

COBRA and Minnesota Continuation Laws

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Continuation of Coverage

There are two main bodies of law that regulate continuation coverage for group health plans in Minnesota: (1) federal COBRA requirements of ERISA, the Internal Revenue Code, and the federal Public Health Service Act (PHSA); and (2) state continuation laws. For the most part, the federal laws contain the same requirements for continuation but apply to different types of health plans. For simplification purposes from this point on, we will only refer to COBRA and state continuation laws. Minnesota continuation laws contain some of the same provisions as federal law but are silent regarding such things as notice requirements and payment obligations, and have different coverage extension periods. The Federal Uniformed Services Employment and Reemployment Rights Act (USERRA) addresses continuation of coverage for active duty uniformed service personnel. In addition, former employees of a political subdivision who have met certain age and service requirements may continue their coverage indefinitely. As a result, it is critical to understand which of these laws apply to the group (or individual) you are working with in order to ensure compliance with the appropriate continuation requirements.

In general, fully insured group health plans are subject to both state and federal continuation laws. Self-insured plans subject to ERISA must follow only federal requirements, although they could choose to follow MN State law where the state law is more generous than federal COBRA. In Minnesota, political subdivision groups (cities, counties, schools, etc.) that self-insure their health plans must comply with federal and state continuation laws.

COBRA

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L.99-272. COBRA is the federal continuation of coverage law. The ERISA provisions apply to all group health plans (fully insured and self-insured) maintained by employers with 20 or more employees, excluding governmental plans and certain church plans. The PHSA provisions apply to states and political subdivisions. COBRA has been amended a number of times.

COBRA requires employers to offer all employees and their covered dependents the opportunity to continue to receive health care coverage upon the occurrence of certain triggering events that result in the termination of their group health care coverage. The offered coverage must be the same as coverage they were receiving before the qualifying event. The coverage may be continued for up to 18, 24, 29 or 36 months, depending on the qualifying event.

State Continuation Laws

Minnesota continuation laws do not apply to self-funded plans that are subject to ERISA. Fully insured health plans that are underwritten by commercial carriers, HMOs and Blue Cross Blue Shield of Minnesota are subject to Minnesota continuation laws. In addition, Multiple Employer Welfare Arrangements (MEWAs); plans of political subdivisions, such as counties, school districts and municipalities, regardless of whether they are self-insured or fully insured; and fully insured church plans are subject to Minnesota continuation laws.

Minnesota continuation laws are similar to many of the federal COBRA provisions. However, they apply to all group health plans that are subject to state regulation, regardless of the number of employees in the group.

In some instances, Minnesota continuation laws contain more liberal provisions than COBRA. In other instances, Minnesota laws are not as specific as COBRA. Unfortunately, there have not been regulations issued on the state level to provide guidance to employers for administering continuation. As a result, in order to make appropriate continuation determinations, a plan administrator may need to look to the COBRA regulations or related case law for additional guidance.

The Relationship Between COBRA and State Continuation Laws

As mentioned above, certain health plans are subject to federal COBRA requirements and state continuation laws. Inconsistencies between these two bodies of law add complexity to COBRA administration. Plan administrators need to be aware of the requirements of both sets of laws to help them make the proper administrative decisions regarding continuation of coverage.

Example Where State Law is More Generous than COBRA:

Under COBRA, once a qualified beneficiary enrolls in Medicare, the employer is allowed to terminate the person's COBRA coverage. Under state law, an employer is not allowed to terminate a qualified beneficiary's continuation coverage when the person enrolls in Medicare. Mary Jones is enrolled in a fully insured employer-provided health care plan and terminated employment January 1, 2005. At that time, she elected 18 months of continuation of coverage. On January 5, 2006, she turned 65 and enrolled in Medicare. Under state law, Mary is entitled to finish her 18 months of continuation even though she also is enrolled in Medicare. The employer should not terminate her coverage.

In this example, state law is more generous than COBRA, therefore state law should be applied.

As a rule of thumb, when there is an inconsistency between what COBRA requires and what state continuation laws require, the plan administrator should always apply the more liberal or generous provision to the qualified beneficiary.

Qualifying Events

The obligation to offer continuation of coverage is triggered by the occurrence of qualifying events. A qualifying

event is the occurrence of a triggering event that results in a loss of coverage. When an individual loses coverage under a health plan, the reason must fall into one of the following categories to ensure eligibility to continue coverage. Both state continuation and federal COBRA laws contain the same triggering events:

- Voluntary or involuntary termination of the covered employee's employment (other than by reason of gross misconduct*), or reduction of hours of the covered employee's employment, including call to active military duty
- Death of the covered employee
- Divorce or legal separation of the covered employee from the employee's spouse
- Covered employee becomes entitled (enrolled in) benefits under Medicare
- Dependent child ceasing to be a dependent child under the generally applicable requirements of the plan
- Covered retirees in Chapter 11 bankruptcy reorganization

**The term "gross misconduct" does not have a specific definition in COBRA or state continuation laws. One federal court applied the standard that the misconduct must be intentional, wanton, willful, deliberate, reckless or in deliberate indifference to the employer's interest. It is misconduct beyond mere minor breaches of employee standards.*

The triggering event plus a loss of coverage equals a COBRA/continuation qualifying event. If the triggering event occurs but there is no loss of plan coverage, there is no qualifying event. Conversely, if the loss of plan coverage happens for a reason other than the six bulleted items listed above, there is no qualifying event and no obligation to offer COBRA/continuation.

Example 1:

Tim and his son Ken are both covered by Tim's fully insured group health plan. The employer's plan provides that dependent children are eligible to stay on the plan until age 19. Ken graduates from high school at 17. Tim no longer wants to pay for Ken to stay on his health plan after graduation even though Ken is still eligible for coverage under the terms of the plan. Tim removes Ken from the plan. This is not a qualifying event. While Ken experiences a loss of coverage it is not caused by one of the specific triggering events listed above. Ken is eligible for portability coverage.

Example 2:

Laurie is covered under her employer's group health plan. While still working, Laurie turns age 65 and becomes entitled to (eligible for and enrolled in) Medicare. Laurie continues to work and the employer does not cancel Laurie's group health plan. While Laurie has experienced a triggering event she did not experience a loss of coverage so there is no obligation to offer COBRA/continuation as a result of her enrollment in Medicare. When Laurie retires, she will be eligible for 18 months of continuation coverage.

What Is a Loss of Coverage?

A loss of coverage means that the participant ceases to be covered under the same terms and conditions that were in effect immediately before the qualifying event. The typical scenario is that the individual experiences a total loss in coverage when they terminate employment. Loss, however, could mean something other than a total loss of coverage. A loss could result from:

- any change in the terms or conditions of the coverage;
- an increase in required premiums;
- a reduction in benefits; and
- a requirement of any action to retain coverage.

Example Where There is Not a Total Loss of Coverage:

Acme is a self-insured company that provides two different medical plans for employees. One plan is Double Gold with 100% benefits and is available to employees who routinely work at least 160 hours a month. The second plan is a high deductible health plan with a \$2,000 deductible 80/20 benefits. This plan is available to all employees who work less than 160 hours a month but more than 100 hours a month. Molly currently works 160 hours a month but due to a slow economy her hours are being reduced to 120 hours a month starting next month. Molly may continue the Double Gold plan for 18 months or she may enroll in the CMM high deductible health plan.

