

# **COBRA AND HIPAA COMPLIANCE SURVIVAL**

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# MANAGING YOUR COMPLIANCE RESPONSIBILITIES

## INTRODUCTION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Internal Revenue Code in the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHSA).

The basics of the law provide continuation of certain insurance benefits for participants (Qualified Beneficiaries) that may have lost benefits because of specific events (COBRA Qualifying Events). The length of the continuation is determined by the event causing the loss of coverage.

While the law addresses continuation of *insurance* benefit rights, it is not a law mandating insurance carriers or third party administrators. COBRA is NOT an insurance law – if it was,

- insurance carriers and administrators would have the compliance liability
- as with other insurance laws, it would be policed by the Department of Insurance.

No - COBRA and HIPAA are *employer* liability laws and the compliance administration and liability are the responsibility of the employer.

- **Employers** are responsible for compliance communications
- The **IRS** and **DOL** are the policing authorities over COBRA and HIPAA
- **Penalties and fines** come in the form of an excise tax assessed by the IRS.

### **COBRA – A Simple Law**

Continuation of certain insurance benefits when participants lose insurance eligibility because of specified events. The length of continuation is determined by the loss of coverage reason.

### **Not an Insurance Law --**

#### **An *Employer* Liability law**

- IRS and DOL Laws
- Penalties
  - Excise Tax
  - ERISA Penalty
  - Pay the Claim
  - Damages
  - Attorney Fees

# MANAGING YOUR COMPLIANCE RESPONSIBILITIES

## **EMPLOYER LIABILITY**

If an employer elects to contract with an outside administrator for their compliance responsibilities, it is important to shift not only the work but, most importantly, the liability. If the outsource solution does not indemnify the employer and assume the compliance liability, then all that has been bought is a letter-writing and premium collection service – and sometimes, not even that!

### **Employer Liability**

- Self-administration
- Outsource
  - Activities AND
  - Liability

## **Risk Analysis**

Proper compliance activities involve much more than just sending a letter. Compliance procedure reviews should include a time and risk analysis – you may discover outsourcing the activities and liability to be the most cost effective solution.

A constant vigilance of legislation and litigation is required to properly maintain an accurate perspective of an employer's compliance liabilities. While a good compliance program includes tracking legislative updates, it also includes monitoring, auditing and tracking compliance activities. A good program providing a consistent administrative "picture" is the best compliance protection.

### **Not Just a Letter!**

- Track legislative changes
- Track Litigation
- Monitor Your Compliance Program

# MANAGING YOUR COMPLIANCE RESPONSIBILITIES

## HOW TO USE THIS MATERIAL

The COBRA legislation, enacted in July 1986, allows employees and/or their dependents the opportunity to temporarily continue their health plan benefits if coverage eligibility is lost due to specific Qualifying Events. The continuation time period is determined by the loss of coverage reason or qualifying event. The premium for this continued coverage is normally on a self-pay basis at 100% of the active participant cost, plus an optional 2% administrative fee.

Since the effective date, the COBRA law has been changed through amendments, guidelines, other laws, litigation and even Supreme Court Rulings.

The February 3, 1999 Final Regulations incorporated many of the changes seen since enactment of the original law. At the same time, new proposed regulations were distributed for review. These regulations were finalized January 10, 2001.

This handbook is a good basic guide to understanding the COBRA and HIPAA laws but, is in no means meant as a single source compliance solution. Constant awareness and review of COBRA and HIPAA activities is a must for keeping any program in compliance.

### Constantly Changing

- Proposed Guidelines
- Amendments
- Other laws
- Litigation
- Supreme Court Rulings
- Final Regulations
- New Proposed Guidelines
- **NEWER** Final Regulations

### **FINALIZED GUIDELINES and REGULATIONS**

- **FINAL REGULATIONS**  
February 3, 1999 to be effective in plans beginning January 1, 2000
- **NEWER FINAL REGULATIONS**  
January 10, 2001 to be effective in plans beginning January 1, 2002

# MANAGING YOUR COMPLIANCE RESPONSIBILITIES

## MANAGING YOUR COMPLIANCE PROGRAM

One of the first things the IRS or DOL audit requests is a copy of a company's written COBRA and HIPAA Procedure Manual. And yet, many employers have no written manual.

- *"We have all the information in the files."*
- *"It is all in Mary's head – it's not written."*
- *"We have outsourced our COBRA and HIPAA – we don't need a manual – they do it all!"*

None of these are sufficient answers to an auditor. A written COBRA and HIPAA Procedure manual is required of every employer. Even if the employer has outsourced the activities to an administrator, carrier or third party, maintenance of a procedure manual is still required.

