

Section 4980B.—Failure to Satisfy Continuous Coverage Requirements of Group Health Plans

26 CFR 54.4980B-1: COBRA in general.

T.D. 8812

**DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Parts 54 and 602**

Continuation Coverage Requirements Applicable to Group Health Plans

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final rule.

SUMMARY: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added health care continuation requirements that apply to group health plans. Coverage required to be provided under those requirements is referred to as COBRA continuation coverage. Proposed regulations interpreting the COBRA continuation coverage requirements were published in the **Federal Register** of June 15, 1987 and of January 7, 1998. This document contains final regulations based on these two sets of proposed regulations. The final regulations also reflect statutory amendments to the COBRA continuation coverage requirements since COBRA was enacted. A new set of proposed regulations REG-121865-98 addressing additional issues under the COBRA continuation coverage provisions is on page 63 of this Bulletin. The regulations will generally affect sponsors of and participants in group health plans, and they provide plan sponsors and plan administrators with guidance necessary to comply with the law.

DATES: Effective Date: These regulations are effective February 3, 1999.

Applicability Dates: Sections 54.4980B-1 through 54.4980B-8 apply to group health plans with respect to qualifying events occurring in plan years beginning on or after January 1, 2000. See the Effective Date portion of this preamble and Q&A-2 of §54.4980B-1.

FOR FURTHER INFORMATION CONTACT: Yurlinda Mathis, 202-622-4695. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collections of information contained in these final regulations have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507) under control number 1545-1581. Responses to these collections of information are mandatory in some cases and required in order to obtain a benefit in other cases. Group health plans are required to provide certain individuals a notice of their COBRA continuation coverage rights when certain qualifying events occur and are required to inform health care providers who contact the plan to confirm the coverage of certain individuals of the individuals' complete rights to coverage. To obtain COBRA continuation coverage or extended coverage, certain individuals are required to notify the plan administrator of certain events or that they are electing COBRA continuation coverage, and plans are required to notify certain individuals of insignificant underpayments if the plan wishes to require the individuals to pay the deficiency. This information will be used to advise employers and plan administrators of their obligation to offer COBRA continuation coverage, or an extended period of such coverage; to advise qualified beneficiaries of their right to elect COBRA continuation coverage and of insignificant errors in payment; and to inform health care providers of individuals' rights to COBRA continuation coverage.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the col-

lection of information displays a valid control number.

The estimated average annual burden per respondent varies from 30 seconds to 330 hours, depending on individual circumstances, with an estimated average of 14 minutes.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be sent to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, OP:FS:FP, Washington, DC 20224, and to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503.

Books or records relating to these collections of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

On June 15, 1987, proposed regulations (EE-143-86, 1987-2 C.B. 929) relating to continuation coverage requirements applicable to group health plans were published in the **Federal Register** (52 F.R. 22716). A public hearing was held on November 4, 1987. Written comments were also received. A supplemental set of proposed regulations (REG-209485-86, 1998-11 I.R.B. 21) was published in the **Federal Register** of January 7, 1998 (63 F.R. 708). No public hearing was requested or held after the publication of the supplemental proposed regulations; written comments were received. After consideration of these comments, after review of the reported court decisions under the parallel COBRA continuation coverage provisions of the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act, and based on the experience of the IRS in administering the COBRA continuation coverage requirements, a portion of the regulations proposed by EE-143-86 and REG-209485-86 is adopted as revised by this Treasury decision. The revisions are summarized in the explanation below. Also being published elsewhere in this issue of the **Federal Register** is a

new set of proposed regulations, which addresses additional issues.

Explanation of Provisions

Overview

The regulations are intended to provide clear, administrable rules regarding COBRA continuation coverage. The regulations give comprehensive guidance on many questions under COBRA, with a view to enhancing the certainty and reliance available to all parties – including employees, qualified beneficiaries, employers, employee organizations, and group health plans – in determining their COBRA rights and obligations. The guidance is designed to further the protective purposes of COBRA without undue administrative burdens or costs on employers, employee organizations, or group health plans.

For example, the regulations:

- Prevent group health plans from terminating COBRA continuation coverage on the basis of other coverage that a qualified beneficiary had prior to electing COBRA continuation coverage, in accordance with the Supreme Court's decision in *Geissal v. Moore Medical Corp.*
- Give employers and employee organizations significant flexibility in determining, for purposes of COBRA, the number of group health plans they maintain. This will reduce burdens on employers and employee organizations by permitting them to structure their group health plans in an efficient and cost-effective manner and to satisfy their COBRA obligations based upon that structure.
- Provide baseline rules for determining the COBRA liabilities of buyers and sellers of corporate stock and corporate assets and permit buyers and sellers to reallocate and carry out those liabilities by agreement. This will significantly enhance employers' ability to negotiate and to plan appropriately for the treatment of qualified beneficiaries in connection with mergers and acquisitions, while protecting the rights of qualified beneficiaries affected by the transactions.
- Limit the application of COBRA for most health flexible spending

arrangements. This will ensure that COBRA continuation coverage under health flexible spending arrangements is available in appropriate cases without requiring continuation coverage where that would not serve the statutory purposes.

- Eliminate the requirement that group health plans offer qualified beneficiaries the option to elect only core (health) coverage under a group health plan that otherwise provides both core and noncore (vision and dental) coverage.
- Give employers, in determining whether the small-employer plan exception applies, the option of counting by pay period rather than by every business day, and provide, for that exception, for the consistent treatment of part-time employees through the use of full-time equivalents.

The COBRA continuation coverage requirements enacted on April 7, 1986 have been amended by the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986), the Tax Reform Act of 1986 (TRA 1986), the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), the Small Business Job Protection Act of 1996 (SBJPA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¹ These amendments made numerous clarifications and modifications to the COBRA continuation coverage requirements, moved the requirements from section 162(k) to section 4980B, added various other features, such as the disability extension to the required period of coverage, and significantly altered the sanctions imposed on employers and plans for failing to comply with the requirements. The specific changes made by these amendments are discussed below in connection with the provisions of the regulations that relate to them.

¹ The COBRA continuation coverage requirements have also been affected by an amendment made to the definition of group health plan by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). OBRA 1993 amended the definition of group health plan in section 5000(b)(1), which the COBRA continuation coverage provisions of the Internal Revenue Code incorporate by reference.

The legislative history of COBRA provides that the Department of the Treasury has the authority to interpret the coverage and tax sanction provisions of COBRA and that the Department of Labor has the authority to interpret the reporting and disclosure provisions. Accordingly, these regulations apply in interpreting the coverage provisions of COBRA in Title I of ERISA, as well as those in the Internal Revenue Code. With minor exceptions, the final regulations and the new proposed regulations being published today do not address the notice provisions of the COBRA continuation coverage requirements.

Organization

The final regulations being published today follow the structure of the 1987 proposed regulations, with related questions-and-answers grouped into topics. Each topic is now in a separate section, and sections have been added to the new proposed regulations being published today for (1) business reorganizations and employer withdrawals from multiemployer plans and (2) the interaction of the Family and Medical Leave Act of 1993 (FMLA) and COBRA. The substance of the 1998 proposed regulations has been integrated into the questions-and-answers of the 1987 proposed regulations. The ordering of some of the questions-and-answers has changed, and all of the questions-and-answers relating to the original statutory effective date have been deleted. In addition, in a few cases, the content of two separate questions-and-answers in the 1987 proposed regulations has been combined into a single question-and-answer; in other cases the content of a single question-and-answer has been expanded to two or more questions-and-answers. These changes have resulted in the renumbering of the questions-and-answers. The new proposed regulations being published today are designed to fill gaps designated in the final regulations as reserved.

Effective Date

The 1987 proposed regulations provide that they will be effective upon publication as final regulations. Some commenters suggested that the final regulations should have a delayed effective date.

The final regulations follow this suggestion; they apply with respect to qualifying events occurring in plan years beginning on or after January 1, 2000. For any period before the effective date of the final regulations, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the requirements in section 4980B. For the period before the effective date of the final regulations, the IRS will consider compliance with the proposed regulations in §1.162-26 (the 1987 proposed regulations) and §54.4980B-1 (the 1998 proposed regulations) to constitute good faith compliance with a reasonable interpretation of the statutory requirements for the topics that those proposed regulations address, except to the extent inconsistent with a statutory amendment adopted after the dates the proposed regulations were issued, during the period the amendment is effective, or with a decision of the United States Supreme Court released after the proposed regulations were issued, during the period after the decision is released. For any period beginning on or after the effective date of the final regulations with respect to topics not addressed in the final regulations, such as how to calculate the applicable premium, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the requirements in section 4980B.

Compliance with the new proposed regulations will constitute good faith compliance with a reasonable interpretation of the statutory requirements addressed in the new proposed regulations until the new proposed regulations are finalized. In addition, actions inconsistent with the terms of the new proposed regulations will not necessarily constitute a lack of good faith compliance with a reasonable interpretation of the statutory requirements addressed in the new proposed regulations; whether there has been good faith compliance with a reasonable interpretation of the statutory requirements will depend on all the facts and circumstances of each case.

The IRS will not assess the excise tax with respect to a plan that operates in good faith compliance with a reasonable interpretation of the statutory requirements, as described in the preceding two paragraphs. Note, however, that in the

case of lawsuits brought by qualified beneficiaries to enforce their COBRA continuation coverage rights under ERISA or the Public Health Service Act, the courts generally have not applied any good faith compliance standard.

Plans That Must Comply

The final regulations provide rules regarding which group health plans are subject to COBRA. These rules are generally similar to those set forth in the 1987 proposed regulations. However, the rules for determining, for purposes of the COBRA continuation coverage requirements, the number of group health plans maintained by an employer have been deleted, and the new proposed regulations set forth substantially different rules, which provide that employers and employee organizations generally have broad discretion to determine the number of group health plans that they maintain. Other significant changes to the 1987 proposed regulations on this point (some of which are set forth in the 1998 proposed regulations) include exceptions for long-term care services and medical savings accounts and new rules regarding the small-employer plan exception.

As in the 1987 proposed regulations, the final regulations provide that, in general, all group health plans are subject to the COBRA continuation coverage requirements. However, small-employer plans (discussed below), church plans (within the meaning of section 414(e)), and governmental plans (within the meaning of section 414(d)) are not subject to COBRA. (The final regulations refer to these as plans excepted from COBRA.) Plans excepted from COBRA are generally not subject to the COBRA continuation coverage requirements or the COBRA excise tax, although group health plans maintained by state or local governments are subject to parallel continuation coverage requirements in the Public Health Service Act (which is administered by the Department of Health and Human Services). Also, the Federal Employees Health Benefit Program is subject to generally similar, although not parallel, temporary continuation of coverage provisions under the Federal Employees Health Benefits Amendments Act of 1988.

The final regulations define *group health plan* in a manner generally similar

to that in the 1987 proposed regulations. However, certain changes in terminology have been made to reflect the statutory cross-reference to section 5000(b)(1) set forth in section 4980B(g)(2) (such as the use of the term *health care* and the definition of *employee*). Additionally, the final regulations, in accordance with section 4980B(g)(2), provide that a plan is not a group health plan if substantially all the coverage provided under the plan is for qualified long-term care services (as defined in section 7702B(c)). The final regulations allow plans to use any reasonable method in determining whether a plan satisfies this exception. The final regulations also provide, in accordance with section 106(b)(5), that amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan for purposes of COBRA (although a high-deductible health plan will not fail to be a group health plan simply because it covers a holder of a medical savings account).

Under the final regulations, a *group health plan* is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to the families of such individuals. In accordance with section 5000(b)(1), these individuals include employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship. The final regulations generally refer to all individuals covered under a plan by virtue of the performance of services or by virtue of membership in an employee organization as employees. (As discussed below, the term *employee* has a narrower meaning for purposes of the small-employer plan exception.) The final regulations use the term *employer* to refer to a person for whom an individual performs services. Pursuant to section 414(t), the term *employer* also includes, with respect to such a person, any member of a group described in section 414(b), (c), (m), or (o) that includes the person (a controlled group) as well as any successor of the person or of a member of the controlled group.

Under the final regulations, as under the 1987 proposed regulations, a plan

generally is considered to provide health care whether it does so directly or through insurance, reimbursement, or other means and whether it does so through an on-site facility or a cafeteria or other flexible benefit arrangement. Insurance includes group insurance policies and one or more individual policies under an arrangement maintained by the employer or employee organization to provide health care to two or more employees. Under the final regulations, as under the 1987 proposed regulations, in the case of a cafeteria plan or other flexible benefit arrangement, the COBRA continuation coverage requirements apply only to the health care benefits under the cafeteria plan or other flexible benefit arrangement that an employee has actually chosen to receive.

Many commenters on the 1987 proposed regulations requested clarification of the application of COBRA to health care benefits provided under flexible spending arrangements (health FSAs). Some commentators argued that health FSAs should not be subject to COBRA. Health FSAs satisfy the definition of group health plan in section 5000(b)(1) and, accordingly, are generally subject to the COBRA continuation coverage requirements. However, COBRA is intended to ensure that a qualified beneficiary has guaranteed access to coverage under a group health plan and that the cost of that coverage is no greater than 102 percent of the applicable premium.

The IRS and Treasury believe that the purposes of COBRA are not furthered by requiring an employer to offer COBRA for a plan year if the amount that the employer could require to be paid for the COBRA coverage for the plan year would exceed the maximum benefit that the qualified beneficiary could receive under the FSA for that plan year and if the qualified beneficiary could not avoid a break in coverage, for purposes of the HIPAA portability provisions², by electing COBRA coverage under the FSA. Accordingly, the new proposed regulations contain a rule limiting the application of

² Under HIPAA, a qualified beneficiary who maintains coverage after termination of employment under a group health plan that is subject to HIPAA can avoid a break in coverage and thereby avoid becoming subject to a preexisting condition exclusion upon later becoming covered by another group health plan.

the COBRA continuation coverage requirements in the case of health FSAs.

Under this rule, if the health FSA satisfies two conditions, the health FSA need not make COBRA continuation coverage available to a qualified beneficiary for any plan year after the plan year in which the qualifying event occurs. The first condition that the health FSA must satisfy for this exception to apply is that the health FSA is not subject to the HIPAA portability provisions in sections 9801 through 9833 because the benefits provided under the health FSA are excepted benefits. (See sections 9831 and 9832.)³ The second condition is that, in the plan year in which the qualifying event of a qualified beneficiary occurs, the maximum amount that the health FSA could require to be paid for a full plan year of COBRA continuation coverage equals or exceeds the maximum benefit available under the health FSA for the year. It is contemplated that this second condition will be satisfied in most cases.

Moreover, if a third condition is satisfied, the health FSA need not make COBRA continuation coverage available with respect to a qualified beneficiary at all. This third condition is satisfied if, as of the date of the qualifying event, the maximum benefit available to the qualified beneficiary under the health FSA for the remainder of the plan year is not more than the maximum amount that the plan could require as payment for the remainder of that year to maintain coverage under the health FSA.

A plan is maintained by an employer or employee organization even if the employer or employee organization does not directly or indirectly contribute to it if coverage under the plan would not be available to an individual at the same cost if the individual did not have an employment-related connection to the employer

or employee organization. The final regulations, for purposes of the definition of a group health plan, use the term *health care* instead of the term *medical care* (which was used in the 1987 proposed regulations). This change reflects the change in the definition of group health plan made by OBRA 1989. However, the final regulations provide that *health care* has the same meaning as the term *medical care* under section 213(d). Like the 1987 proposed regulations, the final regulations set forth a summary of items that do and do not constitute health care.

The final regulations, generally following the 1987 proposed regulations, set forth rules for determining whether a group health plan is a small-employer plan. In general, a group health plan other than a multiemployer plan is a small-employer plan if it is maintained for a calendar year by an employer that normally employed fewer than 20 employees during the preceding calendar year, and a group health plan that is a multiemployer plan is a small-employer plan if each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. Whether the plan is a multiemployer plan or not, the term employer includes all members of a controlled group. An example in the final regulations clarifies that the controlled group includes foreign members, and thus a U.S. subsidiary with fewer than 20 employees is subject to COBRA if the controlled group has 20 or more employees world-wide. The final regulations set forth additional rules for the application of the small-employer plan exception to multiemployer plans, and the new proposed regulations contain the same definition of multiemployer plan that is in section 414(f).

Under the final regulations, an employer is considered to have normally employed fewer than 20 employees during a particular calendar year if it had fewer than 20 employees on at least 50 percent of its typical business days during that year. This rule differs from the rule in the 1987 proposed regulations in two ways. First, the 1987 proposed regulations use the term *working days*, whereas the final regulations use the statutory term *typical business days*.