The reduction in hours is a triggering event and it is clearly a change in the terms and conditions of coverage and a reduction in benefits. Molly will "lose" her coverage under Double Gold unless she acts to continue coverage.

Events That Are Not Qualifying Events

It is important to keep in mind that not every loss of coverage under a health plan is considered a qualifying event. For instance, when an employee decides to drop coverage for a dependent who is still eligible under the health plan, the employer is not required to offer continuation to that dependent because this loss of coverage is not a qualifying event.

Qualified Beneficiary

A qualified beneficiary is someone who was covered under the plan immediately prior to the qualifying event and is a covered employee or the spouse or dependent child of a covered employee. In addition, a child born to or placed for adoption with the covered employee during the period of continuation of coverage is also a qualified beneficiary.

Even if the individual was covered under the plan for only one day prior to the qualifying event, he or she is still considered a qualified beneficiary.

A non-qualified beneficiary is someone who was not on the plan the day before the

Example:

Tom is covered by his employer's group health plan. He terminates employment on April 29, 2006 and timely elects COBRA effective on May 1, 2006. On June 1, 2006 Tom adds his spouse of 10 years, Julie, onto the plan. Tom obtains new employment and cancels his COBRA on July 1, 2006. Julie is not a qualified beneficiary because she was not on the plan the day before the qualifying event. Her COBRA rights are tied to Tom's and since he dropped his continuation coverage, she is no longer eligible. Had Julie been added to the plan April 1, 2006 she would have been on the plan the day before the qualifying event and would have been considered a qualified beneficiary. In that case she could have stayed on the COBRA continuation for the entire 18 months even though Tom terminated his COBRA coverage.

qualifying event, but was added to the coverage at a later date. However, a non-qualified beneficiary does not have independent election rights. Their continuation rights are tied to those of the qualified beneficiary. Thus, a non-qualified beneficiary does not have second qualifying event election rights.

Separate Elections

Each qualified beneficiary has a right to a separate election under COBRA. If the qualifying event is termination of employment, all qualified beneficiaries have the right to continue coverage for up to 18 months. If the former employee decides to waive the right to elect continuation, the remaining qualified beneficiaries still have the right to elect continuation on their own.

Example:

Marty Miller terminates employment. As a result, his former employer offers Marty and his four dependent family members the opportunity to continue coverage for up to 18 months. Marty cannot afford to pay the premium required for the whole family to continue the coverage. He will be obtaining new coverage at his new job in two months so he decides to elect to continue coverage for his youngest child, who has a heart condition. Marty's former employer must allow this election. The employer should set the youngest child up on a single contract and charge the appropriate single premium for the coverage.

Duration of Continuation of Coverage

Both COBRA and state continuation laws provide a maximum period of coverage for each type of qualifying event, and further provide that upon certain events, coverage may be terminated before the end of the maximum period. State continuation laws may provide for longer continuation periods than COBRA. The following table outlines the appropriate timeframes for each qualifying event under COBRA and state continuation laws.

Qualifying Events	Employment ends, (except gross misconduct) retirement, leave of absence, lay-off	Divorce or legal separation	Death of employee	Dependent child loses eligibility
Federal COBRA	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.*	Earliest of: 1. 36 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.*	Earliest of: 1. 36 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.*	Earliest of: 1. 36 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.*
State Continuation	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage, or 3. 24 months under USERRA for employees called to active uniformed service.	Earliest of: 1. Date coverage would otherwise terminate*, or 2. Enrollment in other group coverage.	Earliest of: 1. The date the surviving spouse and dependents enroll in other group coverage, or 2. The date the coverage would have terminated* under the contract had the employee lived.	Earliest of: 1. 36 months, or 2. Enrollment in other group coverage, or 3. Date coverage would otherwise end.*
Who May Continue	Employee and dependents	Former spouse and any dependent children who lose coverage	Surviving spouse and dependent children	Dependent children

*Federal law provides guidance in interpreting the phrase “the date coverage would otherwise end” to mean:

1. Such time as the group ceases offering group health coverage to any employees;
2. The qualified beneficiary fails to pay the required premium;
3. The qualified beneficiary has exhausted a statutorily imposed time period such as 18 or 36 months; or
4. Coverage of the qualified beneficiary is terminated for cause (e.g. submitting fraudulent claims).

Dependents lose eligibility due to employee's enrollment in Medicare (refer to pages 20-21 for exceptions)	Total disability	MN Section 471.61	Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one year of filing)	Surviving dependents of retiree on lifetime continuation due to bankruptcy of employer	Employee's entry into active or reserve military duty, whether voluntary or involuntary
Earliest of: 1. 36 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.*	Earliest of: 1. 29 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.*	Not applicable	Lifetime continuation	36 months following the retiree's death	Earliest of the date on which the employee fails to return to work or apply for a position of employment following return from uniformed service or 24 months
Earliest of: 1. 36 months, or 2. Enrollment in other group coverage, or 3. Date coverage would otherwise end.*	Earliest of: 1. 24 months if the employee is unable to perform his/her position, or 2. Indefinite if after 24 months the employee is unable to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified, or 3. Date coverage would otherwise end.*	Earliest of: 1. Enrollment in other group coverage, or 2. Date coverage would otherwise end.*	Follow Federal law	Follow Federal law	Follow Federal law
All dependents	Employee and dependents	Retiree and eligible dependents	Retiree and dependents	Surviving spouse and dependent children	Employee only may elect for employee and dependents

Same Rights and Benefits as Similarly Situated Beneficiaries

Qualified beneficiaries must be provided with the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. In other words, employers should treat qualified beneficiaries on continuation of coverage the same way they treat active employees and their dependents. The coverage offered to qualified beneficiaries should be the same coverage offered to active employees. If the coverage changes for active employees, then the coverage changes for individuals on COBRA as well.

Example 1:

Employer A offers two types of health care plans. Once a year, the employer offers an open enrollment that allows employees the option to enroll in a different plan without being considered a late entrant. All COBRA beneficiaries may also enroll in a different plan.

Example 2:

Under Employer B's health plan, employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage. Qualified beneficiaries who get married while on continuation must also be afforded this same right. The new spouse, however, will not be a qualified beneficiary.

Terminating Events

Terminating events are circumstances in which the required continuation coverage may terminate before the maximum continuation period has been exhausted. Terminating events include:

1. The payment of premiums required under the plan are not made in a timely manner.
2. The qualified beneficiary becomes covered under any other group plan that does not contain a pre-existing condition exclusion clause.*
3. The employer ceases to provide any group health coverage to its employees.
4. The qualified beneficiary becomes entitled to Medicare (COBRA only).

A plan administrator who terminates COBRA coverage prior to the end of the maximum coverage period must provide a written notice of termination to each affected qualified beneficiary as soon as reasonably practicable.

**A frequent question is whether it is necessary to offer continuation to an individual who is covered under another group health plan prior to the qualifying event. The Supreme Court ruled that employers may not deny continuation benefits to qualified beneficiaries who have other coverage or Medicare at the time they elect continuation. The ruling clarifies that continuation laws are intended to enable individuals to maintain the status quo. Employers may terminate continuation coverage if a qualified beneficiary enrolls in other group coverage with no preexisting condition exclusions after the qualifying event.*

Premium Determination

A qualified beneficiary who wishes to continue coverage must pay for it. The employer may contribute to the cost of continued coverage but is not required to. It does not matter who pays the premium as long as it is paid in a timely manner. In some cases, a new employer or public agency may pay the COBRA premium in an effort to reduce expenses.

