. Reg. § 54.4980B-9 Q/A 6(a)(2) (2001).

³⁸⁵ Treas. Reg. § 54.4980B-9 Q/A 6(b) (2001).

³⁸⁶ Treas. Reg. § 54.4980B-9 Q/A 7 (2001).

pursuant to the agreement. This also means that buyers need to request records of persons covered in the health plan offered to employees employed by the corporation or with respect to the assets/business being sold.

D. COBRA Liability As Allocated by the Final Regulations II

1. General Rule

In any business reorganization, whether it is a stock sale or an asset sale, as long as the selling group still maintains a group health plan after the sale, by any member of the controlled group, the group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to the M&A qualified beneficiaries with respect to that sale.³⁸⁷

2. Stock Sale Exception

In the event the selling group ceases to provide a group health plan to any employee in connection with a stock sale, then the group health plan maintained by the buying group has the obligation to make the COBRA coverage available to M&A qualified beneficiaries with respect to the stock sale. This obligation arises on the beginning on the later of the date the selling group ceases to provide any group health plan or the date of the stock sale and will continue as long as the buying group maintains a group health plan.³⁸⁸ Whether a selling group has ceased to maintain any group health plan is determined based on the facts and circumstances. The regulation indicates that the group health plan of the buying group does not as a result of the stock sale have an obligation to make COBRA coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.³⁸⁹

3. Asset Sale Exception

In the event of an asset sale, if the selling group ceases to provide group health plan coverage to any employee in connection with the sale and the buying group continues business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is a successor employer of the selling group in connection with that asset sale. As a successor employer, the group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that asset sale beginning on the later of the date the selling group ceases to provide any group health to any employee or the date of the asset sale and continuing for as long as the buying group continues to maintain a group health plan.³⁹⁰ Again, whether the selling group ceases to provide any group health plan to any employee is determined based on the facts and circumstances.

³⁸⁷ Treas. Reg. § 54.4980B-9 Q/A 8(a) and (d), Examples 1, 2 and 3 for stock sales and Examples 5 and 7 for asset sales (2001).

³⁸⁸ Treas. Reg. § 54.4980B-9 Q/A 8(b) and (d), Example 4 (2001).

³⁸⁹ Treas. Reg. § 54.4980B-9 Q/A 8(b) and (d), Example 4 (2001).

³⁹⁰ Treas. Reg. § 54.4980B-9 Q/A 6(a)(1) and Q/A 8(c) and (d), Examples 7 and 8 (2001).

Examples 7 and 8 in the Final Regulations II demonstrate that if an intervening sale of substantial assets occurs between the purchaser in question and the termination of the seller's group health plans or the termination (liquidation) of the seller, then the intervening purchaser of substantial assets becomes the successor employer responsible for providing COBRA coverage with respect to the M&A qualified beneficiaries last employed with respect to the assets it purchased, but the original purchaser remains a successor with respect to the M&A qualified beneficiaries whose last employment was associated with the assets it purchased. Thus, obtaining the records of the individuals covered by the seller's group health plan that were employed in association with the assets purchased becomes important information for the purchaser to have to determine who is an M&A qualified beneficiary with respect to the assets it purchased, if such records and unique employment associations exist. The Final Regulations II assume that all workers can be allocated to a distinct plant, business or division and that none provide services to more than one business, plant or division.

In the event of either a stock sale or asset sale, neither type of sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period prior to the sale.³⁹¹

In the first case applying the new rules for COBRA in mergers and acquisitions, the District Court for D.C. found a successor liable for COBRA when a successor purchased some, but not all of the assets out of bankruptcy that were used in the operation of the business (six databases on students, schools, alumni). YFU, Inc. ceased operation on March 8, 2002. YFU USA purchased YFU, Inc.'s assets and continued to support the YFU, Inc.'s exchange students, but did not acquire the "Rosedale Estate" property owned by YFU, Inc. valued at \$10 million. YFU USA was actually incorporated on January 31, 2002, by YFU organizations in Japan, Germany and Denmark to be prepared in case of YFU, Inc.'s insolvency to care for and support students currently in the program with YFU, Inc. YFU USA hired 77 of the 100 YFU, Inc. employees on March 9, 2002, and they continued to work in their offices at the Rosedale Estate. YFU, Inc. also sold other marketing and promotional and training materials, handbooks, software, publications and its Website to YFU USA. The court found that the sale, transfer and use of the databases, trademarks, office equipment, furniture, volunteer network, website, domain name and goodwill constituted a transfer of substantial assets under the new COBRA regulations.³⁹²

³⁹¹ Treas. Reg. § 54.4980B-9 Q/A 8(a) (2001).