The second difference relates to the term *employee*. Under the 1987 proposed

regulations, self-employed individuals and independent contractors are counted as employees for purposes of the small-employer plan exception if they are covered under a plan of the employer. Commenters argued that only common law employees should be counted for this purpose. Unlike the definition of *covered employee* (amended by OBRA 1989 to make clear that individuals who are not common law employees but who are covered under the group health plan of an employer or employee organization by virtue of the performance of services are still considered covered employees) and the definition of *group health plan* (amended by OBRA 1993 to make clear that a health plan covering individuals who are not common law employees of the employer or employee organization, and who are not family members of common law employees, is still a group health plan) the reference to employees for purposes of the small-employer plan exception have not been amended to include individuals who are not common law employees. Consequently, under the final regulations, only common law employees are taken into account for purposes of the small-employer plan exception; self-employed individuals, independent contractors, and directors are not counted.

Although a small-employer plan is generally excepted from COBRA, a plan that is not a small-employer plan for a period remains subject to COBRA for qualifying events that occurred during that period, even if it subsequently becomes a small-employer plan.

In determining whether a plan is eligible for the small-employer plan exception, part-time employees, as well as full-time employees, must be taken into account. Several commenters on the 1987 proposed regulations requested clarification of how to count part-time employees for the small-employer plan exception, and the new proposed regulations provide guidance on this issue. Under the new proposed regulations, instead of each part-time employee counting as a full employee, each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee works for the employer divided by the number of hours that an employee must work in order to be considered a full-time employee. The

³ The IRS and Treasury, together with the U.S. Department of Labor and the U.S. Department of Health and Human Services, have issued a notice (62 F.R. 67688) holding that a health FSA is exempt from HIPAA because the benefits provided under it are excepted benefits under sections 9831 and 9833 if the employer also provides another group health plan, the benefits under the other plan are not limited to excepted benefits, and the maximum reimbursement under the health FSA is not greater than two times the employee's salary reduction election (or if greater, the employee's salary reduction election plus five hundred dollars).

number of hours that must be worked to be considered a full-time employee is determined in a manner consistent with the employer's general employment practices, although for this purpose not more than eight hours a day or 40 hours a week may be used. An employer may count employees for each typical business day or may count employees for a pay period and attribute the total number of employees for that pay period to each typical business day that falls within the pay period. The employer must use the same method for all employees and for the entire year for which the small-employer plan determination is made.

In determining whether a multiemployer plan satisfies the requirements for the small-employer plan exception, the 1987 proposed regulations provide a special rule permitting the multiemployer plan to be considered a small-employer plan for a year if any contributing employer that grew to be too large to qualify for the exception during the preceding year ceases to contribute to the plan by February 1 of the current year. Questions have been raised about the need for and the authority for this special rule, and one commenter pointed out the uncertainty of how to deal with a qualified beneficiary experiencing a qualifying event under such a plan in January of the current year if the qualified beneficiary needed confirmation of coverage for urgent services before it was clear that the too-large employer would cease contributing to the multiemployer plan by February 1. Based on these concerns, the final regulations eliminate this special rule for multiemployer plans.

The new proposed regulations provide guidance, for purposes of the COBRA continuation coverage requirements, on how to determine the number of group health plans that an employer or employee organization maintains. Under these rules, the employer or employee organization is generally permitted to establish the separate identity and number of group health plans under which it provides health care benefits to employees. Thus, if an employer or employee organization provides a variety of health care benefits to employees, it generally may aggregate the benefits into a single group health plan or dis-aggregate benefits into separate group health plans. The status of health care

benefits as part of a single group health plan or as separate plans is determined by reference to the instruments governing those arrangements. If it is not clear from the instruments governing an arrangement or arrangements to provide health care benefits whether the benefits are provided under one plan or more than one plan, or if there are no instruments governing the arrangement or arrangements, all such health care benefits (other than those for qualified long-term care services) provided by a single entity (determined without regard to the controlled group) constitute a single group health plan.

Under the new proposed regulations, a multiemployer plan and a plan other than a multiemployer plan are always separate plans. In addition, any treatment of health care benefits as constituting separate group health plans will be disregarded if a principal purpose of the treatment is to evade any requirement of law. Of course, an employer's flexibility to treat benefits as part of separate plans may be limited by the operation of other laws, such as the prohibition in section 9802 on conditioning eligibility to enroll in a group health plan on the basis of any health factor of an individual.

The final regulations modify the rules set forth in the 1987 proposed regulations for determining the plan year of a group health plan under COBRA. These modifications are made to be consistent with the rules in the temporary regulations under HIPAA. The definition of plan year is important in applying, for example, the effective date provisions under the final regulations and the rules for health FSAs under the new proposed regulations. Under the final regulations, the plan year is the year designated as such in the plan documents. If the plan documents do not designate a plan year (or if there are no plan documents), the plan year is the deductible/limit year used by the plan. If the plan does not impose deductibles or limits on an annual basis, the plan year is the policy year. If the plan does not impose deductibles or limits on an annual basis and the plan is not insured (or the insurance policy is not renewed annually), the plan year is the taxable year of the employer. In any other case, the plan year is the calendar year.

The final regulations reflect the statutory provisions that provide for the im-

position of an excise tax in the event of a failure by a group health plan to comply with the COBRA continuation coverage requirements of section 4980B(f). In the case of a multiemployer plan, the excise tax is imposed on the plan⁴; in the case of any other plan, the excise tax is imposed on the employer maintaining the plan. In certain circumstances, the excise tax can be imposed on other persons involved with the provision of benefits under the plan, such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan. Separate, non-tax remedies may be available in the case of a plan that fails to comply with the COBRA continuation coverage requirements in ERISA.

Qualified Beneficiaries

The rules in the final regulations for determining who is a qualified beneficiary generally follow those set forth in the 1987 proposed regulations, as well as those set forth in the 1998 proposed regulations regarding the status of newborn and adopted children as qualified beneficiaries. However, certain provisions have been added to the final regulations to reflect the special statutory rules that apply in the case of bankruptcy of the employer as a qualifying event. Modifications have also been made to reflect the decision of the Supreme Court in *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998), which held that an individual covered under another group health plan at the time she or he elects COBRA continuation coverage cannot be denied COBRA continuation coverage on the basis of that other coverage.

Under the final regulations, a qualified beneficiary is, in general: (1) any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse of a covered employee, or the dependent child of a covered employee; or (2) any child born to or placed for adoption with a covered employee during a pe-

⁴ In this regard, the U.S. Department of Labor has advised the IRS and Treasury that to the extent a plan fiduciary subjects a plan to liability for the COBRA excise tax on account of her or his imprudent actions, the plan fiduciary may be held personally liable under Title I of ERISA for the amount of the tax.

riod of COBRA continuation coverage. (The final regulations retain the definitions of the terms *placement for adoption* and *being placed for adoption* that were in the 1998 proposed regulations.) For a qualifying event that is the bankruptcy of the employer, any covered employee who retired on or before the date of any substantial elimination of group health plan coverage is a qualified beneficiary; the spouse, surviving spouse, or dependent child of the retired covered employee is also a qualified beneficiary if the spouse, surviving spouse, or dependent child was a beneficiary under the plan on the day before the bankruptcy qualifying event. The final regulations add a provision clarifying that if an individual is denied coverage under a group health plan in violation of applicable law (including HIPAA) and experiences an event that would be a qualifying event if the coverage had not been wrongfully denied, the individual is considered a qualified beneficiary.

A covered employee can be a qualified beneficiary only in connection with a qualifying event that is the termination (or reduction of hours) of the covered employee's employment or the employer's bankruptcy. As under the 1987 proposed regulations, the final regulations provide that a covered employee is not a qualified beneficiary if her or his status as a covered employee is attributable to certain periods in which she or he was a nonresident alien (in which case the covered employee's spouse and dependent children are also not qualified beneficiaries). Although a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is a qualified beneficiary, a child born to or placed for adoption with a qualified beneficiary other than the covered employee after a qualifying event, or a person who becomes the spouse of a qualified beneficiary (regardless of whether the qualified beneficiary is the covered employee) after a qualifying event is not a qualified beneficiary. The final regulations retain the rule of the 1987 proposed regulations under which an individual is not a qualified beneficiary if, on the day before the qualifying event, the individual is covered under the group health plan solely because of another individual's election of COBRA continuation coverage. How-

ever, consistent with *Geissal*, the final regulations eliminate the rule in the 1987 proposed regulations that an individual is not a qualified beneficiary if, on the day before the qualifying event, the individual was entitled to Medicare benefits.

An individual ceases to be a qualified beneficiary if she or he does not elect COBRA continuation coverage by the end of the election period (discussed below). The final regulations clarify that an individual who elects COBRA continuation coverage ceases to be a qualified beneficiary once the plan's obligation to provide COBRA continuation coverage has ended.

The term *covered employee* is defined in the final regulations in a manner substantially the same as in the 1987 proposed regulations. Although some commenters on the 1987 proposed regulations objected to the inclusion in this definition of individuals other than common law employees, the statutory definition was amended by OBRA 1989 to include such individuals. Under the final regulations, a covered employee generally includes any individual who is or has been provided coverage under a group health plan (other than one excepted from COBRA as of the date of what would otherwise be a qualifying event) because of her or his present or past performance of services for the employer maintaining the group health plan (or by reason of membership in the employee organization maintaining the plan). Thus, retirees and former employees covered by a group health plan are covered employees if the coverage is provided in whole or in part because of the previous employment. Any individual who performs services for the employer maintaining the plan or who is a member of the employee organization maintaining the plan may be a covered employee. Thus, common law employees, self-employed individuals, independent contractors, and corporate directors can be covered employees. Generally, mere eligibility for coverage – as opposed to actual coverage – does not make an individual a covered employee. However, if an individual who otherwise would be a covered employee is denied coverage under a group health plan in violation of applicable law (including HIPAA), the individual is considered a covered employee.

Qualifying Events

The rules regarding qualifying events under the final regulations generally are the same as those in the 1987 proposed regulations. Under the final regulations, a qualifying event is any of a set of specified events that occurs while a group health plan is subject to COBRA and that causes a covered employee (or the spouse or dependent child of the covered employee) to lose coverage under the plan. These specified events are: the death of a covered employee; the termination (other than by reason of gross misconduct), or reduction of hours, of a covered employee's employment; the divorce or legal separation of a covered employee from the covered employee's spouse; a covered employee's becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; a dependent child's ceasing to be a dependent child of the covered employee under the plan; and a proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time. The addition of employer bankruptcy as a qualifying event reflects the amendments made to COBRA by OBRA 1986.

The reasons for which an employee has a termination of employment or a reduction of hours of employment generally are not relevant in determining whether the termination or reduction of hours is a qualifying event. Thus, a voluntary termination, a strike, a lockout, a layoff, or an involuntary discharge each may constitute a qualifying event. However, if an employee is discharged for gross misconduct, the termination of employment does not constitute a qualifying event. The final regulations clarify that a reduction of hours of a covered employee's employment includes any decrease in the number of hours that a covered employee works or is required to work that does not constitute a termination of employment. Thus, if a covered employee takes a leave of absence, is laid off, or otherwise performs no hours of work during a period, the covered employee has experienced a reduction in hours that, if the other applicable requirements are satisfied, constitutes a qualifying event. (But see Notice 94-103 (1994-2 C.B. 569) and the new pro-

posed regulations, described below, for special rules regarding FMLA leave.) A covered employee's loss of coverage by reason of a failure to work the minimum number of hours required for coverage constitutes a reduction of hours of employment.

Under the final regulations, *to lose coverage* means to cease to be covered under the same terms and conditions as in effect immediately before the event. The final regulations clarify that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above. The loss of coverage need not be concurrent with the event; it is enough that the loss of coverage occur at any time before the end of the maximum coverage period (described below). For employer bankruptcies, the term *to lose coverage* also includes a substantial elimination of coverage that occurs within 12 months before or after the date on which the bankruptcy proceeding begins.

Under the final regulations, as under the 1987 proposed regulations, reductions or eliminations in coverage in anticipation of an event are disregarded in determining whether the event results in a loss of coverage. Although several commenters objected to this rule, the final regulations retain the provision in order to protect qualified beneficiaries from being deprived of their COBRA rights because an employer or employee organization transposes a loss or reduction of coverage to a time before the qualifying event. This rule also applies in cases where a covered employee discontinues the coverage of a spouse in anticipation of a divorce or legal separation. In such a case, upon receiving notice of the divorce or legal separation, a plan is required to make COBRA continuation coverage available, effective on the date of the divorce or legal separation (but not for any period before the date of the divorce or legal separation).

Under the final regulations, as under the 1987 proposed regulations, an event must occur while the group health plan is subject to COBRA in order to constitute a qualifying event. A plan that is excepted from COBRA (for example, by reason of the small-employer plan exception) and that later becomes subject to COBRA is not required to provide COBRA continua-

tion coverage to individuals who experienced what would otherwise be a qualifying event during the period when the plan was not subject to COBRA.

Finally, in the case of a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the qualifying event that gives rise to that period of COBRA continuation coverage is the qualifying event applicable to that child. Thus, if a second qualifying event has occurred before such a child is born (for example, if the covered employee dies), the second qualifying event also applies to the newborn child.

COBRA Continuation Coverage

The 1987 proposed regulations generally refer to the coverage that a qualified beneficiary is entitled to as the coverage that was in effect on the day before the qualifying event. While that is generally true, the final regulations have been revised to incorporate the statutory standard that a qualified beneficiary is entitled to the coverage made available to similarly situated beneficiaries with respect to whom a qualifying event has not occurred. The final regulations generally use as a shorthand for this statutory language the phrase "similarly situated non-COBRA beneficiaries" instead of the phrase "similarly situated active employees" used in the 1987 proposed regulations. In certain contexts in the final regulations, though, the phrase "similarly situated active employees" is still used because in those contexts – such as the right to make an independent election for COBRA continuation coverage – qualified beneficiaries who are spouses and dependent children of covered employees are entitled to the rights that employees have (and in those contexts, spouses and dependent children who are not qualified beneficiaries typically do not have the rights that employees have).

The 1987 proposed regulations address in a separate question-and-answer the type of coverage that must be made available to qualified beneficiaries if a change is made in the coverage provided to similarly situated non-COBRA beneficiaries. The final regulations include this rule in the question-and-answer that defines COBRA continuation coverage. In doing

so, the final regulations delete several specific requirements in the 1987 proposed regulations. For example, if coverage for the similarly situated non-COBRA beneficiaries is changed or eliminated, the 1987 proposed regulations require that qualified beneficiaries be permitted to elect coverage under any remaining plan made available to the similarly situated active employees. Many commenters objected that in the case of a mere change in benefits, the requirement to give qualified beneficiaries an election among other plans would give them greater rights than those active employees might have. The final regulations follow the suggestion of the commenters in providing that the general principle – that qualified beneficiaries have the same rights as similarly situated non-COBRA beneficiaries – applies in this situation. The same principle also applies in determining whether credit for deductibles must be carried over from a discontinued plan to a new plan. Nevertheless, if an employer or employee organization providing more than one plan to a group of similarly situated non-COBRA beneficiaries eliminates benefits under one plan without giving the similarly situated non-COBRA beneficiaries the right to enroll in another plan, that option would still have to be made available to qualified beneficiaries if the employer continued to maintain a group health plan because of the employer's obligation to continue to make COBRA continuation coverage available.

The 1987 proposed regulations include detailed rules requiring that qualified beneficiaries generally be offered the option of electing only core coverage or both core and noncore coverage. These rules were based on a reference in the conference report to the Tax Reform Act of 1986. Many commenters expressed the opinion that the reference in the conference report is an insufficient basis for including this concept in the regulations when nothing in the statute itself suggests a distinction between core and noncore coverage. Commenters also contended that the core/noncore distinction would create undue administrative complexity and promote adverse selection. After careful consideration, the IRS and Treasury have decided not to include in either the final or the new proposed regulations any such requirement to offer for core

coverage separately. However, comments are invited on whether such a requirement should be adopted.

The 1987 proposed regulations establish standards for determining the deductibles and limits that apply to COBRA continuation coverage in a period in which an individual or a group of family members has coverage that is not COBRA continuation coverage and then elects COBRA continuation coverage. (Of course, during a period in which an individual or group of family members had only COBRA continuation coverage, the rules for deductibles and limits would apply to them in the same manner as they would to similarly situated nonCOBRA beneficiaries.) Some commenters objected to the provisions of the 1987 proposed regulations for computing deductibles or limits on a family basis in the case of a qualifying event (such as divorce) that splits a family into two (or more) units. The 1987 proposed regulations would require that each resulting family unit be credited with all the expenses incurred by the entire family before the qualifying event. The final regulations revise this rule. Under the final regulations, in computing deductibles and limits for the family unit receiving COBRA coverage, the plan is required to take into account only those expenses incurred before the qualifying event by family members who are part of the resulting family unit after the qualifying event.