Premiums charged to a qualified beneficiary may not exceed 102 percent of the plan's cost for other similarly situated active individuals covered under the plan. However, under COBRA a totally disabled individual who extends the continuation period beyond the 18 months to 29 months may be charged up to 150 percent of the applicable contract charge for months 19 to 29.

Minnesota law permits a Plan Administrator to charge the disabled employee only 100% of the premium paid by active employees. No administration fee is permitted.

COBRA Premium Rate IRS Ruling 96-8

On January 22, 1996, the IRS issued a ruling that provides employers guidance on when it is appropriate to charge a family rate vs. a single rate. The ruling confirms

Example:

Mark Stevens terminates employment. He wishes to continue coverage for himself and his wife. His employer's health care coverage costs \$400 a month for family coverage and \$150 a month for single coverage. His employer requires Mark to pay the \$400 family rate to continue coverage for himself and his wife even though it would be cheaper for Mark to pay two individual rates ($\$150 + \$150 = \$300$). According to IRS Ruling 96-8, charging the family rate does not violate COBRA.

that it would not violate COBRA to require family units that elect to continue coverage to pay the appropriate family unit rate. It also states that if only one member of the family unit elects to continue coverage, the single rate, rather than the family rate, should be charged as the applicable premium. The significance of this ruling is that many times it would be cheaper for each member of a family unit to pay the single rate rather than the family unit rate. The ruling does not say that this practice is prohibited. It only clarifies that an employer is not in violation of COBRA for not allowing multiple single rates rather than the family unit rate even if it is cheaper. It is up to the employer to establish a company policy on this and apply it consistently.

Grace Period

Initial Payment

The initial premium payment is due within 45 days of the qualified beneficiary's election to continue coverage.

Subsequent Payments

The contract due dates are established by the employer and can be no more frequent than monthly. The employer is required to allow at least a 30-day grace period from the date contract charges are due.

Stacking of Events – the Second Qualifying Event

An important concept that impacts the length of continuation is commonly referred to as the “stacking of events.” Stacking provides an individual who is already on continuation the opportunity to extend the coverage period beyond 18 months if a subsequent qualifying event occurs during his or her continuation period. Stacking is allowed only when the first qualifying event is the termination of employment. Under COBRA, the maximum continuation period is capped at 36 months. Under state continuation law, the second qualifying event could result in indefinite coverage for the dependent in cases of divorce or the death of the former employee.

Example:

Susan James terminates employment June 30, 2006. She elects to continue family coverage for 18 months. On October 1, 2006, her daughter Jennifer gets married and loses eligibility as a dependent under Susan’s coverage. This situation is considered a second qualifying event. Jennifer now has the opportunity to elect to continue on her own policy for an additional 33 months (36 months from the initial loss of coverage) even though Susan’s coverage will terminate when her 18 months expire.

Notice Requirements

The importance of proper notification and documentation of that notice to qualified beneficiaries should never be underestimated. If the employer does not give proper notice and coverage is terminated, the employer could be held liable for the employee’s coverage to the same extent as the insurer would be if the coverage were still in effect. Keep in mind that the employer bears the burden of proof that proper notification has been made. The employee must give notice of 2 qualifying events within 60 days or may lose the right to continue coverage.

General/Initial COBRA Notice

At the time the health plan coverage begins, the employer must provide each qualified beneficiary written notice of his or her continuation rights and obligations under the plan. As subsequent employees enroll in the health plan, they must also be notified of their continuation rights. Generally, the notice must be furnished not later than the earlier of: 1) either 90 days from the date on which the covered employee or spouse first becomes covered under the plan or, if later, the date the plan first becomes subject to the continuation coverage requirements; or 2) the date on which the employer or administrator is required to furnish an election notice to the employee or his or her spouse or dependent.

At the time the health plan begins, the employer must provide each qualifying beneficiary written notice of his or her right to elect continuation upon the occurrence of a qualifying event.

The Department of Labor’s (DOL) 2004 COBRA regulations permit the general/initial notice to be included in the Summary Plan Description (SPD) provided that the SPD notice meets all the DOL’s requirements. However, if the plan administrator uses the SPD for the COBRA initial notice, the SPD must be

issued within 90 days from the first day of coverage. In addition, if the covered employee and spouse reside at the same address it is acceptable to send the SPD in the same envelope but it should be addressed to both parties and not just the employee. If any dependents reside at an address other than the covered employee’s, they should receive a separate notice.

Reasonable Procedures

The final 2004 DOL COBRA notice regulations require that employers establish “Reasonable Procedures” to be followed by qualified beneficiaries in notifying the employer of certain qualifying events. These procedures should be described in the SPD, specify who is designated to receive the notice, describe how the notice is to be provided, and what information the notice must contain.

Failure to establish reasonable notice procedures may require an employer to offer COBRA coverage to an employee who provides notice to a person other than the employer’s designated COBRA administrator, including when notice is provided after the expiration of the 60-day deadline.

Employer Qualifying Event Notice

Upon notice that a qualifying event has occurred, the employer is required to send out a specific qualifying-event notice to qualified beneficiaries advising them of their continuation rights. This notice must contain an explanation of continuation rights and obligations, as well as all election, payment and notice deadlines. It should also contain an election form and a premium schedule.

Under Minnesota law the qualifying event notice must be in writing, addressed to each qualified beneficiary, and delivered by first class mail to the employees’ last known address. Federal COBRA permits the notice to be sent by first class mail, hand delivered, certified mail, or electronic transmission. However, proving that the notice was sent is easier if the employer’s practice is to use first class mail obtaining a “certificate of mailing” or using “certified without receipt” as the most effective means of establishing that the COBRA notice was sent.

All qualified beneficiaries are entitled to a Qualifying Event notice of COBRA rights but the Department of Labor has indicated that one notice mailed to all qualified beneficiaries who reside at the same address is sufficient provided that the notice explains that each qualified beneficiary has an independent election right. Separate notices must be sent if there are multiple addresses.

Employee Qualifying Event Notice

The covered employee or qualified beneficiary must notify the plan administrator of a qualifying event that is a divorce or legal separation or loss of dependent status according to the plan’s notice procedures. The covered employee or qualified beneficiary must also provide notice of a Social Security disability determination or a determination that an individual is disabled.

Notices Regarding Unavailability and Notice of Early Termination

The final 2004 DOL COBRA notice regulations contain two new notice requirements:

- notice of COBRA unavailability, and
- notice of termination of continuation coverage.

A plan administrator who receives a notice of what a qualified beneficiary believes is a qualifying event must provide a notice of unavailability if they determine that the individual is not entitled to continuation coverage.

Under DOL’s COBRA regulations, a plan administrator who terminates COBRA coverage prior to the end of the maximum coverage period must provide a written notice of termination to each affected qualified beneficiary.

180-Day Conversion Letter

All health plans that offer a conversion option must send a notice during the 180-day period prior to the anticipated expiration of the continuation period. This notice must advise the qualified beneficiary of the option to enroll in a conversion product when the continuation period expires. Please note this does not apply to self-insured groups that do not offer a conversion option.