³⁹² *Risteen v. Youth for Understanding, Inc. and Youth for Understanding USA, Inc.*, 245 F. Supp. 2d 1 (D.D.C. 2002).

	General Rule - Is it a Qualifying Event?	Whose Obligation? General Rule	General Rule - Does Not Apply if
Asset sale	Yes, unless exceptions 1 or 2 apply.	Seller	<ol style="list-style-type: none"> 1. Buyer is successor and seller does not maintain <u>any</u> group health plan and the covered employee is employed by the buyer after the sale. 2. Covered employee does not "lose coverage" under seller's group health plan after sale. <p>If covered employee "loses" coverage, may have qualifying event but COBRA obligation is still the seller's unless seller ceases to offer <u>any</u> group health plan to any employee. Covered employee may "lose coverage" and have a qualifying event without a remedy against the buyer's plan as long as seller maintains any group health plan.</p>
Stock sale	No, if the employees are still employed by the entity sold, regardless of whether or not the buyer continues to provide group health plan coverage after the sale. A stock sale by itself is not a qualifying event and does not make the employees of the entity sold qualified beneficiaries.	Seller	No exception in proposed regulations.

	COBRA Liability - General Rule	Does COBRA Obligation Transfer if Seller Maintains Any Group Health Plan?	Does Obligation Transfer if Seller Does Not Maintain Any Group Health Plan?
Asset sale	Agreement terms	No, COBRA is seller's obligation for seller's employees and M&A qualified beneficiaries.	If seller does not provide a group health plan to <u>any</u> employees and if buyer continues business in substantially the same manner without interruption or substantial change, then the buyer is a successor employer and must provide COBRA to M&A qualified beneficiaries with respect to the sale.
Stock sale	Agreement terms	Seller's COBRA obligation is for seller's employees, not for M&A qualified beneficiaries (because the stock sale is not a qualifying event) as long as seller has any group health plan.	If seller does not provide a group health plan to <u>any</u> employee, then buying group has the obligation to provide COBRA with respect to M&A qualified beneficiaries with respect to the sale.

EXHIBIT A

Content Requirements for Initial COBRA Rights Notice Under DoL's Proposed Regulations

CHECKLIST for Content of Initial Notice

Under proposed rule 2590.606—1(c), an initial notice “shall contain” the following.

- (1)
 - The name of the plan under which continuation coverage is available
 - The name, address and telephone number of the party responsible under the plan for the administration of continuing coverage benefits.
- (2)
 - A general description of the continuation coverage under the plan, including all of the following:
 - identification of the classes of individuals who may become qualified beneficiaries
 - the types of qualifying events that may give rise to the right to continuation coverage
 - the obligation of the employer to notify the plan administrator of the occurrence of certain qualifying events
 - the maximum period for which continuation coverage may be available
 - when and under what circumstances continuation coverage may be extended beyond the applicable maximum period
 - the plan's requirements applicable to the payment of premiums for continuation coverage.
- (3)
 - An explanation of the plan's requirements regarding the responsibility of a qualified beneficiary to notify the administrator of a qualifying event that is a divorce, legal separation, or a child's ceasing to be a dependent under the terms of the plan
 - A description of the plan's procedures for providing such notice.
- (4)
 - Additional notice requirements:
 - An explanation of the plan's requirements regarding the responsibility of qualified beneficiaries who are receiving continuation coverage to provide notice to the administrator of a second qualifying event
AND
 - An explanation of the plan's requirements regarding the responsibility of qualified beneficiaries who are receiving continuation coverage to provide notice to the administrator of a determination by the Social Security Administration that a qualified beneficiary is disabled
AND
 - a description of the plan's procedures for providing such notices.
- (5)
 - An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries
- (6)
 - A statement that the notice does not fully describe continuation coverage or other rights under the plan.
AND
 - that more complete information regarding such rights is available from the plan administrator and in the plan's summary plan description.