The 1987 proposed regulations provide that qualified beneficiaries moving outside the area served by a region-specific plan must be given the right to obtain other coverage from the employer maintaining the region-specific plan. The rule conditions the right to other coverage on the employer having employees in the area to which the qualified beneficiary is moving. This proposed rule unduly limits the application of the rule in the case of an employer or employee organization that could provide other coverage to the qualified beneficiary without having to establish a new plan or enter into a new group insurance contract even though the employer did not have employees or the employee organization did not have members in the area that the qualified beneficiary was moving to. This might be the case, for example, if the employer or

employee organization maintained a self-insured plan or maintained an insured plan through an insurance company licensed to provide that same product in the area that the qualified beneficiary was moving to. The final regulations eliminate the condition that an employer have employees in the area to which the qualified beneficiary is moving and instead require that coverage be made available to the qualified beneficiary if the employer or employee organization would be able to provide coverage to the qualified beneficiary under one of its existing plans. Generally the coverage that must be made available is that made available to the similarly situated nonCOBRA beneficiaries. If, however, the coverage made available to the similarly situated nonCOBRA beneficiaries cannot be made available in the area that the qualified beneficiary is moving to, then the coverage that must be made available is coverage provided to other employees.

The 1987 proposed regulations require, in the case of a plan providing open enrollment rights, that open enrollment rights be extended to qualified beneficiaries if an employer maintains two or more plans. Thus, that rule, by its terms, does not require that open enrollment rights be given if an employer maintains a single plan and allows active employees during open enrollment to switch between categories of coverage such as single and family or among categories such as employee-only, employee-plus-one-dependent, or employee-plus-two-or-more-dependents. The final regulations eliminate the condition that an employer or employee organization maintain two or more plans for a qualified beneficiary to have open enrollment rights. Thus, open enrollment rights must be extended to qualified beneficiaries in any case in which they are extended to similarly situated active employees. (Note that the open enrollment right of employees to enroll when not previously enrolled would not have to be extended to individuals who previously did not elect to receive COBRA continuation coverage because an individual ceases to be a qualified beneficiary if COBRA continuation coverage is not elected.)

The 1987 proposed regulations require that qualified beneficiaries be given the same right to add new family members

that similarly situated active employees have. Many commenters objected to this rule, arguing that it requires more than a mere continuation of coverage. However, COBRA continuation coverage is more than just a continuation of the coverage a qualified beneficiary had before the qualifying event; it includes the same procedural rights to expand or change coverage that similarly situated active employees have. Moreover, the policy behind the 1987 proposed regulations is reflected in the HIPAA amendment to COBRA creating special qualified beneficiary status for certain newborn and adopted children as well as in the HIPAA special enrollment rights in section 9801(f) for new spouses and for newborn and adopted children. Accordingly, the final regulations provide guidance on the application of the HIPAA special enrollment rights to qualified beneficiaries and retain the rule in the 1987 proposed regulations regarding the right of qualified beneficiaries to add new family members (even though not eligible for the HIPAA special enrollment rights) to the same extent that active employees are permitted to add new family members.

Electing COBRA Continuation Coverage

The final regulations set forth rules regarding elections of COBRA continuation coverage by qualified beneficiaries. In general, a group health plan is required to offer a qualified beneficiary the opportunity to elect COBRA continuation coverage at any time during the election period. The election period begins not later than the date the qualified beneficiary would lose coverage by reason of a qualifying event and ends not earlier than 60 days after the later of that date or 60 days after the date on which the qualified beneficiary is provided notice of her or his right to elect COBRA continuation coverage. For purposes of determining whether a qualified beneficiary's election of COBRA continuation coverage is timely, the election is deemed to be made on the date it is sent to the employer or plan administrator. The final regulations clarify that a qualified beneficiary need not herself or himself elect COBRA continuation coverage; that election can be made on behalf of the qualified beneficiary by a third party (including a third party that is not a qualified beneficiary).

Generally, the employer or plan administrator must determine when a qualifying event has occurred, and a qualified beneficiary is not required to give notice of the event. However, a covered employee or qualified beneficiary is required to notify the plan administrator of a qualifying event that is a divorce or legal separation of the covered employee or a dependent child's ceasing to be a dependent child under the plan terms. The 1987 proposed regulations prescribe that the notification should be given to the employer or other plan administrator. The final regulations simply require that the notice be provided to the plan administrator.

The notice must be provided within 60 days after the date of the qualifying event or the date on which the qualified beneficiary would lose coverage because of the qualifying event, whichever is later. If the notice is not provided, the group health plan is not required to make COBRA continuation coverage available to the qualified beneficiary⁵. In the case of the covered employee's divorce or legal separation, a single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries (that is, the spouse or a dependent child) satisfies the notice requirement for all those who become qualified beneficiaries as a result of the divorce or legal separation.

The group health plan must make COBRA continuation coverage available for the entire election period if the qualified beneficiary elects coverage prior to the end of the period (except in the case of a revoked waiver, as discussed below). An employer or employee organization maintaining a group health plan using an indemnity or reimbursement arrangement can satisfy this requirement by continuing the qualified beneficiary's coverage during the election period or by discontinuing the coverage until the qualified bene-

ficiary elects COBRA and then retroactively reinstating the qualified beneficiary's coverage. Under the final regulations, as under the 1987 proposed regulations, the date of the qualifying event (and thus, the beginning of the maximum coverage period) is not delayed merely because a plan provides coverage during the election period. Claims incurred by the qualified beneficiary during the election period do not have to be paid until COBRA continuation coverage is elected and any payment required for coverage is made.

For a group health plan providing health services – including a health maintenance organization or a walk-in clinic – a qualified beneficiary who has not elected and paid for COBRA continuation coverage can be required to choose either to elect and to pay for coverage or to pay a reasonable and customary charge for plan services (but only if the qualified beneficiary will be reimbursed for that charge within 30 days after she or he elects COBRA continuation coverage and makes any payment for coverage). Alternatively, the plan can treat the qualified beneficiary's use of the plan's health services as a constructive election of COBRA continuation coverage and, if it so notifies the qualified beneficiary prior to the use of services, can require payment for COBRA continuation coverage.

The final regulations adopt the position in *Communications Workers of America v. NYNEX Corp.*, 898 F.2d 887 (2d Cir. 1989), regarding the responses that a group health plan must make with respect to the rights of a qualified beneficiary during that qualified beneficiary's election period. Specifically, the final regulations require that the plan make a complete response to any inquiry from a health care provider regarding the qualified beneficiary's right to coverage under the plan during the election period. Thus, if the qualified beneficiary has not yet elected COBRA continuation coverage but remains covered under the plan during the election period (subject to retroactive cancellation if no election is made), the plan must so inform the health care provider. Conversely, if the qualified beneficiary is not covered during the election period prior to her or his election, the plan must inform the health care provider that the qualified beneficiary does not

have current coverage but will have retroactive coverage if COBRA continuation coverage is elected. (The final regulations also include similar requirements with respect to inquiries made by health care providers during the 30- and 45-day grace periods for paying for COBRA continuation coverage.)

A qualified beneficiary who waives COBRA continuation coverage during the election period can revoke the waiver before the end of the election period, but the group health plan is not then required to provide coverage as of any date prior to the revocation. Although several commenters objected to the rule in the 1987 proposed regulations allowing the revocation during the election period of any previous waiver, the final regulations retain this rule. If the rule permitted irrevocable waivers, plans might induce qualified beneficiaries to execute waivers hastily before becoming fully informed of their rights and having the opportunity to carefully consider whether to elect COBRA. As with the election of COBRA continuation coverage, a waiver or a revocation of a waiver is deemed to be made on the date sent. The employer or employee organization maintaining the group health plan is not permitted to withhold money, benefits, or anything else to which the qualified beneficiary is entitled under any law or agreement in order to induce a qualified beneficiary to make payment for COBRA continuation coverage or to surrender any rights under COBRA. Any waiver of COBRA continuation coverage rights obtained through such means will be invalid. However, the general rules for coverage during the election period apply in the case of waivers and revocations of waivers. Thus, in the case of an indemnity arrangement, the plan can deny coverage for claims until payment for the coverage has been made (as can also be done with those health maintenance organizations or walk-in clinics that adopt this method for complying with the COBRA continuation coverage requirements during the election period).

A group health plan must offer each qualified beneficiary the opportunity to make an independent election to receive COBRA continuation coverage and, during an open enrollment period, to choose among any options available to similarly situated active employees. This require-

⁵ The U.S. Department of Labor has advised the IRS and Treasury that, if a covered employee or qualified beneficiary has not been adequately informed of the obligation to provide notice in the case of a qualifying event that is the divorce or legal separation of the covered employee or that is a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the covered employee's or qualified beneficiary's failure to provide timely notice to the plan administrator will not affect the plan's obligation to make continuation coverage available upon receiving notice of such event.

ment also applies to any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. (An election for a minor child may be made by the child's parent or legal guardian.) If a covered employee or the spouse of a covered employee elects COBRA continuation coverage and the election does not specify whether the election is for self-only coverage, the election is deemed to include an election of COBRA continuation coverage on behalf of other qualified beneficiaries with respect to that qualifying event.

Duration of COBRA Continuation Coverage

The 1987 proposed regulations incorporate the statutory bases for terminating COBRA continuation coverage except the rule (added by OBRA 1989 and amended by HIPAA) that COBRA coverage can be terminated in the month that is more than 30 days after a final determination that a qualified beneficiary is no longer disabled. The new proposed regulations add this statutory basis for terminating COBRA coverage, with two clarifications. First, the new proposed regulations clarify that a determination that a qualified beneficiary is no longer disabled allows termination of COBRA continuation coverage for all qualified beneficiaries who were entitled to the disability extension by reason of the disability of the qualified beneficiary who has been determined to no longer be disabled. Second, the new proposed regulations clarify that such a determination does not allow termination of the COBRA continuation coverage of a qualified beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension.

Section 4980B(f)(2)(B)(iv) provides that a qualified beneficiary's right to COBRA continuation coverage may be terminated when the qualified beneficiary "first becomes," after the date of the COBRA election, covered under another group health plan (subject to certain additional conditions) or entitled to Medicare benefits. The final regulations add two new questions-and-answers that provide guidance on this provision.

The 1987 proposed regulations substitute "is" for the statutory phrase "first becomes." The effect of this substitution was to permit an employer to cut off a qualified beneficiary's right to COBRA continuation coverage based upon other group health plan coverage that the qualified beneficiary first became covered under before she or he elected COBRA coverage. In the case of entitlement to Medicare benefits, the 1987 proposed regulations not only shift the statutory "becomes" to "is," they also exclude from the definition of qualified beneficiary anyone who is entitled to Medicare benefits on the day before the qualifying event. After careful consideration, the IRS and Treasury concluded that the better interpretation of the statute is that other group health plan coverage that a qualified beneficiary has before the COBRA election is not a basis for cutting off the qualified beneficiary's right to COBRA continuation coverage. (The same rule applies for entitlement to Medicare benefits.)

Based upon the recommendation of the IRS, the Solicitor General filed an amicus brief before the Supreme Court urging this position, which was unanimously adopted by the Supreme Court in *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998). The final regulations adopt the position urged by the IRS and Treasury and adopted by the Court in *Geissal*. They provide that an employer may cut off the right to COBRA continuation coverage based upon other group health plan coverage or entitlement to Medicare benefits only if the qualified beneficiary first becomes covered under the other group health plan coverage or entitled to the Medicare benefits after the date of the COBRA election.

The statutory rule allowing a plan to discontinue COBRA continuation coverage on account of coverage under another group health plan was amended by OBRA 1989 to prohibit the discontinuance if the qualified beneficiary's other coverage was subject to a preexisting condition exclusion. This amendment was further modified by HIPAA to allow discontinuance of COBRA continuation coverage if the preexisting condition exclusion does not apply or is satisfied by reason of the limitations on preexisting condition ex-

clusions in section 9801. The final regulations reflect this amendment and clarify that coverage under another group health plan includes coverage under a governmental plan.

Many commenters asked whether mere eligibility for Medicare justifies a discontinuance of COBRA continuation coverage. In addition, many inquiries have been received that ask whether the qualified beneficiary must be entitled to both Part A and B of Medicare. The final regulations clarify that entitlement to Medicare benefits means being enrolled in Medicare and does not mean merely being eligible to enroll in Medicare. The final regulations also clarify that being entitled to either Part A or B is sufficient for the plan to discontinue COBRA continuation coverage (assuming that the entitlement to Medicare benefits first arises after COBRA continuation coverage has been elected).

The 1987 proposed regulations allow a plan to discontinue providing COBRA continuation coverage to a qualified beneficiary for cause on the same basis that the plan could terminate for cause the coverage of a similarly situated active employee (except for payments that would be untimely if made by a nonCOBRA beneficiary but that are made within the grace periods provided by COBRA). The final regulations provide that, for example, if a plan terminates the coverage of similarly situated active employees for the submission of a fraudulent claim, then the COBRA continuation coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim.

The 1987 proposed regulations reflect the statutory rules that were then in effect for the maximum period that a plan is required to make COBRA continuation coverage available. Since then the statute has been amended to add the disability extension, to permit plans to extend the notice period if the maximum coverage period is also extended (referred to as the optional extension of the required periods), and to add a special rule in the case of Medicare entitlement preceding a qualifying event that is the termination or reduction of hours of employment. The new proposed regulations reflect these statutory changes. The maximum coverage period

for a qualifying event that is the bankruptcy of the employer has also been added to the new proposed regulations.

The 1998 proposed regulations set forth the requirements for a disability extension to apply to a qualified beneficiary. Those requirements have been incorporated into the final regulations, with one clarification. One of the conditions for a disability extension to apply is that the qualified beneficiary be disabled during the first 60 days of COBRA continuation coverage. In the case of a qualified beneficiary who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the final regulations clarify that the 60-day period is measured from the date of the child's birth or placement for adoption.

The 1987 proposed regulations set forth standards for expanding the maximum coverage period in the case of multiple qualifying events. Since 1987, the statutory rules for multiple qualifying events have been affected by the addition of the disability extension and the optional extension of required periods. The final regulations reflect the statutory changes.

In addition, the final regulations clarify that a termination of employment following a qualifying event that is a reduction of hours of employment does not expand the maximum coverage period. *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). The underlying pattern in the statute is generally to require 18 months (or 29 months, in the case of a disability extension) of coverage for qualifying events that are the termination or reduction of hours of a covered employee's employment and 36 months for other qualifying events. The statutory provision for expansion of the 18-month period to 36 months upon the occurrence of a second qualifying event generally follows this pattern by allowing a qualified beneficiary who would have been entitled to 36 months of coverage if the second qualifying event had occurred first to get a total of 36 months of COBRA continuation coverage. The statute lists six categories of qualifying events, and termination of employment and reduction of hours of employment are in the same category

(just as divorce and legal separation are in the same category of qualifying event). Treating a reduction of hours of employment and a termination of employment as variations of a single qualifying event rather than as two distinct qualifying events is consistent with the overall design of the statute.

The 1987 proposed regulations address situations in which, following a qualifying event, an employer provides alternative coverage, rather than COBRA continuation coverage, to a former employee and her or his spouse and dependent children. The 1987 proposed regulations provide that if the alternative coverage does not satisfy the requirements for COBRA continuation coverage, each qualified beneficiary must be given the opportunity to elect COBRA continuation coverage instead of the alternative coverage. If, however, the alternative coverage would satisfy the requirements for COBRA continuation coverage, the 1987 proposed regulations provide that, at the time of the original qualifying event, the employee, spouse, and dependent children need not be provided with the opportunity to elect COBRA continuation coverage. The final regulations generally retain these rules but also clarify that if the employer increases the employee share of premiums upon the occurrence of a qualifying event, the qualified beneficiaries must be offered the opportunity to elect COBRA continuation coverage.

The 1987 proposed regulations further provide that, if the alternative coverage does not satisfy the requirements for COBRA continuation coverage and if, after the original qualifying event, a qualifying event occurs that would cause a spouse or dependent child to lose the alternative coverage, the spouse or child must be offered COBRA continuation coverage. However, if the alternative coverage satisfies the requirements for COBRA continuation coverage, and if another qualifying event that causes the spouse or dependent child to lose the alternative coverage occurs more than 18 months after the original qualifying event, the 1987 proposed regulations provide that the spouse or dependent child need not be offered COBRA continuation coverage. The final regulations modify the 1987 proposed regulations and provide that if an event such as the death of or di-

vorce from the covered employee would end the right of a spouse or dependent child to receive the alternative coverage (whether during or after the first 18 months of COBRA continuation coverage), then that event is a qualifying event, regardless of whether the alternative coverage would satisfy the requirements for COBRA continuation coverage.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives certain members of the military reserves the right to up to 18 months of continuation coverage when they are called to active duty. Many people have asked if the USERRA and COBRA periods of continuation coverage run concurrently or consecutively. The final regulations clarify that USERRA coverage is alternative coverage. Thus, the periods run concurrently.

The 1987 proposed regulations include the statutory rule requiring that a conversion option otherwise made available under the plan be made available within 180 days before the end of the maximum coverage period. The final regulations adopt this rule without change.