Notification Requirements Time Line

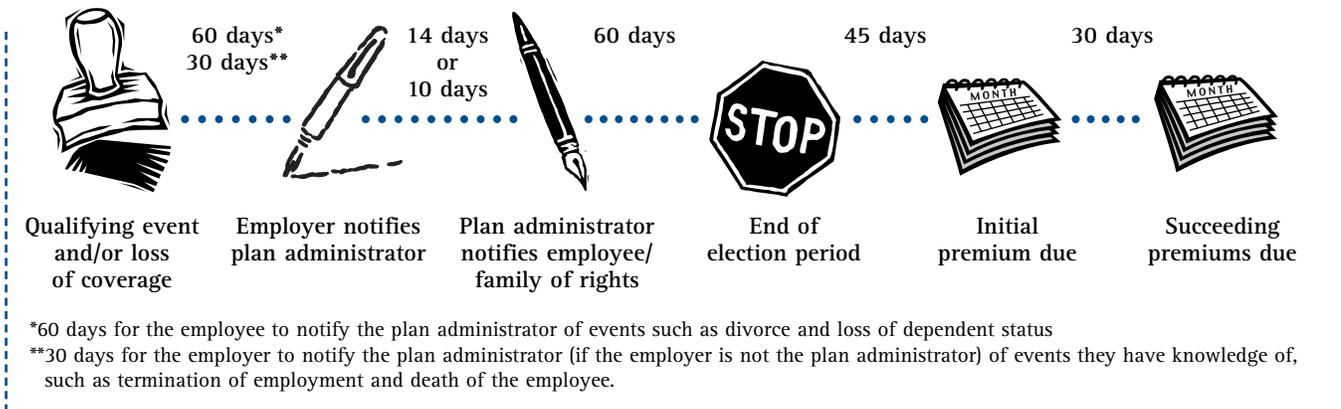
Covered Employees and Qualified Beneficiaries

The covered employee or qualified beneficiary must notify the plan administrator within 60 days of a divorce, a child's losing dependent status, or a Social Security disability determination. The DOL's 2004 COBRA regulations require plans to establish "reasonable procedures" for qualified beneficiaries to use in providing notices to the plan. These procedures must be disclosed in the plan's Summary Plan Description (SPD). If a plan fails to establish and disclose "reasonable procedures" as required by the regulations, qualified beneficiaries will be permitted to give notices to individuals other than the plan administrator, including after the normal 60-day deadline.

Employers

Employers have 30 days to notify the plan administrator of events they know have occurred, such as termination of employment or death of the employee. (This 30-day notice to the plan administrator is not often used because usually the plan administrator is the employer.) After plan administrators are put on notice of the qualifying event, they have 14 days under COBRA or 10 days under MN continuation laws to send the qualifying event notice.

The qualified beneficiaries must be allowed 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage would end due to the qualifying event or the date of the qualifying-event notice, whichever is later. If the qualified beneficiary fails to make an election to continue within this time frame, he or she forfeits the right to continue coverage.



COBRA and the Family Medical Leave Act (FMLA)

Although continuation may be elected if a reduction in hours results in the loss of health coverage, continuation does not apply to employees taking leave under FMLA. According to the IRS, for an employee on a qualified FMLA leave, a qualifying event takes place only in the following situations:

1. On the last day of the FMLA leave
2. If the employee does not return to work
3. When the employer learns that the employee will not return from leave, even if the employee did not have health coverage during the leave

The continuation coverage cannot be conditioned on the employee's repayment of health plan premium that the employer paid during the FMLA leave. If the plan changes while the employee is on leave, the employee is entitled to either the same type of coverage he or she was enrolled in immediately prior to the leave or to whatever coverage is available to other employees. Even if the employee does not maintain coverage at all during the FMLA leave, he or she is still eligible to continue coverage when the leave is over. In this situation, there could actually be a gap in coverage during the FMLA leave before continuation coverage became effective.

COBRA and Open Enrollment

A qualified beneficiary who elects to continue one of the employer's plan options, for example, the dental plan, may elect other types of coverage at open enrollment if similarly situated active employees may do so.

Example:

Frank's employer offers three health plans and two dental plans. Frank terminates employment and elects dental coverage. During the former employer's annual open enrollment period, not only may Frank choose to enroll in the other dental plan, he may choose to enroll in any of the three health plan offerings.

COBRA and Domestic Partners

Under federal COBRA, domestic partners are not spouses, and are therefore not eligible to elect COBRA. Under Blue Cross and Blue Plus fully insured health plans, domestic partners are treated as spouses and are allowed to continue coverage as if they were a spouse.

Total Disability

COBRA and Total Disability

Under COBRA, if an employee or covered dependent is determined to be totally disabled by the Social Security Administration or becomes totally disabled within 60 days after the employee's termination of employment, all qualified beneficiaries

Example 1:

Joe Mitchell is diagnosed with advanced multiple sclerosis (MS) November 4, 2005. His condition has deteriorated to a point where he can no longer fulfill the responsibilities of his job. He resigns from employment December 1, 2005. He elects to continue his coverage for 18 months as a result of his termination of employment. He applies for Social Security benefits right away but does not receive approval for these benefits until July 1, 2006. The disability date indicated on the Social Security approval letter is December 1, 2005. As soon as he gets this determination letter, he forwards a copy to his former employer and requests an additional 11 months of continuation because his disabled status has been confirmed by the Social Security Administration. As a result, the employer should set Joe and his family members up on continuation for 29 months.

This is not an unusual circumstance. There is usually a significant time lag between the employee's termination of employment and Social Security determination of disability. The request for the 11-month extension must be made during the 18-month continuation period.

It is helpful to understand the intent behind this provision to apply it in the appropriate circumstances. When individuals become disabled, they must apply to the Social Security Administration to receive supplemental income benefits. The benefits commence after five months of total disability. Individuals must receive social security disability benefits for 24 months before they are eligible for health care coverage under Medicare. This COBRA provision was specifically designed to avoid a gap in coverage for these individuals between their COBRA coverage and their Medicare eligibility. Thus the 29-month continuation period for totally disabled qualified beneficiaries. $(5 + 24) = (18 + 11)$

are eligible for up to 29 months of continuation of coverage. The employer may charge up to 150 percent of the applicable premium for the 19th through 29th month of continuation. Certain conditions, however, must be met in order to qualify for the additional time under the plan. These conditions are:

- 1) The first event must have been the termination of employment or a reduction in hours.
- 2) The qualified beneficiary must have been determined by the Social Security Administration to be totally disabled at the time of the first qualifying event or within the first 60 days of the COBRA coverage.
- 3) The qualified beneficiary must notify the plan administrator of the disability determination within 60 days after the latest of (1) the date of the Social Security disability determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice.
- 4) Notice must be provided before the end of the first 18 months of continuation coverage.

The DOL clarified in the 2004 regulations that an individual who previously received a disability determination and has not received a subsequent determination that he or she is no longer

disabled would have at least 60 days after the occurrence of a qualifying event to provide the plan with a disability notice in order to be entitled to the disability extension.