EXHIBIT B

Content Requirements for COBRA Election Notices Under DoL's Proposed Regulations

CHECKLIST for Content of Notice of Qualifying Event

Under proposed rule 2590.606—3(b)(4), a notice of right to elect continuation coverage “shall contain” the following. Note: for 36-month form – must check all but (x). For 18-month form – must check all.

- (i)
 - The name of the plan under which continuation coverage is available
 - The name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits.
- (ii)
 - Identification of the qualifying event.
- (iii)
 - Identification of each qualified beneficiary who is recognized by the plan as being entitled to elect continuation coverage with respect to the qualifying event
 - The date on which coverage under the plan will terminate (or has terminated) unless continuation coverage is elected.
- (iv)
 - A statement including all of the following:
 - Each individual who is a qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage
 - A covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event
 - A parent or legal guardian may elect continuation coverage on behalf of a minor child.
- (v)
 - An explanation of the plan's procedures for electing continuation coverage, including all of the following:
 - An explanation of the time period during which the election must be made
 - the date by which the election must be made.
- (vi)
 - An explanation of the consequences of failing to elect or waiving continuation coverage, including all of the following:
 - An explanation that a qualified beneficiary's decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under Part 7 of title I of the ERISA
 - A reference to where a qualified beneficiary may obtain additional information about such rights
 - A description of the plan's procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made.
- (vii)
 - A description of the continuation coverage that will be made available under the plan, if elected, including the date on which such coverage will commence, either:
 - by providing a description of the coverage, OR
 - by reference to the plan's summary plan description.

(viii)

- ❑ Explanations of all of the following:
 - ❑ The maximum period for which continuation coverage will be available under the plan, if elected.
 - ❑ The continuation coverage termination date.
 - ❑ Any events that might cause continuation coverage to be terminated earlier than the end of the maximum period.

(ix)

- ❑ A description of the circumstances (if any) under which the maximum period of continuation coverage may be extended due either to the occurrence of a second qualifying event or a determination by the Social Security Administration...that the beneficiary is disabled.
- ❑ The length of any such extension.

(x) IF APPLICABLE – FOR PLANS OFFERING COVERAGE TO QUALIFIED BENEFICIARIES FOR MAXIMUM PERIODS UNDER 36 MONTHS:

- ❑ *In the case of a notice that offers continuation coverage with a maximum duration of less than 36 months,*
 - ❑ *A description of the plan's requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event AND notice of a disability determination under the SSA, along with*
 - ❑ *a description of the plan's procedures for providing such notices, including*
 - ❑ *the times within which such notices must be provided and the consequences of failing to provide such notices*
 - ❑ *The responsibility of qualified beneficiaries to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled.*

(xi)

- ❑ A description of the amount, if any, that each qualified beneficiary will be required to pay for continuation coverage.

(xii)

- ❑ A description of all of the following:
 - ❑ the due dates for payments
 - ❑ the qualified beneficiaries' right to pay on a monthly basis
 - ❑ the grace periods for payment
 - ❑ the address to which payments should be sent
 - ❑ the consequence of delayed payment and non-payment.

(xiii)

- ❑ A description of any opportunity provided under the plan for other health coverage for which the covered employee or qualified beneficiary may be eligible, either as an alternative to continuation coverage or in addition to continuation coverage (e.g. coverage under USERRA or conversion coverage).
- ❑ An explanation of how election of such other coverage would affect the qualified beneficiaries' continuation coverage rights under the plan and rights to guaranteed access to individual health coverage.

(xiv)

- ❑ An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries.

(xv)

- A statement that the notice does not fully describe continuation coverage or other rights under the plan, and that more complete information regarding such rights is available in the plan's summary plan description or from the plan administrator.

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