Paying for COBRA Continuation Coverage

The 1987 proposed regulations identify the qualified beneficiary as the person that can be required to pay the applicable premium. Many plans and employers have asked whether they must accept payment on behalf of a qualified beneficiary from third parties, such as a hospital or a new employer. Nothing in the statute requires the qualified beneficiary to pay the amount required by the plan; the statute merely permits the plan to require that payment be made. In order to make clear that any person may make the required payment on behalf of a qualified beneficiary, the final regulations modify the rule in the 1987 proposed regulations to refer to the payment requirement without identifying the person who makes the payment.

The 1998 proposed regulations address the amount that a plan can require to be paid for COBRA continuation coverage during the disability extension. This amount is 150 percent of the applicable premium instead of the limit of 102 percent of the applicable premium that applies for coverage outside the disability

extension. The 1998 proposed regulations specifically reserve the issue of the amount a plan could require to be paid in a case where only nondisabled family members of the disabled individual receive COBRA continuation coverage during the disability extension. The preamble to the 1998 proposed regulations solicited comments on this issue. Commenters suggested that the 150 percent rate could be required if the disabled individual was part of the coverage group but that the limit could be the 102 percent rate if only nondisabled qualified beneficiaries were in the coverage group. The final regulations adopt this suggestion.

The 1987 proposed regulations provide that the amount required to be paid for a qualified beneficiary's COBRA continuation coverage must be fixed in advance for each 12-month determination period. Many commenters suggested exceptions that could be made to this general rule. Section 4980B(f)(4)(C) explicitly requires that the determination of the applicable premium be made for a period of 12 months and that the determination be made before the beginning. Therefore, the final regulations do not permit an increase in the applicable premium during the 12-month determination period. However, the final regulations do revise the general rule from the 1987 proposed regulations to recognize the difference between the applicable premium (which may not be increased during a 12-month determination period and which is the basis for calculating the maximum amount that the plan can require to be paid for COBRA continuation coverage) and the maximum amount that the plan can require to be paid for COBRA continuation coverage. Thus, the final regulations permit a plan to increase the amount it requires to be paid for COBRA continuation coverage during a determination period to take into account the permitted increases during the disability extension, to explicitly permit a plan that is requiring payment of less than the maximum permissible amount to increase the amount required to be paid during the 12-month determination period, and to permit an increase if a qualified beneficiary changes to more expensive coverage (but also to require a reduction if the qualified beneficiary changes to less expensive coverage).

The 1987 proposed regulations set forth the statutory requirement that qualified beneficiaries be allowed to pay for COBRA coverage in monthly installments. The 1987 proposed regulations add that plans may allow payment to be made at other intervals, and specifically mention quarterly or semiannual payment as examples. The final regulations adopt the rule in the 1987 proposed regulations, but the final regulations add weekly payment as an example to make clear that shorter than monthly installments are also permitted.

The 1987 proposed regulations provide that the first payment for COBRA continuation coverage does not apply prospectively only. In order to make clear that a plan is not precluded from allowing a qualified beneficiary to apply the first payment prospectively only, the final regulations provide that qualified beneficiaries need not be given the option of having the first payment for COBRA continuation coverage apply prospectively only.

The 1987 proposed regulations address the issue of timely payment for COBRA continuation coverage, including an interpretation of the statutory grace periods of 45 days for the initial payment and 30 days for all other payments. Commenters pointed out that the application of the statutory grace period rules could produce an anomalous result in some situations, such as allowing a plan to require payment for the third month of COBRA continuation coverage earlier than the plan could require payment for the first two months. OBRA 1989 amended the 45-day grace period rule to prevent this, and the final regulations conform to the OBRA 1989 change. The final regulations also clarify that payment is considered made on the date it is sent.

The final regulations also add a requirement (similar to the one described above for the election period) relating to the response that a plan must give when a health care provider, such as a physician, a hospital, or a pharmacy, contacts the plan to confirm coverage of a qualified beneficiary with respect to whom the required payment has not been made for the current period (but for whom any applicable grace period has not expired). In such a case, the plan is required to inform the health care provider of all of the details of

the qualified beneficiary's right to coverage during the applicable grace periods.

Many individuals have inquired about a plan's right to discontinue their COBRA continuation coverage because the amount of the payment made was short by an amount that is not significant. Sometimes the error has been clearly one of transposed digits on a check tendered for payment; in other instances, payment has been short by such a small amount that it would be unreasonable to attribute the shortfall to anything other than mistake. The final regulations establish a mechanism for the treatment of payments that are short by an insignificant amount. Either the plan must treat the payment as satisfying the plan's payment requirement or it must notify the qualified beneficiary of the amount of the deficiency and grant the qualified beneficiary a reasonable period of time for the deficiency to be paid. The final regulations provide that, as a safe harbor, a period of 30 days is deemed to be a reasonable period for this purpose.

Business Reorganizations

The 1987 proposed regulations provide little direct guidance on the allocation of responsibility for COBRA continuation coverage in the event of corporate transactions, such as a sale of stock of a subsidiary or a sale of substantial assets. Commenters on the 1987 proposed regulations requested further guidance on corporate transactions, pointing out that the existing degree of uncertainty tends to drive up the costs and risks of a transaction to both buyers and sellers. The IRS and Treasury share this view and believe also that greater certainty helps to protect the rights of qualified beneficiaries in these transactions. The IRS has been contacted by many qualified beneficiaries whose COBRA continuation coverage has been dropped or denied in the context of a corporate transaction. In many cases, these qualified beneficiaries have been told by each of the buyer and the seller that the other party is the one responsible for providing them with COBRA continuation coverage.

The preamble to the 1998 proposed regulations requested comments on a possible approach to allocating responsibility for COBRA continuation coverage in corporate transactions. Commenters sug-

gested that, in a stock sale, as in an asset sale, it would be consistent with standard commercial practice to provide that the seller retains liability for all existing qualified beneficiaries, including those formerly associated with the subsidiary being sold. The IRS and Treasury have studied the comments and given consideration to several alternatives with a view to establishing rules that will minimize the administrative burden and transaction costs for the parties to transactions while protecting the rights of qualified beneficiaries and maintaining consistency with the statute.

Accordingly, the new proposed regulations make clear that the parties to a transaction are free to allocate the responsibility for providing COBRA continuation coverage by contract, even if the contract imposes responsibility on a different party than would the new proposed regulations. So long as the party to whom the contract allocates responsibility performs its obligations, the other party will have no responsibility for providing COBRA continuation coverage. If, however, the party allocated responsibility under the contract defaults on its obligation, and if, under the new proposed regulations, the other party would have the obligation to provide COBRA continuation coverage in the absence of a contractual provision, then the other party would retain that obligation. This approach would avoid prejudicing the rights of qualified beneficiaries to COBRA continuation coverage based upon the provisions of a contract to which they were not a party and under which the employer with the underlying obligation under the regulations to provide COBRA continuation coverage could otherwise contract away that obligation to a party that fails to perform. Moreover, the party with the underlying responsibility under the regulations can insist on appropriate security and, of course, could pursue contractual remedies against the defaulting party.

The new proposed regulations provide, for both sales of stock and sales of substantial assets, such as a division or plant or substantially all the assets of a trade or business, that the seller retains the obligation to make COBRA continuation coverage available to existing qualified beneficiaries. In addition, in situations in which the seller ceases to provide any group

health plan to any employee in connection with the sale – whether such a cessation is in connection with the sale is determined on the basis of the facts and circumstances of each case – and thus is not responsible for providing COBRA continuation coverage, the new proposed regulations provide that the buyer is responsible for providing COBRA continuation coverage to existing qualified beneficiaries. This secondary liability for the buyer applies in all stock sales and in all sales of substantial assets in which the buyer continues the business operations associated with the assets without interruption or substantial change.

A particular type of asset sale raises issues for which the new proposed regulations do not provide any special rules. (Thus, the general rules in the new proposed regulations for business reorganizations would apply to this type of transaction.) This type of asset sale is one in which, after purchasing a business as a going concern, the buyer continues to employ the employees of that business and continues to provide those employees exactly the same health coverage that they had before the sale (either by providing coverage through the same insurance contract or by establishing a plan that mirrors the one that provided benefits before the sale). The application of the rules in the new proposed regulations to this type of asset sale would require the seller to make COBRA continuation coverage available to the employees continuing in employment with the buyer (and to other family members who are qualified beneficiaries). Ordinarily, the continuing employees (or their family members) would be very unlikely to elect COBRA continuation coverage from the seller when they can receive the same coverage (usually at much lower cost) as active employees of the buyer.

Consideration is being given to whether, under appropriate circumstances, such an asset sale would be considered not to result in a loss of coverage for those employees who continue in employment with the buyer after the sale. A countervailing concern, however, relates to those qualified beneficiaries who might have a reason to elect COBRA continuation coverage from the seller. An example of such a qualified beneficiary would be an employee who continues in employ-

ment with the buyer, whose family is likely to have medical expenses that exceed the cost of COBRA coverage, and who has significant questions about the solvency of the buyer or other concerns about how long the buyer might continue to provide the same health coverage.

Under one possible approach, a loss of coverage would be considered not to have occurred so long as the purchasing employer in an asset sale continued to maintain the same group health plan coverage that the seller maintained before the sale without charging the employees any greater percentage of the total cost of coverage than the seller had charged before the sale. For this purpose, the coverage would be considered unchanged if there was no obligation to provide a summary of material modifications within 60 days after the change due to a material reduction in covered services or benefits under the rules that apply under Title I of ERISA. If these conditions were satisfied for the maximum coverage period that would otherwise apply to the seller's termination of employment of the continuing employees (generally 18 months from the date of the sale), then those terminations of employment would never be considered qualifying events. If the conditions were not satisfied for the full maximum coverage period, then on the date when they ceased to be satisfied the seller would be obligated to make COBRA continuation coverage available for the balance of the maximum coverage period.

Comments are invited on the utility of such a rule, either in situations in which the seller retains an ownership interest in the buyer after the sale (for example, a sale of assets from a 100-percent owned subsidiary to a 75-percent owned subsidiary) or, more generally, in situations in which the seller and the buyer are unrelated. Suggestions are also solicited for other rules that would protect qualified beneficiaries while providing relief to employers in these situations.

Although the new proposed regulations address how COBRA obligations are affected by a sale of stock (and a sale of substantial assets), the new proposed regulations do not address how the obligation to make COBRA continuation coverage available is affected by the transfer of an ownership interest in a noncorporate en-

tity that causes the noncorporate entity to cease to be a member of a group of trades or businesses under common control (whether or not it becomes a member of a different group of trades or business under common control). Comments are invited on this issue.

Employer Withdrawals From Multiemployer Plans

The new proposed regulations also address COBRA obligations in connection with an employer's cessation of contributions to a multiemployer group health plan. The new proposed regulations provide that the multiemployer plan generally continues to have the obligation to make COBRA continuation coverage available to qualified beneficiaries associated with that employer. (There generally would not be any obligation to make COBRA continuation coverage available to continuing employees in this situation because a cessation of contributions is not a qualifying event.) However, once the employer provides group health coverage to a significant number of employees who were formerly covered under the multiemployer plan, or starts contributing to another multiemployer plan on their behalf, the employer's plan (or the new multiemployer plan) would have the obligation to make COBRA continuation coverage available to the existing qualified beneficiaries. This rule is contrary to the holding in *In re Appletree Markets, Inc.*, 19 F.3d 969 (5th Cir. 1994), which held that the multiemployer plan continued to have the COBRA obligations with respect to existing qualified beneficiaries after the withdrawing employer established a plan for the same class of employees previously covered under the multiemployer plan.

Interaction of FMLA and COBRA

The new proposed regulations set forth rules regarding the interaction of the COBRA continuation coverage requirements with the provisions of the Family and Medical Leave Act of 1993 (FMLA). The rules under the new proposed regulations are substantially the same as those set forth in Notice 94-103. The last two questions-and-answers in that notice have not been included in the new proposed regulations because they relate to general

subject matter that is addressed elsewhere in the regulations.

Under the new proposed regulations, the taking of FMLA leave by a covered employee is not itself a qualifying event. Instead, a qualifying event occurs when an employee who is covered under a group health plan immediately prior to FMLA leave (or who becomes covered under a group health plan during FMLA leave) does not return to work with the employer at the end of FMLA leave and would, but for COBRA continuation coverage, lose coverage under the group health plan. (As under the general rules of COBRA, this would also constitute a qualifying event with respect to the spouse or any dependent child of the employee.) The qualifying event is deemed to occur on the last day of the employee's FMLA leave, and the maximum coverage period generally begins on that day. (The new proposed regulations provide a special rule for cases where coverage is not lost until a later date and the plan provides for the optional extension of the required periods.) In the case of such a qualifying event, the employer cannot condition the employee's rights to COBRA continuation coverage on the employee's reimbursement of any premiums paid by the employer to maintain the employee's group health plan coverage during the period of FMLA leave.

Any lapse of coverage under the group health plan during the period of FMLA leave and any state or local law requiring that group health plan coverage be provided for a period longer than that required by the FMLA are disregarded in determining whether the employee has a qualifying event on the last day of that leave. However, the employee's loss of coverage at the end of FMLA leave will not constitute a qualifying event if, prior to the employee's return from FMLA leave, the employer has eliminated group health plan coverage for the class of employees to which the employee would have belonged if she or he had not taken FMLA leave.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assess-

ment is not required. It is hereby certified that the collections of information in these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based upon the fact that employers with fewer than 20 employees are not subject to the requirements set forth in the final regulations and, thus, the very smallest employers are not affected by the collection of information requirements. Moreover, even for small entities with 20 or more employees who maintain group health plans and who, thus, are subject to the requirements of COBRA, the collections of information will not impose a substantial economic impact. The only collections of information imposed on small entities by the regulations are (1) to notify qualified beneficiaries of their right to elect COBRA continuation coverage upon the occurrence of a qualifying event and (2) to notify certain qualified beneficiaries that make insignificant payment errors of those errors. With respect to this first notice requirement, it is estimated that, on average, in a given year, qualifying events will occur with respect to approximately 10 percent of all covered employees. Thus, an employer with 100 employees would be required to send 10 notices to qualified beneficiaries each year. The average cost of sending such a notice is estimated to be \$.50. Thus, the total estimated cost for 10 notices is \$5.00, which is the estimated annual average burden on an employer with 100 employees. With respect to the second notice requirement, it is estimated that, on average, at any time, the number of qualified beneficiaries is approximately equal to two percent of an employer's workforce. Of that number, approximately 1 in 10 will make an insignificant error in payment each year that requires the employer to send such a notice. For example, an employer with 100 employees will have an average of two qualified beneficiaries at any time. Thus, the employer will receive an insignificant underpayment about once every five years. Even if the employer chose to send out a notice each time such an insignificant underpayment occurred, this would amount to only one notice every five years. The average cost of sending such a notice is estimated to be \$.50, resulting in an average annual burden of \$1.00 for an employer with 100

employees. Thus, the total annual cost of these two notice requirements for an employer with 100 employees is \$6.00, which is not a significant economic impact. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. Pursuant to section 7805(f) of the Internal Revenue Code, the 1998 notice of proposed rulemaking preceding these final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these regulations is Russ Weinheimer, Office of the Associate Chief Counsel (Employee Benefits and Exempt Organizations), IRS. However, other personnel from the IRS and Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding the following entries in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *

Section 54.4980B-1 also issued under 26 U.S.C. 4980B.

Section 54.4980B-2 also issued under 26 U.S.C. 4980B.

Section 54.4980B-3 also issued under 26 U.S.C. 4980B.

Section 54.4980B-4 also issued under 26 U.S.C. 4980B.

Section 54.4980B-5 also issued under 26 U.S.C. 4980B.

Section 54.4980B-6 also issued under 26 U.S.C. 4980B.

Section 54.4980B-7 also issued under 26 U.S.C. 4980B.

Section 54.4980B-8 also issued under 26 U.S.C. 4980B. * * *

Par. 2. Sections 54.4980B-0, 54.4980B-1, 54.4980B-2, 54.4980B-3, 54.4980B-4, 54.4980B-5, 54.4980B-6, 54.4980B-7, and 54.4980B-8 are added to read as follows:

§54.4980B-0 Table of contents.

This section contains first a list of the section headings and then a list of the questions in each section in §§54.4980B-1 through 54.4980B-8.

LIST OF SECTIONS

§54.4980B-1 COBRA in general.

§54.4980B-2 Plans that must comply.

§54.4980B-3 Qualified beneficiaries.

§54.4980B-4 Qualifying events.

§54.4980B-5 COBRA continuation coverage.

§54.4980B-6 Electing COBRA continuation coverage.

§54.4980B-7 Duration of COBRA continuation coverage.

§54.4980B-8 Paying for COBRA continuation coverage.

LIST OF QUESTIONS

§54.4980B-1 COBRA in general.

Q-1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

Q-2: What is the effective date of §§54.4980B-1 through 54.4980B-8?

§54.4980B-2 Plans that must comply.

Q-1: For purposes of section 4980B, what is a group health plan?

Q-2: For purposes of section 4980B, what is the employer?

Q-3: **[Reserved]**

Q-4: What group health plans are subject to COBRA?

Q-5: What is a small-employer plan?

Q-6: **[Reserved]**

Q-7: What is the plan year?