Example 2:

Rose is Patrick's daughter and both are covered under Patrick's self-insured group health plan subject to COBRA. Rose has been disabled from birth. Patrick applied for and received Rose's disability determination from Social Security in 2002. On April 5, 2006, Patrick terminated employment and elected COBRA for himself and Rose effective May 1, 2006. On May 6, 2006 Patrick brought his former employer a copy of the disability determination letter and requested additional time under the plan. Both Patrick and Rose are eligible for up to 29 months beginning May 1, 2006.

Minnesota Law and Total Disability

Minnesota law pertaining to continuation rights for employees considered to be totally disabled are notably different than COBRA. In particular, Minnesota's disability continuation law applies when a "covered employee" becomes totally disabled. The disabled employee's dependents may also continue coverage. The law specifically defines total disability to mean "the inability of an injured or ill employee to engage in or perform the duties of the employee's regular occupation or employment" for the first two years. After the first two years of disability, the employee must be unable to engage in any paid employment or work for which the employee may be educated or trained, including rehabilitative training, become qualified.

In addition, under state law, a disabled employee is not limited to 29 months of continuation. A disabled individual who meets the above criteria is eligible to remain on continuation 24 months or indefinitely. Even when the disabled employee enrolls in Medicare, he or she would still be eligible to remain on continuation.

Under state law, a Social Security Administration disability determination is not required, but may be relied on. The employer can also rely on a physician's certification that the former employee is in fact totally disabled under the criteria established by state law. Employers may wish to periodically request updates from the former employee's physician on his or her disability status. A totally disabled employee may be required to pay part or all of the cost of coverage, but the employer may not charge an administrative fee.

Minnesota Statutes section 471.61 subdivision 2b – Retiree Continuation

Political subdivisions such as counties, municipal corporations, towns, school districts, etc., may provide group insurance to their officers, employees, retired officers and employees.

Political subdivisions that provide group health and dental insurance to their employees must provide former employees who meet certain criteria, and their dependents, the opportunity to continue their coverage indefinitely. Minnesota Statutes section 471.61 does not apply to group life insurance. The former employee must pay the equivalent of what it costs the group to maintain this coverage.

Who Is Eligible?

The law defines those eligible for this benefit as former employees who are receiving a disability benefit or an annuity from a Minnesota public pension plan other than a volunteer firefighter plan, or those who have met the age and service requirements necessary to receive an annuity from such a plan.

Eligible individuals must remain in the same pool as active employees up to age 65 for purposes of rating and benefits. The employer may establish different benefits and rates for retirees age 65 and over.

Conflicts with State and Federal Law

Some of the provisions in Minnesota Statutes section 471.61 are not consistent with federal or other state continuation statutes. In situations where section 471.61 may be less favorable than state or federal law, the more liberal provision will apply. Section 471.61 does not limit the rights granted to former employees under other state or federal law, or under collective bargaining agreements or personnel plans.

For example, Minnesota Statutes section 471.61 provides that dependent coverage is not permitted after the death of the employee. However, under state continuation laws, a surviving spouse is eligible to continue coverage indefinitely.

Minnesota Statutes section 471.61 provides that former employees may not drop their own coverage and retain dependent coverage. Under state and federal law, each dependent covered under the coverage prior to a qualifying event would have a right to a separate election regardless of the former employee's decision to continue. If the former employee opted not to continue his or her own coverage, his dependents could elect at least 18 months of continuation from the termination of employment.

Notice to Employees

The Political Subdivision employer is required to notify an employee of available options prior to his or her retirement date. This is different from state and federal requirements that do not require notice until after the qualifying event.

Upon the employee's termination of employment, the employee has 60 days in which to elect this coverage and 45 days from his election to bring his or her account up to date.

Who Must Comply?

This law applies to fully insured and self-insured political subdivisions. The law defines these entities as, counties, municipal corporations, towns, school districts, county extension committees, other political subdivisions or body corporate or politic of Minnesota, other than the state or any department of the state.

The law does not apply to former employees terminated prior to August 1, 1992 who have not maintained continuous coverage with the group.

Frequently Asked Questions Regarding Minnesota Statutes section 471.61

- Q1. The former employee is covered indefinitely according to section 471.61. His/her dependent spouse is also covered indefinitely under section 471.61. The former employee will be turning age 65 and would like to drop his/her coverage in favor of a Medicare Supplement plan. What continuation rights does the spouse have?
- A1. There is no impact to continuation coverage under section 471.61 when retirees turn age 65. The retiree may stay on the group's health plan even though they are eligible for Medicare. However, section 471.61 does *not* allow the dependent to remain on the health plan if the former employee cancels coverage. If a retiree discontinues group coverage under 471.61 in favor a Medicare supplemental plan the dependent is no longer eligible for continuation coverage under section 471.61.

Are there rights for the spouse under other state and federal continuation laws? The listed triggering event (Medicare entitlement) is motivating the retiree to drop group coverage even though under the terms of the plan the triggering event does not create a loss of coverage for the retiree or spouse. It seems the answer would be that there are no continuation rights for the spouse. However, the Minnesota Department of Commerce has ruled that since the spouse is losing coverage, the spouse is entitled to continue coverage for 36 months consistent with Minnesota Statutes section 62A.20.

- Q2. The employee and spouse were covered under a political subdivision group, ABC School. The employee retired and waived coverage under ABC school because the former employee was able to obtain coverage under his/her

spouse's group plan. Several months later the former employee of ABC School requests to be added back onto the ABC School plan due to the spouse losing coverage under his/her health plan. Is ABC School required under section 471.61 or other continuation laws to add the former employee and spouse onto the plan?

- A2. There is no obligation under any state or federal continuation law to add either the former employee or spouse onto the health plan. The former employee waived rights to continuation. Some groups, however, have a policy to allow the participants back onto their plan. Groups should have a policy regarding this issue and apply it consistently.
- Q3. A former employee with single coverage retires from ABC School and elects to continue coverage under section section 471.61. May the former employee add a spouse onto the plan at a later date?
- A3. The answer will vary based on the specific circumstances causing the request for addition. Under section 471.61 only those dependents receiving coverage immediately before the employee leaves employment are eligible to continue.

However, HIPAA applies to political subdivision groups such as ABC School. Therefore, ABC School should allow the addition of a dependent if this addition is the result of a HIPAA special enrollment event. An example of a HIPAA special enrollment event is that the spouse waived coverage under ABC School when it was initially offered due to other coverage. The spouse is now losing that coverage due to termination of employment and is requesting to be added to the ABC School's plan within 30 days of losing his/her coverage.

Section 471.61 does not limit rights granted to former employees under other state or federal laws; thus the former employee could waive their section 471.61 rights and elect continuation rights under other state and federal provisions. Under state and federal continuation laws dependents may be added to continuation coverage in the same manner that other similarly situated active beneficiaries can add dependents. If the group allows active employees to add late entrants then they should allow the retiree to add a dependent as a late entrant. It is important to remember, however, that state and federal provisions do not provide indefinite coverage. For example, both state and federal continuation laws limit continuation to 18 months for an individual who left employment through retirement.

- Q4. ABC School provided coverage for the former employee and the spouse under Minnesota Statutes section 471.61. Several months after retirement the former employee requested that the spouse be deleted from the plan. If the former employee wants to add the spouse back to the plan at a later date, would this be allowed?
- A4. Since the dependent was on the plan immediately before the employee left employment it would seem they *may* be eligible under section 471.61 if active employees are allowed to add dependents as late entrants to the plan. Groups should have a policy and administer it consistently.

Groups should consult with their legal counsel for specific advice on areas of legislation that are not clear cut or appear in conflict with other state or federal laws. There are differing views on how Section 471.61 and other state and federal continuation provisions interrelate. To date, none of these views have been tested in court and the Department of Commerce has not published guidance.

Divorced Spouses and Minnesota Law

Minnesota law requires that divorced spouses may continue coverage under a group or individual fully insured plan. The law requires that the cost to the divorced spouse may not exceed 102% of the cost to other similarly situated covered spouses who are not divorced.

The Department of Commerce (DOC) has advised that a divorced spouse under a single/family-rated contract who elects to continue coverage may not be charged a premium that is greater than what is being charged for family coverage. When a divorced spouse elects continuation, Blue Cross and Blue Shield of Minnesota does not charge an additional premium to cover the former spouse if the employee is required to pay a family premium in order to cover dependent children. This is in keeping with a ruling from DOC in 1988 that to charge a divorced spouse an additional premium would amount to unjust enrichment.

In addition, DOC has advised that under a single/family contract, when either of the divorced spouses remarries and adds their new spouse to the coverage, no additional premium may be charged to cover the new spouse. Blue Cross does not charge groups an additional premium for former spouses on family coverage when the group has a single/family rating structure and either spouse remarries.

A former spouse covered under a family rate may elect a different health plan when two or more plan options are available, but only at open enrollment or a special enrollment event. If a divorced spouse elects a different plan than the rest of the family, they are charged the appropriate rate for that plan.

How this is Applied

Groups with age-dependent graded rates (separate charge for each individual)

Where each covered individual pays a separate charge for coverage, the rule stated above does not apply. A former spouse or employee and their new spouse are each required to pay the appropriate premium.

Groups with single/family rating

As long as the employee must carry family coverage to cover dependent children, Blue Cross will not charge an additional premium to cover the former spouse under the same plan, even if the employee or former spouse remarries and adds a new spouse.

If or when the employee has no other dependents, then the group can be charged a single rate to cover the employee and a single or family rate to cover the former spouse and any dependents as appropriate.

Example 1:

Jon is enrolled under his employer's fully insured group health plan and covers his spouse Mary and two children under a family rate. Jon and Mary then divorce. Mary elects COBRA. Blue Cross does not charge an additional premium to cover Mary.

Jon then marries Sue and adds Sue to the coverage (along with the two children). Blue Cross does not charge an additional premium to cover Mary.

Groups with tiered rates

Groups with tiered rates may vary based on how the charges are applied to the tiers.

Typically there are five tiers –

- (1) single
- (2) single plus child
- (3) single plus spouse
- (4) single plus children
- (5) single plus spouse and children.

When there is a separate charge for each tier and the employee must cover children, then a divorced spouse must pay either a single charge or the difference between tier 5 minus tier 4 (or tier 5 minus tier 2 if appropriate), whichever is less.

When the charges for tiers 4 and 5 (or tiers 2 and 5) are identical, then the rate does not change due to the divorce if the employee must cover 1 or more dependent children. In these cases, Blue Cross may not charge an additional premium until the employee no longer covers any dependent child. At that time,

Example 2:

Maija is covered under her employer's fully insured group health plan and covers her husband Luke and their two children. The group is charged a tier 5 rate. Maija and Luke then divorce. Luke elects COBRA.

If the same amount is charged for tier 4 and tier 5, Blue Cross does not charge an additional premium to cover Luke.

If different amounts are charged for tier 4 and tier 5, then Blue Cross charges the group a tier 4 rate to cover Maija and the two children, and either a tier 1 or the difference between tier 5 and tier 4 (whichever is less) to cover Luke.

Two years later, one child reaches age 19 and is longer covered under the plan. Blue Cross then charges a tier 2 premium to cover Maija and her other child, and either a tier 1 premium or the difference between tier 5 and tier 2, whichever is less, to cover Luke.

Maija then marries Harry and adds Harry to the coverage (along with her child). The group is charged a tier 5 rate to cover Maija, Harry, and Maija's child. Blue Cross charges a tier 1 rate to cover Luke.

the employee will be charged a tier 1 rate and the former spouse will be charged a tier 1 (or the appropriate) rate.

However, if the employee remarries and adds the new spouse, or the former spouse remarries or acquires a new child dependent, and adds the new spouse or child dependent to the plan, the former spouse will have to pay the appropriate rate.

Groups with composite rate

Groups with a composite rate structure have one rate for each employee, whether or not there are dependents. Blue Cross will not charge an additional premium to cover the former spouse under the same plan, even if the employee or former spouse remarries and adds a new spouse.

If or when the employee terminates employment, then the group can be charged a composite rate to cover the former spouse (and any dependents).

Example 3:

Kevin is enrolled in his employer's group health plan and covers his spouse Melinda and their two children under a composite rate. Kevin and Melinda then divorce. Melinda elects COBRA. Blue Cross does not charge an additional premium to cover Melinda.

Kevin marries Joanne and adds Joanne to coverage (along with the two children). Blue Cross does not charge an additional premium to cover Melinda.

Medicare and COBRA

How Medicare entitlement will affect an individual's COBRA rights is a complicated subject and will depend on many variables.

Example:

Tom becomes entitled to Medicare August 1, 2006; however he continues to work. There is a triggering event but the triggering event does not cause a loss of coverage under the plan so there is no qualifying event.

Covered Employee's Medicare Entitlement As the First Qualifying Event

Medicare entitlement is listed as a triggering event under the state requirements and COBRA. However, under the Medicare Secondary payer rules plans are generally not permitted to terminate the coverage of an employee because they are entitled to Medicare. Because Medicare entitlement will rarely cause a loss of coverage, it will rarely be a COBRA qualifying event. Remember: Trigger Event + Loss of Coverage as Result of Event = Qualifying Event.

Covered Employee's Medicare Entitlement As A Second Qualifying Event

Under COBRA, certain events can extend the 18-month coverage period to 36 months if the first event is termination of employment. However, the same logic that applies to a first qualifying event applies to a second qualifying event. Since Medicare entitlement would rarely have caused a loss of coverage had the employee still been working, it will rarely, if ever, cause an extension of benefits to 36 months under federal COBRA.

Example:

Tim and Lisa are covered under Tim's group health plan. Tim becomes entitled to (enrolled in) Medicare effective October 1, 2005. He is still working and his entitlement to Medicare does not cause him to lose his coverage. On February 14, 2006 Tim retires and his group covers him until March 1, 2006. As of March 1, 2006, Tim is eligible to continue coverage for 18 months. His spouse, Lisa, is eligible to continue for a total of 36 months from Tim's entitlement to Medicare.

Covered Employee's Medicare Entitlement Before the Qualifying Event of Termination of Employment or Reduction in Hours

When an employee terminates employment within 18 months after they become eligible for Medicare, the employee's spouse and dependent children become entitled to a maximum of 36 months of coverage from the date of Medicare entitlement. The employee, however, is still only eligible for 18 months of coverage from the date of loss of coverage due to terminating employment.