Q-8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

Q-9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

Q-10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

§54.4980B-3 Qualified beneficiaries.

Q-1: Who is a qualified beneficiary?

Q-2: Who is an employee and who is a covered employee?

Q-3: Who are the similarly situated non-COBRA beneficiaries?

§54.4980B-4 Qualifying events.

Q-1: What is a qualifying event?

Q-2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

§54.4980B-5 COBRA continuation coverage.

Q-1: What is COBRA continuation coverage?

Q-2: What deductibles apply if COBRA continuation coverage is elected?

Q-3: How do a plan's limits apply to COBRA continuation coverage?

Q-4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

Q-5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

§54.4980B-6 Electing COBRA continuation coverage.

Q-1: What is the election period and how long must it last?

Q-2: Is a covered employee or qualified beneficiary responsible for informing the plan administrator of the occurrence of a qualifying event?

Q-3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

Q-4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

Q-5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

Q-6: Can each qualified beneficiary make an independent election under COBRA?

§54.4980B-7 Duration of COBRA continuation coverage.

Q-1: How long must COBRA continuation coverage be made available to a qualified beneficiary?

Q-2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?

Q-3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

Q-4: **[Reserved]**

Q-5: How does a qualified beneficiary become entitled to a disability extension?

Q-6: Under what circumstances can the maximum coverage period be expanded?

Q-7: If health coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

Q-8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the

maximum coverage period for COBRA continuation coverage?

§54.4980B-8 Paying for COBRA continuation coverage.

Q-1: Can a group health plan require payment for COBRA continuation coverage?

Q-2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?

Q-3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?

Q-4: Is a plan required to allow a qualified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?

Q-5: What is timely payment for COBRA continuation coverage?

§54.4980B-1 COBRA in general.

The COBRA continuation coverage requirements are described in general in the following questions-and-answers:

Q-1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

A-1: (a) Section 4980B provides generally that a group health plan must offer each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the election period, continuation coverage under the plan. The continuation coverage requirements were added to section 162 by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 (100 Stat. 222), and moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988, Public Law 100-647 (102 Stat. 3342). Continuation coverage required under section 4980B is referred to in §§54.4980B-1 through 54.4980B-8 as COBRA continuation coverage.

(b) COBRA also added parallel continuation coverage requirements to Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1161-1168), which is administered by the U.S. Department of

Labor. If a plan does not comply with the COBRA continuation coverage requirements, the Internal Revenue Code imposes an excise tax on the employer maintaining the plan (or on the plan itself), whereas ERISA gives certain parties – including qualified beneficiaries who are participants or beneficiaries within the meaning of Title I of ERISA, as well as the Department of Labor – the right to file a lawsuit to redress the noncompliance. The rules in §§54.4980B-1 through 54.4980B-8 apply for purposes of section 4980B and generally also for purposes of the COBRA continuation coverage requirements in Title I of ERISA. However, certain provisions of the COBRA continuation coverage requirements (such as the definitions of group health plan, employee, and employer) are not identical in the Internal Revenue Code and Title I of ERISA. In those cases in which the statutory language is not identical, the rules in §§54.4980B-1 through 54.4980B-8 nonetheless apply to the COBRA continuation coverage requirements of Title I of ERISA, except to the extent those rules are inconsistent with the statutory language of Title I of ERISA.

(c) A group health plan that is subject to section 4980B (or the parallel provisions under ERISA) is referred to as being subject to COBRA. (See Q&A-4 of §54.4980B-2). A qualified beneficiary can be required to pay for COBRA continuation coverage. The term *qualified beneficiary* is defined in Q&A-1 of §54.4980B-3. The term *qualifying event* is defined in Q&A-1 of §54.4980B-4. COBRA continuation coverage is described in §54.4980B-5. The election procedures are described in §54.4980B-6. Duration of COBRA continuation coverage is addressed in §54.4980B-7, and payment for COBRA continuation coverage is addressed in §54.4980B-8. Unless the context indicates otherwise, any reference in §§54.4980B-1 through 54.4980B-8 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

Q-2: What is the effective date of §§54.4980B-1 through 54.4980B-8?

A-2: Sections 54.4980B-1 through 54.4980B-8 apply with respect to qualifying events occurring in plan years beginning on or after January 1, 2000. For

purposes of section 4980B, with respect to qualifying events that occur in plan years beginning before that date, and with respect to qualifying events that occur in plan years beginning on or after that date for topics relating to the COBRA continuation coverage requirements of section 4980B that are not addressed in §§54.4980B-1 through 54.4980B-8 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in section 4980B.

§54.4980B-2 Plans that must comply.

The following questions-and-answers apply in determining which plans must comply with the COBRA continuation coverage requirements:

Q-1: For purposes of section 4980B, what is a group health plan?

A-1: (a) For purposes of section 4980B, a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A-1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. For purposes of this Q&A-1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or em-

ployee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A-1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A-1, and for medical savings accounts in paragraph (f) of this Q&A-1.

(b) For purposes of §§54.4980B-1 through 54.4980B-8, *health care* has the same meaning as *medical care* under section 213(d). Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer or employee organization maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides health care and so is not a group health plan. For example, if an employer maintains a spa, swimming pool, gymnasium, or other exercise/fitness program or facility that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility does not constitute a program that provides health care and thus is not a group health plan. In contrast, if an employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem, the facility or program is considered to be the provision of health care and so is considered a group health plan.

(c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132

(relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.

(d) The provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if –

(1) The health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;

(2) The health care is available only to current employees; and

(3) Employees are not charged for the use of the facility.

(e) A plan does not constitute a group health plan subject to COBRA if substantially all of the coverage provided under the plan is for qualified long-term care services (as defined in section 7702B(c)). For this purpose, a plan is permitted to use any reasonable method in determining whether substantially all of the coverage provided under the plan is for qualified long-term care services.

(f) Under section 106(b)(5), amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan subject to COBRA. Thus, a plan is not required to make COBRA continuation coverage available with respect to amounts contributed by an employer to a medical savings account. A high deductible health plan does not fail to be a group health plan subject to COBRA merely because it covers a medical savings account holder.

Q-2: For purposes of section 4980B, what is the employer?

A-2: For purposes of section 4980B, *employer* refers to –

(a) A person for whom services are performed;

(b) Any other person that is a member of a group described in section 414(b), (c), (m), or (o) that includes a person described in paragraph (a) of this Q&A-2; and

(c) Any successor of a person described in paragraph (a) or (b) of this Q&A-2.

Q-3: [Reserved]

A-3: [Reserved]

Q-4: What group health plans are subject to COBRA?

A-4: (a) All group health plans are subject to COBRA except group health plans described in paragraph (b) of this Q&A-4. Group health plans described in paragraph (b) of this Q&A-4 are referred to in §§54.4980B–1 through 54.4980B–8 as excepted from COBRA.

(b) The following group health plans are excepted from COBRA –

(1) Small-employer plans (see Q&A-5 of this section);

(2) Church plans (within the meaning of section 414(e)); and

(3) Governmental plans (within the meaning of section 414(d)).

(c) The COBRA continuation coverage requirements generally do not apply to group health plans that are excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when the plan is not a small-employer plan (see paragraph (g) of Q&A-5 of this section).

(d) Although governmental plans are not subject to the COBRA continuation coverage requirements, group health plans maintained by state or local governments are generally subject to parallel continuation coverage requirements that were added by section 10003 of COBRA to the Public Health Service Act (42 U.S.C. 300bb–1 through 300bb–8), which is administered by the U.S. Department of Health and Human Services. Federal employees and their family members covered under the Federal Employees Health Benefit Program are covered by generally similar, but not parallel, temporary con-

tinuation of coverage provisions enacted by the Federal Employees Health Benefits Amendments Act of 1988. See 5 U.S.C. 8905a.

Q-5: What is a small-employer plan?

A-5: (a) Except in the case of a multi-employer plan, a *small-employer plan* is a group health plan maintained by an employer (within the meaning of Q&A-2 of this section) that normally employed fewer than 20 employees (within the meaning of paragraph (c) of this Q&A-5) during the preceding calendar year. 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. The rules of this paragraph (a) are illustrated in the following example:

Example. (i) Corporation *S* employs 12 employees, all of whom work and reside in the United States. *S* maintains a group health plan for its employees and their families. *S* is a wholly-owned subsidiary of *P*. In the previous calendar year, the controlled group of corporations including *P* and *S* employed more than 19 employees, although the only employees in the United States of the controlled group that includes *P* and *S* are the 12 employees of *S*.

(ii) Under §1.414(b)–1 of this chapter, foreign corporations are not excluded from membership in a controlled group of corporations. Consequently, the group health plan maintained by *S* is not a small-employer plan during the current calendar year because the controlled group including *S* normally employed at least 20 employees in the preceding calendar year.

(b) An employer is considered to have normally employed fewer than 20 employees during a particular calendar year if, and only if, it had fewer than 20 employees on at least 50 percent of its typical business days during that year.

(c) All full-time and part-time common law employees of an employer are taken into account in determining whether an employer had fewer than 20 employees; however, an individual who is not a common law employee of the employer is not taken into account. Thus, the following individuals are not counted as employees for purposes of this Q&A-5 even though they are referred to as employees for all other purposes of §§54.4980B–1 through 54.4980B–8 –

(1) Self-employed individuals (within the meaning of section 401(c)(1));

(2) Independent contractors (and their employees and independent contractors); and

(3) Directors (in the case of a corporation).

(d) [Reserved]

(e) [Reserved]

(f) [Reserved]

(g) A small-employer plan is generally excepted from COBRA. If, however, a plan that has been subject to COBRA (that is, was not a small-employer plan) becomes a small-employer plan, the plan remains subject to COBRA for qualifying events that occurred during the period when the plan was subject to COBRA. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. An employer maintains a group health plan. The employer employed 20 employees on more than 50 percent of its working days during 2001, and consequently the plan is not excepted from COBRA during 2002. Employee *E* resigns and does not work for the employer after January 31, 2002. Under the terms of the plan, *E* is no longer eligible for coverage upon the effective date of the resignation, that is, February 1, 2002. The employer does not hire a replacement for *E*. *E* timely elects and pays for COBRA continuation coverage. The employer employs 19 employees for the remainder of 2002, and consequently the plan is not subject to COBRA in 2003. The plan must nevertheless continue to make COBRA continuation coverage available to *E* during 2003 until the obligation to make COBRA continuation coverage available ceases under the rules of §54.4980B–7. The obligation could continue until August 1, 2003, the date that is 18 months after the date of *E*'s qualifying event, or longer if *E* is eligible for a disability extension.

Example 2. The facts are the same as in *Example 1*. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005. Spouse *S* is covered under the plan because *S* is married to one of the employer's employees. On April 1, 2002, *S* is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because *X* normally employed 20 employees during 2001. *S* timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to *S* during those years until the obligation to make COBRA continuation coverage available ceases under the rules of §54.4980B–7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of *S*'s qualifying event.

Example 3. The facts are the same as in *Example 2*. *C* is a dependent child of one of the employer's employees and is covered under the plan. A dependent child is no longer eligible for coverage under

the plan upon the attainment of age 23. *C* attains age 23 on November 16, 2005. The plan is excepted from COBRA with respect to *C* during 2005 because the employer normally employed fewer than 20 employees during 2004. Consequently, the plan is not obligated to make COBRA continuation coverage available to *C* (and would not be obligated to make COBRA continuation coverage available to *C* even if the plan later became subject to COBRA again).

Q-6: [Reserved]

A-6: [Reserved]

Q-7: What is the plan year?

A-7: (a) The *plan year* is the year that is designated as the plan year in the plan documents.

(b) If the plan documents do not designate a plan year (or if there are no plan documents), then the plan year is determined in accordance with this paragraph (b).

(1) The plan year is the deductible/limit year used under the plan.

(2) If the plan does not impose deductibles or limits on an annual basis, then the plan year is the policy year.

(3) If the plan does not impose deductibles or limits on an annual basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year.

(4) In any other case, the plan year is the calendar year.

Q-8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

A-8: The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. The rules of this Q&A-8 are illustrated by the following example:

Example: (i) Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a health maintenance organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indem-

nity arrangement are the arrangements providing health care. The instruments governing the HMO and indemnity arrangements indicate that they are separate group health plans. These group health plans are subject to COBRA. The employer does not provide any group health plan outside of the cafeteria plan. *B* and *C* are unmarried employees. *B* has chosen the life insurance coverage, and *C* has chosen the indemnity arrangement.

(ii) *B* does not have to be offered COBRA continuation coverage upon terminating employment, nor is a subsequent open enrollment period for active employees required to be made available to *B*. However, if *C* terminates employment and the termination constitutes a qualifying event, *C* must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If *C* makes such an election and an open enrollment period for active employees occurs while *C* is still receiving the COBRA continuation coverage, *C* must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute coverage provided under a group health plan).

Q-9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

A-9: Under section 4980B(a), if a group health plan subject to COBRA fails to comply with section 4980B(f), an excise tax is imposed. Moreover, non-tax remedies may be available if the plan fails to comply with the parallel requirements in ERISA, which are administered by the Department of Labor.

Q-10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

A-10: (a) In general, the excise tax is imposed on the employer maintaining the plan, except that in the case of a multiemployer plan the excise tax is imposed on the plan.

(b) In certain circumstances, the excise tax is also imposed on a person involved with the provision of benefits under the plan (other than in the capacity of an employee), such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan. In general, such a person will be liable for the excise tax if the person assumes, under a legally enforceable written agreement, the responsibility for performing the act to which the failure to comply with the COBRA continuation coverage requirements relates. Such a person will be liable for the excise tax notwithstanding the absence of a written agreement assuming responsibility for complying with COBRA if the person

provides coverage under the plan to a similarly situated nonCOBRA beneficiary (see Q&A-3 of §54.4980B-3 for a definition of similarly situated nonCOBRA beneficiaries) and the employer or plan administrator submits a written request to the person to provide to a qualified beneficiary the same coverage that the person provides to the similarly situated nonCOBRA beneficiary. If the person providing coverage under the plan to a similarly situated nonCOBRA beneficiary is the plan administrator and the qualifying event is a divorce or legal separation or a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the plan administrator will also be liable for the excise tax if the qualified beneficiary submits a written request for coverage.

§54.4980B-3 *Qualified beneficiaries.*

The determination of who is a qualified beneficiary, an employee, or a covered employee, and of who are the similarly situated nonCOBRA beneficiaries is addressed in the following questions-and-answers:

Q-1: Who is a qualified beneficiary?

A-1: (a)(1) Except as set forth in paragraphs (c) through (f) of this Q&A-1, a qualified beneficiary is –

(i) Any individual who, on the day before a qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee; or

(ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.

(2) In the case of a qualifying event that is the bankruptcy of the employer, a covered employee who had retired on or before the date of substantial elimination of group health plan coverage is also a qualified beneficiary, as is any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan.

(3) In general, an individual (other than a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation cover-

age) who is not covered under a plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event, and the reason for the individual's lack of actual coverage (such as the individual's having declined participation in the plan or failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the individual is denied or not offered coverage under a plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101–12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§54.4980B–1 through 54.4980B–8, the individual will be considered to have had the coverage that was wrongfully denied or not offered.

(4) Paragraph (b) of this Q&A-1 describes how certain family members are not qualified beneficiaries even if they become covered under the plan; paragraphs (c), (d), and (e) of this Q&A-1 place limits on the general rules of this paragraph (a) concerning who is a qualified beneficiary; paragraph (f) of this Q&A-1 provides when an individual who has been a qualified beneficiary ceases to be a qualified beneficiary; paragraph (g) of this Q&A-1 defines *placed for adoption*; and paragraph (h) of this Q&A-1 contains examples.

(b) In contrast to a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, an individual who marries any qualified beneficiary on or after the date of the qualifying event and a 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 the spouse or the child's status as a dependent of the qualified beneficiary. These new family members do not themselves become qualified beneficiaries even if they become covered under the plan. (For situations in which a plan is required to make coverage available to new family members of a qualified beneficiary who is receiving COBRA continuation coverage, see Q&A-5 of

§54.4980B–5, paragraph (c) in Q&A-4 of §54.4980B–5, section 9801(f)(2), and §54.9801–6T(b).)

(c) An individual is not a qualified beneficiary if, on the day before the qualifying event referred to in paragraph (a) of this Q&A-1, 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.

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

(e) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of section 911(d)(2)) that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

(f) A qualified beneficiary who does not elect COBRA continuation coverage in connection with a qualifying event ceases to be a qualified beneficiary at the end of the election period (see Q&A-1 of §54.4980B–6). Thus, for example, if such a former qualified beneficiary is later added to a covered employee's coverage (e.g., during an open enrollment period) and then another qualifying event occurs with respect to the covered employee, the former qualified beneficiary does not become a qualified beneficiary by reason of the second qualifying event. If a covered employee who is a qualified beneficiary does not elect COBRA continuation coverage during the election period, then any child born to or placed for adoption with the covered employee on or after the date of the qualifying event is not a qualified beneficiary. Once a plan's obligation to make COBRA continuation coverage available to an individual who has been a qualified beneficiary ceases

under the rules of §54.4980B–7, the individual ceases to be a qualified beneficiary.

(g) For purposes of §§54.4980B–1 through 54.4980B–8, *placement for adoption or being placed for adoption* means the assumption and retention by the covered employee of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement for adoption with the covered employee terminates upon the termination of the legal obligation for total or partial support. A child who is immediately adopted by the covered employee without a preceding placement for adoption is considered to be placed for adoption on the date of the adoption.

(h) The rules of this Q&A-1 are illustrated by the following examples:

Example 1. (i) *B* is a single employee who voluntarily terminates employment and elects COBRA continuation coverage under a group health plan. To comply with the requirements of section 9801(f) and §54.9801–6T(b), the plan permits a covered employee who marries to have her or his spouse covered under the plan. One month after electing COBRA continuation coverage, *B* marries and chooses to have *B*'s spouse covered under the plan.

(ii) *B*'s spouse is not a qualified beneficiary. Thus, if *B* dies during the period of COBRA continuation coverage, the plan does not have to offer *B*'s surviving spouse an opportunity to elect COBRA continuation coverage.

Example 2. (i) *C* is a married employee who terminates employment. *C* elects COBRA continuation coverage for *C* but not *C*'s spouse, and *C*'s spouse declines to elect such coverage. *C*'s spouse thus ceases to be a qualified beneficiary. At the next open enrollment period, *C* adds the spouse as a beneficiary under the plan.

(ii) The addition of the spouse during the open enrollment period does not make the spouse a qualified beneficiary. The plan thus will not have to offer the spouse an opportunity to elect COBRA continuation coverage upon a later divorce from or death of *C*.

Example 3. (i) Under the terms of a group health plan, a covered employee's child, upon attaining age 19, ceases to be a dependent eligible for coverage.

(ii) At that time, the child must be offered an opportunity to elect COBRA continuation coverage. If the child elects COBRA continuation coverage, the child marries during the period of the COBRA continuation coverage, and the child's spouse becomes covered under the group health plan, the child's spouse is not a qualified beneficiary.

Example 4. (i) *D* is a single employee who, upon retirement, is given the opportunity to elect COBRA continuation coverage but declines it in favor of an alternative offer of 12 months of employer-paid retiree health benefits. At the end of the election period, *D* ceases to be a qualified beneficiary and will not have to be given another opportunity to elect COBRA continuation coverage (at the end of those 12 months or at any other time). *D* marries *E* during

the period of retiree health coverage and, under the terms of that coverage, *E* becomes covered under the plan.

(ii) If a divorce from or death of *D* will result in *E*'s losing coverage, *E* will be a qualified beneficiary because *E*'s coverage under the plan on the day before the qualifying event (that is, the divorce or death) will have been by reason of *D*'s acceptance of 12 months of employer-paid coverage after the prior qualifying event (*D*'s retirement) rather than by reason of an election of COBRA continuation coverage.

Example 5. (i) The facts are the same as in *Example 4*, except that, under the terms of the plan, the divorce or death does not cause *E* to lose coverage so that *E* continues to be covered for the balance of the original 12-month period.

(ii) *E* does not have to be allowed to elect COBRA continuation coverage because the loss of coverage at the end of the 12-month period is not caused by the divorce or death, and thus the divorce or death does not constitute a qualifying event. See Q&A-1 of §54.4980B-4.

Q-2: Who is an employee and who is a covered employee?

A-2: (a)(1) For purposes of §§54.4980B-1 through 54.4980B-8 (except for purposes of Q&A-5 in §54.4980B-2, relating to the exception from COBRA for plans maintained by an employer with fewer than 20 employees), an *employee* is any individual who is eligible to be covered under a group health plan by virtue of the performance of services for the employer maintaining the plan or by virtue of membership in the employee organization maintaining the plan. Thus, for purposes of §§54.4980B-1 through 54.4980B-8 (except for purposes of Q&A-5 in §54.4980B-2), the following individuals are employees if their relationship to the employer maintaining the plan makes them eligible to be covered under the plan –

(i) Self-employed individuals (within the meaning of section 401(c)(1));

(ii) Independent contractors (and their employees and independent contractors); and

(iii) Directors (in the case of a corporation).

(2) Similarly, whenever reference is made in §§54.4980B-1 through 54.4980B-8 (except in Q&A-5 of §54.4980B-2) to an employment relationship (such as by referring to the termination of employment of an employee or to an employee's being employed by an employer), the reference includes the relationship of those individuals who are employees within the meaning of this paragraph (a). See paragraph (c) in

Q&A-5 of §54.4980B-2 for a narrower meaning of employee solely for purposes of Q&A-5 of §54.4980B-2.

(b) For purposes of §§54.4980B-1 through 54.4980B-8, a *covered employee* is any individual who is (or was) provided coverage under a group health plan (other than a plan that is excepted from COBRA on the date of the qualifying event; see Q&A-4 of §54.4980B-2) by virtue of being or having been an employee. For example, a retiree or former employee who is covered by a group health plan is a covered employee if the coverage results in whole or in part from her or his previous employment. An employee (or former employee) who is merely eligible for coverage under a group health plan is generally not a covered employee if the employee (or former employee) is not actually covered under the plan. In general, the reason for the employee's (or former employee's) lack of actual coverage (such as having declined participation in the plan or having failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the employee (or former employee) is denied or not offered coverage under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101 through 12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§54.4980B-1 through 54.4980B-8, the employee (or former employee) will be considered to have had the coverage that was wrongfully denied or not offered.

Q-3: Who are the similarly situated nonCOBRA beneficiaries?

A-3: For purposes of §§54.4980B-1 through 54.4980B-8, *similarly situated nonCOBRA beneficiaries* means the group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than the rights provided under the COBRA continuation coverage requirements and who, based on all of the facts and circumstances, are most similarly situated to the situation of

the qualified beneficiary immediately before the qualifying event.

§54.4980B-4 *Qualifying events.*

The determination of what constitutes a qualifying event is addressed in the following questions-and-answers:

Q-1: What is a qualifying event?

A-1: (a) A *qualifying event* is an event that satisfies paragraphs (b), (c), and (d) of this Q&A-1. Paragraph (e) of this Q&A-1 further explains a reduction of hours of employment, paragraph (f) of this Q&A-1 describes the treatment of children born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and paragraph (g) of this Q&A-1 contains examples.

(b) An event satisfies this paragraph (b) if the event is any of the following –

(1) The death of a covered employee;

(2) The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment;

(3) The divorce or legal separation of a covered employee from the employee's spouse;

(4) A covered employee's becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg);

(5) A dependent child's ceasing to be a dependent child of a covered employee under the generally applicable requirements of the plan; or

(6) A proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

(c) An event satisfies this paragraph (c) if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan. For this purpose, to *lose coverage* means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. Any increase in the premium or contribution that must be paid by a covered employee (or the spouse or dependent child of a covered employee) for coverage under a group health plan that results from the occurrence of one of the events listed in paragraph (b) of this

Q&A-1 is a *loss of coverage*. In the case of an event that is the bankruptcy of the employer, loss of coverage also means any substantial elimination of coverage under the plan, occurring within 12 months before or after the date the bankruptcy proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage or for any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan. For purposes of this paragraph (c), a loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum coverage period (see Q&A-1 and Q&A-6 of §54.4980B-7). However, if neither the covered employee nor the spouse or a dependent child of the covered employee loses coverage before the end of what would be the maximum coverage period, the event does not satisfy this paragraph (c). If coverage is reduced or eliminated in anticipation of an event (for example, an employer's eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee's eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs while the plan is excepted from COBRA (see Q&A-4 of §54.4980B-2). Even if the plan later becomes subject to COBRA, it is not required to make COBRA continuation coverage available to anyone whose coverage ends as a result of an event during a year in which the plan is excepted from COBRA. For example, if a group health plan is excepted from COBRA as a small-employer plan during the year 2001 (see Q&A-5 of §54.4980B-2) and an employee terminates employment on December 31, 2001, the termination is not a qualifying event and the plan is not required to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a

small-employer plan as of January 1, 2002. Also, the same result will follow even if the employee is given three months of coverage beyond December 31 (that is, through March of 2002), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the three-month coverage through March 2002, but the spouse divorces the employee before the end of the three months and loses coverage as a result of the divorce, the divorce will constitute a qualifying event during 2002 and so entitle the spouse to elect COBRA continuation coverage. See Q&A-7 of §54.4980B-7 regarding the maximum coverage period in such a case.

(e) A reduction of hours of a covered employee's employment occurs whenever there is a decrease in the hours that a covered employee is required to work or actually works, but only if the decrease is not accompanied by an immediate termination of employment. This is true regardless of whether the covered employee continues to perform services following the reduction of hours of employment. For example, an absence from work due to disability, a temporary layoff, or any other reason is a reduction of hours of a covered employee's employment if there is not an immediate termination of employment. If a group health plan measures eligibility for the coverage of employees by the number of hours worked in a given time period, such as the preceding month or quarter, and an employee covered under the plan fails to work the minimum number of hours during that time period, the failure to work the minimum number of required hours is a reduction of hours of that covered employee's employment.

(f) The qualifying event of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the qualifying event giving rise to the period of COBRA continuation coverage during which the child is born or placed for adoption. If a second qualifying event has occurred before the child is born or placed for adoption (such as the death of the covered employee), then the second qualifying event also applies to the newborn or adopted child. See Q&A-6 of §54.4980B-7.

(g) The rules of this Q&A-1 are illustrated by the following examples, in each of which the group health plan is subject to COBRA:

Example 1. (i) An employee who is covered by a group health plan terminates employment (other than by reason of the employee's gross misconduct) and, beginning with the day after the last day of employment, is given 3 months of employer-paid coverage under the same terms and conditions as before that date. At the end of the three months, the coverage terminates.

(ii) The loss of coverage at the end of the three months results from the termination of employment and, thus, the termination of employment is a qualifying event.

Example 2. (i) An employee who is covered by a group health plan retires (which is a termination of employment other than by reason of the employee's gross misconduct) and, upon retirement, is required to pay an increased amount for the same group health coverage that the employee had before retirement.

(ii) The increase in the premium or contribution required for coverage is a loss of coverage under paragraph (c) of this Q&A-1 and, thus, the retirement is a qualifying event.

Example 3. (i) An employee and the employee's spouse are covered under an employer's group health plan. The employee retires and is given identical coverage for life. However, the plan provides that the spousal coverage will not be continued beyond six months unless a higher premium for the spouse is paid to the plan.

(ii) The requirement for the spouse to pay a higher premium at the end of the six months is a loss of coverage under paragraph (c) of this Q&A-1. Thus, the retirement is a qualifying event and the spouse must be given an opportunity to elect COBRA continuation coverage.

Example 4. (i) *F* is a covered employee who is married to *G*, and both are covered under a group health plan maintained by *F*'s employer. *F* and *G* are divorced. Under the terms of the plan, the divorce causes *G* to lose coverage. The divorce is a qualifying event, and *G* elects COBRA continuation coverage, remarries during the period of COBRA continuation coverage, and *G*'s new spouse becomes covered under the plan. (See Q&A-5 in §54.4980B-5, paragraph (c) in Q&A-4 of §54.4980B-5, section 9801(f)(2), and §54.9801-6T(b).) *G* dies. Under the terms of the plan, the death causes *G*'s new spouse to lose coverage under the plan.

(ii) *G*'s death is not a qualifying event because *G* is not a covered employee.

Example 5. (i) An employer maintains a group health plan for both active employees and retired employees (and their families). The coverage for active employees and retired employees is identical, and the employer does not require retirees to pay more for coverage than active employees. The plan does not make COBRA continuation coverage available when an employee retires (and is not required to because the retired employee has not lost coverage under the plan). The employer amends the plan to eliminate coverage for retired employees effective January 1, 2002. On that date, several retired em-

ployees (and their spouses and dependent children) have been covered under the plan since their retirement for less than the maximum coverage period that would apply to them in connection with their retirement.

(ii) The elimination of retiree coverage under these circumstances is a deferred loss of coverage for those retirees (and their spouses and dependent children) under paragraph (c) of this Q&A-1 and, thus, the retirement is a qualifying event. The plan must make COBRA continuation coverage available to them for the balance of the maximum coverage period that applies to them in connection with the retirement.

Q-2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

A-2: Apart from facts constituting gross misconduct, the facts surrounding the termination or reduction of hours are irrelevant in determining whether a qualifying event has occurred. Thus, it does not matter whether the employee voluntarily terminated or was discharged. For example, a strike or a lockout is a termination or reduction of hours that constitutes a qualifying event if the strike or lockout results in a loss of coverage as described in paragraph (c) of Q&A-1 of this section. Similarly, a layoff that results in such a loss of coverage is a qualifying event.

§54.4980B-5 COBRA continuation coverage.

The following questions-and-answers address the requirements for coverage to constitute COBRA continuation coverage:

Q-1: What is COBRA continuation coverage?

A-1: (a) If a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any immediate or deferred loss of coverage) must be offered an opportunity to elect to receive the group health plan coverage that is provided to similarly situated nonCOBRA beneficiaries (ordinarily, the same coverage that the qualified beneficiary had on the day before the qualifying event). See Q&A-3 of §54.4980B-3 for the definition of similarly situated nonCOBRA beneficiaries. This coverage is COBRA continuation coverage. If coverage under the plan is modified for similarly situated

nonCOBRA beneficiaries, then the coverage made available to qualified beneficiaries is modified in the same way. If the continuation coverage offered differs in any way from the coverage made available to similarly situated nonCOBRA beneficiaries, the coverage offered does not constitute COBRA continuation coverage and the group health plan is not in compliance with COBRA unless other coverage that does constitute COBRA continuation coverage is also offered. Any elimination or reduction of coverage in anticipation of an event described in paragraph (b) of Q&A-1 of §54.4980B-4 is disregarded for purposes of this Q&A-1 and for purposes of any other reference in §§54.4980B-1 through 54.4980B-8 to coverage in effect immediately before (or on the day before) a qualifying event. COBRA continuation coverage must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(b) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to elect immediately to have the same coverage that dependent children of active employees receive under the benefit packages under which the covered employee has coverage at the time of the birth or placement for adoption. Such a child would be entitled to elect coverage different from that elected by the covered employee during the next available open enrollment period under the plan. See Q&A-4 of this section.

Q-2: What deductibles apply if COBRA continuation coverage is elected?

A-2: (a) Qualified beneficiaries electing COBRA continuation coverage generally are subject to the same deductibles as similarly situated nonCOBRA beneficiaries. If a qualified beneficiary's COBRA continuation coverage begins before the end of a period prescribed for accumulating amounts toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward those deductibles before the beginning of COBRA continuation coverage as though the qualifying event had not occurred. The specific application of this rule depends on the type of deductible, as set forth in paragraphs (b) through (d) of this Q&A-2. Special

rules are set forth in paragraph (e) of this Q&A-2, and examples appear in paragraph (f) of this Q&A-2.

(b) If a deductible is computed separately for each individual receiving coverage under the plan, each individual's remaining deductible amount (if any) on the date COBRA continuation coverage begins is equal to that individual's remaining deductible amount immediately before that date.

(c) If a deductible is computed on a family basis, the remaining deductible for the family on the date that COBRA continuation coverage begins depends on the members of the family electing COBRA continuation coverage. In computing the family deductible that remains on the date COBRA continuation coverage begins, only the expenses of those family members receiving COBRA continuation coverage need be taken into account. If the qualifying event results in there being more than one family unit (for example, because of a divorce), the family deductible may be computed separately for each resulting family unit based on the members in each unit. These rules apply regardless of whether the plan provides that the family deductible is an alternative to individual deductibles or an additional requirement.

(d) Deductibles that are not described in paragraph (b) or (c) of this Q&A-2 must be treated in a manner consistent with the principles set forth in those paragraphs.

(e) If a deductible is computed on the basis of a covered employee's compensation instead of being a fixed dollar amount and the employee remains employed during the period of COBRA continuation coverage, the plan is permitted to choose whether to apply the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began, or to apply the deductible by taking the employee's actual compensation into account. In applying a deductible that is computed on the basis of the covered employee's compensation instead of being a fixed dollar amount, for periods of COBRA continuation coverage in which the employee is not employed by the em-

ployer, the plan is required to compute the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage either at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began or at the level that was used to compute the deductible in effect immediately before the employee's employment was terminated.

(f) The rules of this Q&A-2 are illustrated by the following examples; in each example, deductibles under the plan are determined on a calendar year basis:

Example 1. (i) A group health plan applies a separate \$100 annual deductible to each individual it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 2001. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 2001. As of July 31, 2001, the spouse has incurred \$80 of covered expenses, the older child has incurred no covered expenses, and the younger one has incurred \$120 of covered expenses (and therefore has already satisfied the deductible).