Example 1:

Margaret is covered under a self-insured group plan subject to COBRA. On January 5, 2006 Margaret terminates employment and experiences a loss of coverage as a result of the termination effective February 1, 2006. Margaret elects 18 months of COBRA. On May 1, 2006, Margaret becomes entitled to (enrolled in) Medicare. Her employer may terminate her COBRA coverage effective May 1, 2006.

Termination of COBRA Due to Medicare Entitlement

When the qualified beneficiary becomes entitled to Medicare *after* they elect COBRA, his or her COBRA coverage may be terminated under federal law. However, if the group is fully insured and subject to MN State continuation laws, the former employee may not have continuation coverage through the group cancelled. The reason is that the Departments of Commerce and Health do not consider Medicare to qualify as other coverage.

Example 2:

Assume the same facts as example 1 except that Margaret is covered by a MN fully insured plan. The employer may not terminate Margaret's coverage.

Example:

Tim is enrolled in his employer's fully insured group health plan. Tim turned 65 in October, 2006, but continues to work. In March 2007, Tim drops his employer-sponsored coverage and enrolls in a Medicare Advantage plan. Tim's wife, Lynn, is eligible to continue coverage for 36 months beginning in March, 2007.

Medicare and Minnesota Law

Under Minnesota Statutes section 62A.20, a spouse and dependent children can elect to continue coverage for up to 36 months when a covered employee or contractholder becomes enrolled in Medicare. The Minnesota Department of Commerce has ruled that this provision applies when a spouse or dependent loses coverage as a result of an employee or contractholder dropping group or individual coverage in favor of a Medicare supplement plan. The 36-month period begins to run from the time of election.

COBRA and Consumer Directed Health Care (CDHP)

The components of a CDHP are a high deductible health plan (HDHP) with a health plan account that offsets the first portion of the deductible.

Both the HDHP and a health *reimbursement* account (HRA) are subject to COBRA because they are defined as group health plans, subject to all applicable continuation provisions. A health *savings* account is not subject to COBRA.

A qualified beneficiary generally has the right to continue at the same level of coverage he or she had on the day before the qualifying event. This includes access to the available HRA balance on the day before the qualifying event. Employers should consult their own legal counsel or tax advisor for advice on how to administer COBRA for an HRA.

USERRA

Under the Federal and Uniformed Services Employment and Reemployment Rights Act (USERRA), an employee called to active duty in the uniformed services may, in addition to electing COBRA, elect to continue coverage under USERRA. Employees who qualify are those who are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, rather than state, call-up), the commissioned corps of the Public Health Service, and any other category of persons designated by the president. Employees who have entered active military duty can elect to continue coverage for themselves and their dependents under an employer-sponsored health plan for up to 24 months. The previous limit was 18 months. The limit was extended effective December 10, 2004 by amendments to USERRA.

USERRA and COBRA rights run concurrently. An employer should offer both USERRA and COBRA at the time an employee is called to active duty.

Trade Act of 2002

The federal Trade Act of 2002 applies to workers displaced by import competition or shifts of production to other countries. Eligible workers receive benefits called Trade Adjustment Assistance (TAA).

Tax Credits

The Act gives federal tax credits for certain health insurance premium costs to former employees who are eligible for TAA, or if the former employee is eligible for a pension benefit paid by the Pension Benefit Guaranty Corporation. This includes individuals covered under COBRA. TAA eligible individuals are given a federal tax credit for 65% of the premiums for COBRA coverage. The Treasury Department has established a program for making tax credit payments directly to employers for the COBRA premium.

TAA Second COBRA Qualifying Event

The Act also authorizes a special second COBRA qualifying event for former employees who are eligible to receive the tax credit. In order to be eligible for the second COBRA qualifying event, the former employee must have lost group coverage due to a job loss that resulted in eligibility for TAA, and then failed to elect COBRA during the regular election period triggered by the job loss.

This election is unlike the standard COBRA election because only the former employee may elect during the special second election period. The former employee may, however, elect coverage for a spouse and dependent children.

Individuals are eligible for a second election if they file a petition for certification for TAA after November 4, 2002 and later became TAA recipients. The special second 60-day election period begins on the first day of the month in which the former employee becomes eligible for TAA, but only if the election is made within 6 months after the initial loss of group health plan coverage.

The COBRA coverage period runs for 18 months beginning on the original COBRA eligibility date unless extended due to a disability determination or a second qualifying event.

Risk of Litigation and Sanctions for Noncompliance with Continuation Requirements

Sanctions for Noncompliance

The Internal Revenue Code contains excise tax sanctions for failure to comply with continuation of coverage requirements. The amount of tax imposed on any failure with respect to a qualified beneficiary is \$110 per each day of noncompliance. Where a failure occurs with respect to more than one qualified beneficiary of the same family, the amount of the excise tax is capped at \$200 per day.

In order to ensure that employers monitor themselves for compliance, the Internal Revenue Code contains a special audit provision. Under this rule, a minimum tax of \$2,500 will be imposed if a failure is not corrected by the date a notice of examination of income tax liability is sent to the employer and the failure occurred or continued during the period under examination. This minimum tax can be raised to \$15,000 for gross violations.

The maximum tax liability is the lesser of (1) 10 percent of the total amount paid or incurred by the employer during the preceding year for group health plans or (2) \$500,000. These caps do not apply where noncompliance is due to willful neglect.

Liability for Sanctions

Generally, the employer is the party liable for the excise tax. In addition, each person responsible for administering the plan or providing plan benefits is liable if his or her act or failure to act caused the failure. These parties may include the insurance company and the plan administrator.

Plan administrators can be held liable for the tax imposed only if they assume responsibility under a written agreement for the performance of the act to which the failure relates. Other parties, including the plan administrators, can also be held liable if they fail to comply with the employer's written requests to make the same benefits provided to active employees available to an employee or beneficiary.

Risk of Litigation

Aside from the imposition of tax penalties, a more likely threat to an employer is the risk of litigation for noncompliance with continuation requirements. The best way to avoid litigation or minimize its effects is to administer continuation very carefully. An employer should keep records of employees' addresses up-to-date so that notices will be sent to the correct address. Notices should be sent by first-class mail to the last known address, preferably with a certificate of mailing. An employer should always get elections or waivers in writing, keep records, give the required notices, have reasonable notice procedures, and document all conversations with employees regarding their continuation rights. Whenever in doubt, an employer should seek legal advice.

The following is a list of some of the most commonly asked COBRA questions.

- Q1. The qualified beneficiary said they did not want COBRA and signed a waiver of COBRA coverage. Now they change their mind and state they want COBRA. Should we still offer them the coverage?
- A1. The qualified beneficiary may revoke their waiver anytime during the 60-day election period. The Plan does not, however, need to provide COBRA coverage for the time period from the loss of coverage to the date of the revocation. This could result in a gap in coverage for the qualified beneficiary. If the beneficiary revokes the waiver of coverage beyond the 60-day election period, the group is not required to offer coverage.

Example:

John terminates employment January 10, 2006. He was covered by a fully insured group plan. His coverage will cease as of January 31, 2006. The group sends an offer to John by first class mail prior to January 31, 2006 explaining his option to continue coverage. If John elects continuation at any time during the 60-day election period beginning on February 1, 2006, his continuation coverage will be retroactive to February 1, 2006.

John is healthy and decides he does not need health insurance coverage through the group. He declines continuation coverage on February 15, 2006 by signing a waiver.