(ii) At the beginning of COBRA continuation coverage on August 1, the spouse has a remaining deductible of \$20, the older child still has the full \$100 deductible, and the younger one has no further deductible.

Example 2. (i) A group health plan applies a separate \$200 annual deductible to each individual it covers, except that each family member is treated as having satisfied the individual deductible once the family has incurred \$500 of covered expenses during the year. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. A covered employee with four dependent children is divorced, the spouse obtains custody of the two oldest children, and the spouse and those children all elect COBRA continuation coverage to begin immediately. The family had accumulated \$420 of covered expenses before the divorce, as follows: \$70 by each parent, \$200 by the oldest child, \$80 by the youngest child, and none by the other two children.

(ii) The resulting family consisting of the spouse and the two oldest children accumulated a total of \$270 of covered expenses, and thus the remaining deductible for that family could be as high as \$230 (because the plan would not have to count the incurred expenses of the covered employee and the youngest child). The remaining deductible for the resulting family consisting of the covered employee and the two youngest children is not subject to the rules of this Q&A-2 because their coverage is not COBRA continuation coverage.

Example 3. Each year a group health plan pays 70 percent of the cost of an individual's psychotherapy after that individual's first three visits during the

year. A qualified beneficiary whose election of COBRA continuation coverage takes effect beginning August 1, 2001 and who has already made two visits as of that date need only pay for one more visit before the plan must begin to pay 70 percent of the cost of the remaining visits during 2001.

Example 4. (i) A group health plan has a \$250 annual deductible per covered individual. The plan provides that if the deductible is not satisfied in a particular year, expenses incurred during October through December of that year are credited toward satisfaction of the deductible in the next year. A qualified beneficiary who has incurred covered expenses of \$150 from January through September of 2001 and \$40 during October elects COBRA continuation coverage beginning November 1, 2001.

(ii) The remaining deductible amount for this qualified beneficiary is \$60 at the beginning of the COBRA continuation coverage. If this individual incurs covered expenses of \$50 in November and December of 2001 combined (so that the \$250 deductible for 2001 is not satisfied), the \$90 incurred from October through December of 2001 are credited toward satisfaction of the deductible amount for 2002.

Q-3: How do a plan's limits apply to COBRA continuation coverage?

A-3: (a) Limits are treated in the same way as deductibles (see Q&A-2 of this section). This rule applies both to limits on plan benefits (such as a maximum number of hospital days or dollar amount of reimbursable expenses) and limits on out-of-pocket expenses (such as a limit on copayments, a limit on deductibles plus copayments, or a catastrophic limit). This rule applies equally to annual and lifetime limits and applies equally to limits on specific benefits and limits on benefits in the aggregate under the plan.

(b) The rule of this Q&A-3 is illustrated by the following examples; in each example limits are determined on a calendar year basis:

Example 1. (i) A group health plan pays for a maximum of 150 days of hospital confinement per individual per year. A covered employee who has had 20 days of hospital confinement as of May 1, 2001 terminates employment and elects COBRA continuation coverage as of that date.

(ii) During the remainder of the year 2001 the plan need only pay for a maximum of 130 days of hospital confinement for this individual.

Example 2. (i) A group health plan reimburses a maximum of \$20,000 of covered expenses per family per year, and the same \$20,000 limit applies to unmarried covered employees. A covered employee and spouse who have no children divorce on May 1, 2001, and the spouse elects COBRA continuation coverage as of that date. In 2001, the employee had incurred \$5,000 of expenses and the spouse had incurred \$8,000 before May 1.

(ii) The plan can limit its reimbursement of the amount of expenses incurred by the spouse on and

after May 1 for the remainder of the year to \$12,000 (\$20,000 - \$8,000 = \$12,000). The remaining limit for the employee is not subject to the rules of this Q&A-3 because the employee's coverage is not COBRA continuation coverage.

Example 3. (i) A group health plan pays for 80 percent of covered expenses after satisfaction of a \$100-per-individual deductible, and the plan pays for 100 percent of covered expenses after a family has incurred out-of-pocket costs of \$2,000. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. An employee and spouse with three dependent children divorce on June 1, 2001, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 2001, the spouse incurred \$600 of covered expenses and each of the two children in the spouse's custody after the divorce incurred covered expenses of \$1,100. This resulted in total out-of-pocket costs for these three individuals of \$800 (\$300 total for the three deductibles, plus \$500 for 20 percent of the other \$2,500 in incurred expenses [\$600 + \$1,100 + \$1,100 = \$2,800; \$2,800 - \$300 = \$2,500]).

(ii) For the remainder of 2001, the resulting family consisting of the spouse and two children has an out-of-pocket limit of \$1,200 (\$2,000 - \$800 = \$1,200). The remaining out-of-pocket limit for the resulting family consisting of the employee and one child is not subject to the rules of this Q&A-3 because their coverage is not COBRA continuation coverage.

Q-4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

A-4: (a) In general, a qualified beneficiary need only be given an opportunity to continue the coverage that she or he was receiving immediately before the qualifying event. This is true regardless of whether the coverage received by the qualified beneficiary before the qualifying event ceases to be of value to the qualified beneficiary, such as in the case of a qualified beneficiary covered under a region-specific health maintenance organization (HMO) who leaves the HMO's service region. The only situations in which a qualified beneficiary must be allowed to change from the coverage received immediately before the qualifying event are as set forth in paragraphs (b) and (c) of this Q&A-4 and in Q&A-1 of this section (regarding changes to or elimination of the coverage provided to similarly situated nonCOBRA beneficiaries).

(b) If a qualified beneficiary participates in a region-specific benefit package

(such as an HMO or an on-site clinic) that will not service her or his health needs in the area to which she or he is relocating (regardless of the reason for the relocation), the qualified beneficiary must be given an opportunity to elect alternative coverage that the employer or employee organization makes available to active employees. If the employer or employee organization makes group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating, then that coverage is the alternative coverage that must be made available to the relocating qualified beneficiary. If the employer or employee organization does not make group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating but makes coverage available to other employees that can be extended in that area, then the coverage made available to those other employees must be made available to the relocating qualified beneficiary. However, the employer or employee organization is not required to make any other coverage available to the relocating qualified beneficiary if the only coverage the employer or employee organization makes available to active employees is not available in the area to which the qualified beneficiary relocates (because all such coverage is region-specific and does not service individuals in that area).

(c) If an employer or employee organization makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. An open enrollment period means a period during which an employee covered under a plan can choose to be covered under another group health plan or under another benefit package within the same plan, or to add or eliminate coverage of family members.

(d) The rules of this Q&A-4 are illustrated by the following examples:

Example 1. (i) *E* is an employee who works for an employer that maintains several group health plans. Under the terms of the plans, if an employee chooses to cover any family members under a plan,

all family members must be covered by the same plan and that plan must be the same as the plan covering the employee. Immediately before *E*'s termination of employment (for reasons other than gross misconduct), *E* is covered along with *E*'s spouse and children by a plan. The coverage under that plan will end as a result of the termination of employment.

(ii) Upon *E*'s termination of employment, each of the four family members is a qualified beneficiary. Even though the employer maintains various other plans and options, it is not necessary for the qualified beneficiaries to be allowed to switch to a new plan when *E* terminates employment.

(iii) COBRA continuation coverage is elected for each of the four family members. Three months after *E*'s termination of employment there is an open enrollment period during which similarly situated active employees are offered an opportunity to choose to be covered under a new plan or to add or eliminate family coverage.

(iv) During the open enrollment period, each of the four qualified beneficiaries must be offered the opportunity to switch to another plan (as though each qualified beneficiary were an individual employee). For example, each member of *E*'s family could choose coverage under a separate plan, even though the family members of employed individuals could not choose coverage under separate plans. Of course, if each family member chooses COBRA continuation coverage under a separate plan, the plan can require payment for each family member that is based on the applicable premium for individual coverage under that separate plan. See Q&A-1 of §54.4980B-8.

Example 2. (i) The facts are the same as in *Example 1*, except that *E*'s family members are not covered under *E*'s group health plan when *E* terminates employment.

(ii) Although the family members do not have to be given an opportunity to elect COBRA continuation coverage, *E* must be allowed to add them to *E*'s COBRA continuation coverage during the open enrollment period. This is true even though the family members are not, and cannot become, qualified beneficiaries (see Q&A-1 of §54.4980B-3).

Q-5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

A-5: (a) Yes. Under section 9801 and §54.9801-6T, employees eligible to participate in a group health plan (whether or not participating), as well as former employees participating in a plan (referred to in those rules as participants), are entitled to special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for

adoption, if certain requirements are satisfied. Employees not participating in the plan also can obtain rights for self-enrollment under those rules. Once a qualified beneficiary is receiving COBRA continuation coverage (that is, has timely elected and made timely payment for COBRA continuation coverage), the qualified beneficiary has the same right to enroll family members under those special enrollment rules as if the qualified beneficiary were an employee or participant within the meaning of those rules. However, neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules.

(b) In addition to the special enrollment rights described in paragraph (a) of this Q&A-5, if the plan covering the qualified beneficiary provides that new family members of active employees can become covered (either automatically or upon an appropriate election) before the next open enrollment period, then the same right must be extended to the new family members of a qualified beneficiary.

(c) If the addition of a new family member will result in a higher applicable premium (for example, if the qualified beneficiary was previously receiving COBRA continuation coverage as an individual, or if the applicable premium for family coverage depends on family size), the plan can require the payment of a correspondingly higher amount for the COBRA continuation coverage. See Q&A-1 of §54.4980B-8.

(d) The right to add new family members under this Q&A-5 is in addition to the rights that newborn and adopted children of covered employees may have as qualified beneficiaries; see Q&A-1 in §54.4980B-3.

§54.4980B-6 Electing COBRA continuation coverage.

The following questions-and-answers address the manner in which COBRA continuation coverage is elected:

Q-1: What is the election period and how long must it last?

A-1: (a) A group health plan can condition the availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA

continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the qualified beneficiary would lose coverage on account of the qualifying event. (See paragraph (c) of Q&A-1 of §54.4980B-4 for the meaning of lose coverage.) The election period must not end before the date that is 60 days after the later of –

(1) The date the qualified beneficiary would lose coverage on account of the qualifying event; or

(2) The date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage.

(b) An election is considered to be made on the date it is sent to the plan administrator.

(c) The rules of this Q&A-1 are illustrated by the following example:

Example. (i) An unmarried employee without children who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 2001. The employee is not disabled at the time of the termination of employment nor at any time thereafter, and the plan does not provide for the extension of the required periods (as is permitted under section 4980B(f)(8)).

(ii) *Case 1:* If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin not later than June 1, 2001, and must not end earlier than July 31, 2001. If notice of the right to elect COBRA continuation coverage is not provided to the employee until June 15, 2001, the election period must not end earlier than August 14, 2001.

(iii) *Case 2:* If the plan provides that the employer-paid coverage does not end until 6 months after the termination of employment, the employee does not lose coverage until December 1, 2001. The election period can therefore begin as late as December 1, 2001, and must not end before January 30, 2002.

(iv) *Case 3:* If employer-paid coverage for 6 months after the termination of employment is offered only to those qualified beneficiaries who waive COBRA continuation coverage, the employee loses coverage on June 1, 2001, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage need not be provided for more than 18 months after the termination of employment, and in certain circumstances might be provided for a shorter period (see Q&A-1 of §54.4980B-7).

Q-2: Is a covered employee or qualified beneficiary responsible for informing

the plan administrator of the occurrence of a qualifying event?

A-2: (a) In general, the employer or plan administrator must determine when a qualifying event has occurred. However, each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of a qualifying event that is either a dependent child's ceasing to be a dependent child under the generally applicable requirements of the plan or a divorce or legal separation of a covered employee. The group health plan is not required to offer the qualified beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the plan administrator within 60 days after the later of –

(1) The date of the qualifying event; or

(2) The date the qualified beneficiary would lose coverage on account of the qualifying event.

(b) For purposes of this Q&A-2, if more than one qualified beneficiary would lose coverage on account of a divorce or legal separation of a covered employee, a timely notice of the divorce or legal separation that is provided by the covered employee or any one of those qualified beneficiaries will be sufficient to preserve the election rights of all of the qualified beneficiaries.

Q-3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

A-3: (a) In general, each qualified beneficiary has until 60 days after the later of the date the qualifying event would cause her or him to lose coverage or the date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage to decide whether to elect COBRA continuation coverage. If the election is made during that period, coverage must be provided from the date that coverage would otherwise have been lost (but see Q&A-4 of this section). This can be accomplished as described in paragraph (b) or (c) of this Q&A-3.

(b) In the case of an indemnity or reimbursement arrangement, the employer or employee organization can provide for plan coverage during the election period or, if the plan allows retroactive reinstatement, the employer or employee organization can terminate the coverage of the

qualified beneficiary and reinstate her or him when the election is made. Claims incurred by a qualified beneficiary during the election period do not have to be paid before the election (and, if applicable, payment for the coverage) is made. If a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary during the election period, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights during the election period. For example, if the plan provides coverage during the election period but cancels coverage retroactively if COBRA continuation coverage is not elected, then the plan must inform a provider that a qualified beneficiary for whom coverage has not been elected is covered but that the coverage is subject to retroactive termination. Similarly, if the plan cancels coverage but then retroactively reinstates it once COBRA continuation coverage is elected, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the date coverage was lost if COBRA continuation coverage is elected. (See paragraph (c) of Q&A-5 in §54.4980B-8 for similar rules that a plan must follow in confirming coverage during a period when the plan has not received payment but that is still within the grace period for a qualified beneficiary for whom COBRA continuation coverage has been elected.)

(c)(1) In the case of a group health plan that provides health services (such as a health maintenance organization or a walk-in clinic), the plan can require with respect to a qualified beneficiary who has not elected and paid for COBRA continuation coverage that the qualified beneficiary choose between –

(i) Electing and paying for the coverage; or

(ii) Paying the reasonable and customary charge for the plan's services, but only if a qualified beneficiary who chooses to pay for the services will be reimbursed for that payment within 30 days after the election of COBRA continuation coverage (and, if applicable, the payment of any balance due for the coverage).

(2) In the alternative, the plan can provide continued coverage and treat the

qualified beneficiary's use of the facility as a constructive election. In such a case, the qualified beneficiary is obligated to pay any applicable charge for the coverage, but only if the qualified beneficiary is informed that use of the facility will be a constructive election before using the facility.

Q-4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

A-4: If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver of COBRA continuation coverage is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, employee organization, or plan administrator, as applicable.

Q-5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

A-5: No. An employer, and an employee organization, must not withhold anything to which a qualified beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA continuation coverage or to coerce the qualified beneficiary to give up rights to COBRA continuation coverage (including the right to use the full election period to decide whether to elect such coverage). Such a withholding constitutes a failure to comply with the COBRA continuation coverage requirements. Furthermore, any purported waiver obtained by means of such a withholding is invalid.

Q-6: Can each qualified beneficiary make an independent election under COBRA?

A-6: Yes. Each qualified beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to

make an independent election to receive COBRA continuation coverage. If the plan allows similarly situated active employees with respect to whom a qualifying event has not occurred to choose among several options during an open enrollment period (for example, to switch to another group health plan or to another benefit package under the same group health plan), then each qualified beneficiary must also be offered an independent election to choose during an open enrollment period among the options made available to similarly situated active employees with respect to whom a qualifying event has not occurred. If a qualified beneficiary who is either a covered employee or the spouse of a covered employee elects COBRA continuation coverage and the election does not specify whether the election is for self-only coverage, the election is deemed to include an election of COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to that qualifying event. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a qualified beneficiary who is incapacitated or dies can be made by the legal representative of the qualified beneficiary or the qualified beneficiary's estate, as determined under applicable state law, or by the spouse of the qualified beneficiary. (See also Q&A-5 of §54.4980B-7 relating to the independent right of each qualified beneficiary with respect to the same qualifying event to receive COBRA continuation coverage during the disability extension.) The rules of this Q&A-6 are illustrated by the following examples; in each example each group health plan is subject to COBRA:

Example 1. (i) Employee *H* and *H*'s spouse are covered under a group health plan immediately before *H*'s termination of employment (for reasons other than gross misconduct). Coverage under the plan will end as a result of the termination of employment.

(ii) Upon *H*'s termination of employment, both *H* and *H*'s spouse are qualified beneficiaries and each must be allowed to elect COBRA continuation coverage. Thus, *H* might elect COBRA continuation coverage while the spouse declines to elect such coverage, or *H* might elect COBRA continuation coverage for both of them. In contrast, *H* cannot decline COBRA continuation coverage on behalf of *H*'s spouse. Thus, if *H* does not elect COBRA continuation coverage on behalf of the spouse, the spouse must still be allowed to elect COBRA continuation coverage.

Example 2. (i) An employer maintains a group health plan under which all employees receive employer-paid coverage. Employees can arrange to cover their families by paying an additional amount. The employer also maintains a cafeteria plan, under which one of the options is to pay part or all of the employee share of the cost for family coverage under the group health plan. Thus, an employee might pay for family coverage under the group health plan partly with before-tax dollars and partly with after-tax dollars.

(ii) If an employee's family is receiving coverage under the group health plan when a qualifying event occurs, each of the qualified beneficiaries must be offered an opportunity to elect COBRA continuation coverage, regardless of how that qualified beneficiary's coverage was paid for before the qualifying event.

§54.4980B-7 Duration of COBRA continuation coverage.

The following questions-and-answers address the duration of COBRA continuation coverage:

Q-1: How long must COBRA continuation coverage be made available to a qualified beneficiary?

A-1: (a) Except for an interruption of coverage in connection with a waiver, as described in Q&A-4 of §54.4980B-6, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates –

(1) The last day of the maximum required period under section 4980B(f)(2)(B)(i) (the maximum coverage period) and, if applicable, section 4980B(f)(8) (relating to the optional extension of required periods in a case where coverage is lost after the date of, instead of on the date of, the qualifying event);

(2) The first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A-5 in §54.4980B-8);

(3) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

(4) The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, as described in Q&A-2 of this section; and

(5) The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare bene-

fits, as described in Q&A-3 of this section.

(b) However, a group health plan can terminate for cause the coverage of a qualified beneficiary receiving COBRA continuation coverage on the same basis that the plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries. For example, if a group health plan terminates the coverage of active employees for the submission of a fraudulent claim, then the coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim. Notwithstanding the preceding two sentences, the coverage of a qualified beneficiary can be terminated for failure to make timely payment to the plan only if payment is not timely under the rules of Q&A-5 in §54.4980B-8.

(c) In the case of an individual who is not a qualified beneficiary and who is receiving coverage under a group health plan solely because of the individual's relationship to a qualified beneficiary, if the plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases under this section, the plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Q-2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?

A-2: (a) If a qualified beneficiary first becomes covered under another group health plan (including for this purpose any group health plan of a governmental employer or employee organization) after the date on which COBRA continuation coverage is elected for the qualified beneficiary and the other coverage satisfies the requirements of paragraphs (b), (c), and (d) of this Q&A-2, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary first becomes covered under the other group health plan (even if the other coverage is less valuable to the qualified beneficiary). By contrast, if a qualified beneficiary first becomes covered under another group health plan on or before the date on which COBRA continuation coverage is elected, then the other coverage cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) The requirement of this paragraph (b) is satisfied if the qualified beneficiary is actually covered, rather than merely eligible to be covered, under the other group health plan.

(c) The requirement of this paragraph (c) is satisfied if the other group health plan is a plan that is not maintained by the employer or employee organization that maintains the plan under which COBRA continuation coverage must otherwise be made available.

(d) The requirement of this paragraph (d) is satisfied if the other group health plan does not contain any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary (other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary by reason of the provisions in section 9801 (relating to limitations on preexisting condition exclusion periods in group health plans)).

(e) The rules of this Q&A-2 are illustrated by the following examples:

Example 1. (i) Employer X maintains a group health plan subject to COBRA. C is an employee covered under the plan. C is also covered under a group health plan maintained by Employer Y, the employer of C's spouse. C terminates employment (for reasons other than gross misconduct), and the termination of employment causes C to lose coverage under X's plan (and, thus, is a qualifying event). C elects to receive COBRA continuation coverage under X's plan.

(ii) Under these facts, X's plan cannot terminate C's COBRA continuation coverage on the basis of C's coverage under Y's plan.

Example 2. (i) Employer W maintains a group health plan subject to COBRA. D is an employee covered under the plan. D terminates employment (for reasons other than gross misconduct), and the termination of employment causes D to lose coverage under W's plan (and, thus, is a qualifying event). D elects to receive COBRA continuation coverage under W's plan. Later D becomes employed by Employer V and is covered under V's group health plan. D's coverage under V's plan is not subject to any exclusion or limitation with respect to any preexisting condition of D.

(ii) Under these facts, W can terminate D's COBRA continuation coverage on the date D becomes covered under V's plan.

Example 3. (i) The facts are the same as in *Example 2*, except that D becomes employed by V and becomes covered under V's group health plan before D elects COBRA continuation coverage under W's plan.

(ii) Because the termination of employment is a qualifying event, D must be offered COBRA continuation coverage under W's plan, and W is not permitted to terminate D's COBRA continuation coverage on account of D's coverage under V's plan because D first became covered under V's plan before COBRA continuation coverage was elected for D.

Q-3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

A-3: (a) If a qualified beneficiary first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) after the date on which COBRA continuation coverage is elected for the qualified beneficiary, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary becomes so entitled. By contrast, if a qualified beneficiary first becomes entitled to Medicare benefits on or before the date that COBRA continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.

Q-4: [Reserved]

A-4: [Reserved]

Q-5: How does a qualified beneficiary become entitled to a disability extension?

A-5: (a) A qualified beneficiary becomes entitled to a disability extension if the requirements of paragraphs (b), (c), and (d) of this Q&A-5 are satisfied with respect to the qualified beneficiary. If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to COBRA continuation coverage because of that qualifying event. Thus, for example, the 29-month maximum coverage period applies to each qualified beneficiary who is not disabled as well as to the qualified beneficiary who is disabled, and it applies independently with respect to each of the qualified beneficiaries. See Q&A-1 in §54.4980B-8, which permits a plan to require payment of an increased amount during the disability extension.

(b) The requirement of this paragraph (b) is satisfied if a qualifying event occurs that is a termination, or reduction of hours, of a covered employee's employment.

(c) The requirement of this paragraph (c) is satisfied if an individual (whether or

not the covered employee) who is a qualified beneficiary in connection with the qualifying event described in paragraph (b) of this Q&A-5 is determined under Title II or XVI of the Social Security Act (42 U.S.C. 401–433 or 1381–1385) to have been disabled at any time during the first 60 days of COBRA continuation coverage. For this purpose, the period of the first 60 days of COBRA continuation coverage is measured from the date of the qualifying event described in paragraph (b) of this Q&A-5 (except that if a loss of coverage would occur at a later date in the absence of an election for COBRA continuation coverage and if the plan provides for the extension of the required periods in accordance with section 4980B(f)(8), then the period of the first 60 days of COBRA continuation coverage is measured from the date on which the coverage would be lost). However, in the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. For purposes of this paragraph (c), an individual is determined to be disabled within the first 60 days of COBRA continuation coverage if the individual has been determined under Title II or XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage and has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage.

(d) The requirement of this paragraph (d) is satisfied if any of the qualified beneficiaries affected by the qualifying event described in paragraph (b) of this Q&A-5 provides notice to the plan administrator of the disability determination on a date that is both within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period that applies to the qualifying event.

Q-6: Under what circumstances can the maximum coverage period be expanded?

A-6: (a) The maximum coverage period can be expanded if the requirements of Q&A-5 of this section (relating to the

disability extension) or paragraph (b) of this Q&A-6 are satisfied.

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of the employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to receive COBRA continuation coverage through December 31, 2003.

Q-7: If health coverage is provided to a qualified beneficiary after a qualifying

event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

A-7: (a) No. The end of the maximum coverage period is measured solely as described in Q&A-1 and Q&A-6 of this section, which is generally from the date of the qualifying event.

(b) If the alternative coverage does not satisfy all the requirements for COBRA continuation coverage, or if the amount that the group health plan requires to be paid for the alternative coverage is greater than the amount required to be paid by similarly situated nonCOBRA beneficiaries for the coverage that the qualified beneficiary can elect to receive as COBRA continuation coverage, the plan covering the qualified beneficiary immediately before the qualifying event must offer the qualified beneficiary receiving the alternative coverage the opportunity to elect COBRA continuation coverage. See Q&A-1 of §54.4980B-6.

(c) If an individual rejects COBRA continuation coverage in favor of alternative coverage, then, at the expiration of the alternative coverage period, the individual need not be offered a COBRA election. However, if the individual receiving alternative coverage is a covered employee and the spouse or a dependent child of the individual would lose that alternative coverage as a result of a qualifying event (such as the death of the covered employee), the spouse or dependent child must be given an opportunity to elect to continue that alternative coverage, with a maximum coverage period of 36 months measured from the date of that qualifying event.

Q-8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

A-8: If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expi-

ration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

§54.4980B-8 Paying for COBRA continuation coverage.

The following questions-and-answers address paying for COBRA continuation coverage:

Q-1: Can a group health plan require payment for COBRA continuation coverage?

A-1: (a) Yes. For any period of COBRA continuation coverage, a group health plan can require the payment of an amount that does not exceed 102 percent of the applicable premium for that period. (See paragraph (b) of this Q&A-1 for a rule permitting a plan to require payment of an increased amount due to the disability extension.) The *applicable premium* is defined in section 4980B(f)(4). A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the plan with respect to that qualified beneficiary (see Q&A-1 of §54.4980B-7). For the meaning of *timely payment*, see Q&A-5 of this section.

(b) A group health plan is permitted to require the payment of an amount that does not exceed 150 percent of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary (for example, whether single or family coverage) if the coverage would not be required to be made available in the absence of a disability extension. (See Q&A-5 of §54.4980B-7 for rules to determine whether a qualified beneficiary is entitled to a disability extension.) A plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage to which a qualified beneficiary is entitled without regard to the disability extension. Thus, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event within the original 18-month maxi-

um coverage period, then the plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage. By contrast, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event after the end of the original 18-month maximum coverage period, then the plan may require the payment of an amount that is up to 150 percent of the applicable premium for the remainder of the period of COBRA continuation coverage (that is, from the beginning of the 19th month through the end of the 36th month) as long as the disabled qualified beneficiary is included in that coverage. The rules of this paragraph (b) are illustrated by the following examples; in each example the group health plan is subject to COBRA:

Example 1. (i) An employer maintains a group health plan. The plan determines the cost of covering individuals under the plan by reference to two categories, individual coverage and family coverage, and the applicable premium is determined for those two categories. An employee and members of the employee's family are covered under the plan. The employee experiences a qualifying event that is the termination of the employee's employment. The employee's family qualifies for the disability extension because of the disability of the employee's spouse. (Timely notice of the disability is provided to the plan administrator.) Timely payment of the amount required by the plan for COBRA continuation coverage for the family (which does not exceed 102 percent of the cost of family coverage under the plan) was made to the plan with respect to the employee's family for the first 18 months of COBRA continuation coverage, and the disabled spouse and the rest of the family continue to receive COBRA continuation coverage through the 29th month.

(ii) Under these facts, the plan may require payment of up to 150 percent of the applicable premium for family coverage in order for the family to receive COBRA continuation coverage from the 19th month through the 29th month. If the plan determined the cost of coverage by reference to three categories (such as employee, employee-plus-one-dependent, employee-plus-two-or-more-dependents) or more than three categories, instead of two categories, the plan could still require, from the 19th month through the 29th month of COBRA continuation coverage, the payment of 150 percent of the cost of coverage for the category of coverage that included the disabled spouse.

Example 2. (i) The facts are the same as in *Example 1*, except that only the covered employee elects and pays for the first 18 months of COBRA continuation coverage.

(ii) Even though the employee's disabled spouse does not elect or pay for COBRA continuation coverage, the employee satisfies the requirements for the disability extension to apply with respect to the employee's qualifying event. Under these facts, the

plan may not require the payment of more than 102 percent of the applicable premium for individual coverage for the entire period of the employee's COBRA continuation coverage, including the period from the 19th month through the 29th month. If COBRA continuation coverage had been elected and paid for with respect to other nondisabled members of the employee's family, then the plan could not require the payment of more than 102 percent of the applicable premium for family coverage (or for any other appropriate category of coverage that might apply to that group of qualified beneficiaries under the plan, such as employee-plus-one-dependent or employee-plus-two-or-more-dependents) for those family members to continue their coverage from the 19th month through the 29th month.

(c) A group health plan does not fail to comply with section 9802(b) and §54.9802-1T(b) (which generally prohibit an individual from being charged, on the basis of health status, a higher premium than that charged for similarly situated individuals enrolled in the plan) with respect to a qualified beneficiary entitled to the disability extension merely because the plan requires payment of an amount permitted under paragraph (b) of this Q&A-1.

Q-2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?

A-2: (a) The applicable premium for each determination period must be computed and fixed by a group health plan before the determination period begins. A determination period is any 12-month period selected by the plan, but it must be applied consistently from year to year. The determination period is a single period for any benefit package. Thus, each qualified beneficiary does not have a separate determination period beginning on the date (or anniversaries of the date) that COBRA continuation coverage begins for that qualified beneficiary.

(b) During a determination period, a plan can increase the amount it requires to be paid for a qualified beneficiary's COBRA continuation coverage only in the following three cases:

(1) The plan has previously charged less than the maximum amount permitted under Q&A-1 of this section and the increased amount required to be paid does not exceed the maximum amount permitted under Q&A-1 of this section;

(2) The increase occurs during the disability extension and the increased amount required to be paid does not ex-

ceed the maximum amount permitted under paragraph (b) of Q&A-1 of this section; or

(3) A qualified beneficiary changes the coverage being received (see paragraph (c) of this Q&A-2 for rules on how the amount the plan requires to be paid may or must change when a qualified beneficiary changes the coverage being received).

(c) If a plan allows similarly situated active employees who have not experienced a qualifying event to change the coverage they are receiving, then the plan must also allow each qualified beneficiary to change the coverage being received on the same terms as the similarly situated active employees. (See Q&A-4 in §54.4980B-5.) If a qualified beneficiary changes coverage from one benefit package (or a group of benefit packages) to another benefit package (or another group of benefit packages), or adds or eliminates coverage for family members, then the following rules apply. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as family coverage, self-plus-one-dependent, or self-plus-two-or-more-dependents) for which the applicable premium is higher, then the plan may increase the amount that it requires to be paid for COBRA continuation coverage to an amount that does not exceed the amount permitted under Q&A-1 of this section as applied to the new coverage. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as individual or self-plus-one-dependent) for which the applicable premium is lower, then the plan cannot require the payment of an amount that exceeds the amount permitted under Q&A-1 of this section as applied to the new coverage.

Q-3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?

A-3: Yes. A group health plan must allow payment for COBRA continuation coverage to be made in monthly installments. A group health plan is permitted to also allow the alternative of payment for COBRA continuation coverage being made at other intervals (for example, weekly, quarterly, or semiannually).

Q-4: Is a plan required to allow a qual-

ified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?

A-4: No. A plan is permitted to apply the first payment for COBRA continuation coverage to the period of coverage beginning immediately after the date on which coverage under the plan would have been lost on account of the qualifying event. Of course, if the group health plan allows a qualified beneficiary to waive COBRA continuation coverage for any period before electing to receive COBRA continuation coverage, the first payment is not applied to the period of the waiver.

Q-5: What is timely payment for COBRA continuation coverage?

A-5: (a) Except as provided in this paragraph (a) or in paragraph (b) or (d) of this Q&A-5, timely payment for a period of COBRA continuation coverage under a group health plan means payment that is made to the plan by the date that is 30 days after the first day of that period. Payment that is made to the plan by a later date is also considered timely payment if either –

(1) Under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage for the period; or

(2) Under the terms of an arrangement between the employer or employee organization and an insurance company, health maintenance organization, or other entity that provides plan benefits on the employer's or employee organization's behalf, the employer or employee organization is allowed until that later date to pay for coverage of similarly situated nonCOBRA beneficiaries for the period.

(b) Notwithstanding paragraph (a) of this Q&A-5, a plan cannot require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary.

(c) If, after COBRA continuation coverage has been elected for a qualified beneficiary, a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary for a period for which the plan has not yet received pay-

ment, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights, if any, described in paragraphs (a), (b), and (d) of this Q&A-5. For example, if the plan provides coverage during the 30- and 45-day grace periods described in paragraphs (a) and (b) of this Q&A-5 but cancels coverage retroactively if payment is not made by the end of the applicable grace period, then the plan must inform a provider with respect to a qualified beneficiary for whom payment has not been received that the qualified beneficiary is covered but that the coverage is subject to retroactive termination if timely payment is not made. Similarly, if the plan cancels coverage if it has not received payment by the first day of a period of coverage but retroactively reinstates coverage if payment is made by the end of the grace period for that period of coverage, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the first date of the period if timely payment is made. (See paragraph (b) of Q&A-3 in §54.4980B-6 for similar rules that the plan must follow in confirming coverage during the election period.)

(d) If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the plan's requirement for the amount that must be paid, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. For this purpose, as a safe harbor, 30 days after the date the notice is provided is deemed to be a reasonable period of time.

(e) Payment is considered made on the date on which it is sent to the plan.

PART 602 – OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 3. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 4. In §602.101, paragraph (c) is amended by adding entries in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

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(c) * * *

CFR part or section where identified and described	Current OMB control No.
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54.4980B-6	1545-1581
54.4980B-7	1545-1581
54.4980B-8	1545-1581

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Robert E. Wenzel,
*Deputy Commissioner of
Internal Revenue.*

Approved December 28, 1998.

Donald C. Lubick,
*Assistant Secretary of
the Treasury
(Tax Policy).*

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