On March 1, 2006 John becomes very ill and is hospitalized. He contacts his former employer on March 8, 2006 and asks if he can change his mind (revoke the waiver) and take continuation coverage because he is going to have a lot of medical bills.

Since John is still within the 60-day election period, the group must allow him to revoke his waiver. However, coverage need not be provided from February 1, 2006 to March 8, 2006. This will result in a gap in coverage for John. The 18-months of continuation coverage will be calculated from his health coverage termination date of February 1, 2006 (not from March 8, 2006).

If John had asked to revoke his waiver beyond the 60-day election period (e.g. April 5, 2006), he would not be eligible for coverage.

Self-insured groups, including self-insured political subdivisions, may decide to follow this policy or to cover the qualified beneficiary retroactively back to the date coverage was initially lost.

- Q2. What happens when an employee eliminates coverage for their spouse before a divorce is final?
- A2. The employer is required to make COBRA continuation coverage available effective on the date of the divorce, but not for any period before the date of divorce or legal separation. This could result in a gap in coverage for the former spouse.

Example:

Rob and Paige are married and covered under Paige's group health plan. Paige, while still married to Rob, requests that Rob be removed from her health plan. Six months later Paige and Rob divorce. In this case the group must ignore the fact that the divorce did not cause a loss in coverage. Individuals who are removed from coverage in anticipation of a qualifying event must be given an opportunity to elect COBRA/continuation effective from the date of the qualifying event. This may mean that there is a gap in coverage from the active plan coverage to the continuation coverage.

Unfortunately, there is no guidance outlining a length of time that would toll a removal from coverage being considered "anticipation of a qualifying event". Groups must use their own judgement and carefully review the facts of each case to determine if continuation should be offered.

- Q3. If a person is covered by another health plan and COBRA or continuation coverage, which plan is primary?

- A3. The National Association of Insurance Commissioners (NAIC) coordination of benefits (COB) rules govern order of payment when an individual is covered under more than one health plan. The COB rules establish a uniform order of benefit determination under which plans pay claims. One of the primacy determination rules addresses continuation coverage.

The general COB rules state that each primacy determination rule is followed in order until a primary determination can be made. If one of the rules, for example, the birthday rule, determines primacy, the rule governing continuation coverage does not come into play. This means that a COBRA or continuation plan could be primary for a former employee who is also covered as a dependent under a spouse's plan. The COB rules also contain special rules regarding coordination of benefits for children who are covered under more than one plan and these rules would take precedence over the continuation rule. If none of the primacy determination rules controls prior to reaching the continuation coverage rule, then the continuation rule will apply to make the COBRA coverage primary.

- Q4. Can a spouse or children who were not covered by the health plan when the former employee was an active employee, be added to a COBRA plan?

- A4. Yes, if similarly situated active employees are allowed to add dependents. Employers should treat qualified beneficiaries on COBRA in the same manner that they treat their active employees. Dependents who were not covered prior to the qualifying event and later added to the COBRA coverage are not qualified beneficiaries and do not have rights to a second qualifying event.

- Q5. Not everyone who was covered under the health plan wants to continue coverage. Can the family determine which family members they want to cover under COBRA?

- A5. Yes, each qualified beneficiary has an independent right to elect COBRA.

Example:

Bob is covered under his fully insured group health plan that allows the addition of dependents mid-year as late entrants. Bob leaves employment and elects continuation. Two months later Bob asks to add his spouse Kathy onto the continuation plan. Since an active employee may add dependents mid-year, Bob may add Kathy to his continuation plan.

Q6. The employee is required to notify the employer within 60 days of a divorce or a child losing dependent status. The employee did not provide this notice within 60 days. Can we allow the spouse or dependent to come on the plan now?

A6. The group health plan is not required to offer the spouse or dependent an opportunity to elect continuation coverage if the employee does not provide notice to the plan administrator (usually the employer) within 60 days of the divorce or loss of dependent status. However, if the employee's former spouse or student dependent never received a general initial notice of COBRA rights and obligations and a description of reasonable notice procedures, the employee's obligation to inform the plan administrator may be waived. In these situations, the plan administrator should offer continuation. The decision to offer continuation coverage is left to the group in these situations because they will know if the spouse or student dependent was provided the initial notice and the plan's reasonable notice procedures.

Q7. What is "gross misconduct?"

A7. There is no standard definition of gross misconduct. Unfortunately, the courts have not agreed on a common standard to apply in gross misconduct cases. Certain federal courts have looked to the unemployment insurance laws of the state in which the court sits. One federal court applied the following definition of gross misconduct:

"Gross misconduct may be intentional, wanton, willful, deliberate, reckless or in deliberate indifference to the employer's interest. It is misconduct beyond mere minor breaches of employee standards, but conduct which would be considered gross in nature."

The Federal Employee Health Benefits Amendment Act of 1988 defines gross misconduct as a "flagrant and extreme transgression of law or established rule of action."

The plan administrator (usually the employer) must decide whether to offer continuation coverage when an employee's conduct may be considered gross misconduct. Misconduct that would lead to the termination of employment may not necessarily be considered gross misconduct.

Q8. The employee is taking a leave of absence, should COBRA be offered?

A8. The answer to this may vary depending on the type of leave the employee is taking and the employer's policy.

Taking leave under the Family Medical Leave Act (FMLA) is not considered a qualifying event. The qualifying event occurs on either the last day of FMLA leave or the day the employee gives notice that they will not be returning to work.

If the leave of absence is not taken under FMLA there are 3 options:

- Treat the start of the leave as the qualifying event;
- Treat the end of the leave as the qualifying event;
- Treat the start of leave as qualifying event but offer alternative coverage.

The employer should have a policy and administer it consistently.

Q9. Who has the COBRA liability in the case of a sale of a company?

A9. This frequently asked question is often complicated. The IRS has provided guidance in 2002 regulations regarding COBRA consequences during business

sales and reorganizations. Generally, the parties to the transaction should determine COBRA liability or the IRS regulations will determine which plan is responsible to cover the affected employees. Since the parties to the transaction have the facts needed to make a determination, they must make the decisions regarding COBRA coverage responsibility.

Q10. What effect does workers' compensation have on continuation benefits?

A10. Health coverage in general is not addressed in most workers' compensation settlements since usually the discussion of health care is limited to the medical issue that relates to the injury. Eligibility for workers' compensation is not listed as a triggering event under either state continuation or federal COBRA. Employers should determine when an individual with a work-related injury loses coverage due to a reduction in hours or loss of employment and offer COBRA appropriately.

Fully Insured Groups

Fully insured groups should follow the guidelines for the qualifying event of total disability if the employee is unable to work due to a workers' compensation claim. If the employee is unable to perform his/her own job, they may remain on the plan for two years. If after two years, the employee is able to perform another occupation, then they would no longer qualify for coverage under the state disability laws and if they do not return to work, then it would be the employer's decision whether to formally end employment. When employment ends, the obligation to offer 18-months of continuation coverage is triggered. If, however, after two years the employee is unable to perform any other occupation for which they may become reasonably qualified by training or education, the employee may remain on the group's health plan indefinitely.

Self-Insured Groups

It is the employer's decision when employment ends that is the trigger to offer COBRA. We rely on the employer to notify us regarding the duration of continuation coverage the person on workers' compensation should receive.