## PROCEDURE MANUAL

The manual is a guide of when and what must be done to be in compliance. It should have the basics of the law and the procedures an employer follows when an event occurs. Even if the employer has outsourced their COBRA and HIPAA responsibilities, they must still maintain a working knowledge of the law to know when a compliance activity is required.

**COBRA and HIPAA  
Procedure Manual**

**Every Employer Must  
Maintain a Written  
Procedure Manual**

**Book of Your Compliance  
Program**

**The FIRST Thing the IRS  
Wants To See**

# COBRA and HIPAA PROCEDURE MANUAL

## PROCEDURE MANUAL (cont)

### ✓ **Basics of the Laws**

The COBRA & HIPAA Procedure Manual should include the basics of the law – a paper copy is not required. It is best to download the laws to your computer. This way you can use the “word search” capabilities to find the area of the law you may be seeking.

Electronic copies of the law may be found on the IRS and DOL websites  
[www.irs.gov](http://www.irs.gov) or [www.dol.gov](http://www.dol.gov).

From the Home Page, click on the word EMPLOYERS, then RESOURCES. Here you will find

- 1999 Final COBRA Regs
- 2001 NEWER Final Regs
- 2002 Trade Act

Each regulation refers to the previous - you must download all three of the regulations in order to obtain a full “picture” of the law.

## **COBRA and HIPAA Procedure Manual**

- ✓ **Basics of the Laws**
- ✓ **Update Sources (Legislation, Litigation, IRS and DOL rulings, Compliance consultants)**
- ✓ **Copies of Notices**
- ✓ **COBRA Premium calculations**
- ✓ **Corporate Compliance Philosophy (i.e. receive a less than significantly short payment)**
- ✓ **Exception Practices (who can make exceptions)**
- ✓ **Proof of Training**
- ✓ **Tracking System – established, monitored and updated**
- ✓ **Audit Record**
- ✓ **Activity Standards (i.e. what to do if a lawyer calls . . .)**

# COBRA and HIPAA PROCEDURE MANUAL

## PROCEDURE MANUAL (cont)

- ✓ **Update Sources (Legislation, Litigation, IRS and DOL rulings, Compliance consultants)**

Your manual must include Update Sources – how to keep up with the changes in the COBRA and HIPAA laws? Obviously, you probably do not read the Federal Register everyday. But, what source do you have to track the changes in the laws? While you could periodically monitor the IRS and DOL websites, it would be difficult to find the changes.

You may want to subscribe to Legislative and Litigation Review Services or a Benefit Publication. An excellent source for updates is your Compliance Administrator.

- ✓ **Copies of Notices**

Sample copies of all Communications of Compliance should be maintained in your manual.

- Initial HIPAA Rights Notice (Special Enrollment Rights)
- Initial COBRA Rights Notice
- HIPAA Certificate of Creditable Coverage
- COBRA Election Notice

### **COBRA and HIPAA Procedure Manual**

- ✓ **Basics of the Laws**
- ✓ **Update Sources (Legislation, Litigation, IRS and DOL rulings, Compliance consultants)**
- ✓ **Copies of Notices**
- ✓ **COBRA Premium calculations**
- ✓ **Corporate Compliance Philosophy (i.e. receive a less than significantly short payment)**
- ✓ **Exception Practices (who can make exceptions)**
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- ✓ **Tracking System – established, monitored and updated**
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# COBRA and HIPAA PROCEDURE MANUAL

## PROCEDURE MANUAL (cont)

### ✓ **COBRA Premium calculations**

A COBRA premium page must be maintained in your manual. This page should provide an actuarial calculation of the premium charged your COBRA participants (see page 44 for allowable COBRA premium calculation procedures).

### ✓ **Corporate Compliance Philosophy**

#### *Less than significantly short payment)*

The COBRA law provides two options for handling less than significantly short COBRA payments – which option will you take? You must know now, before a short payment is received (see page 45 for short payment and NFS procedures).

#### *Exceptions*

Your manual should identify the Corporate Officer with COBRA and HIPAA exception authority. Of course, it is best that exceptions not be made. Exceptions open your company to discrimination and unnecessary financial risk and exposure.

### **COBRA and HIPAA Procedure Manual**

- ✓ **Basics of the Laws**
- ✓ **Update Sources (Legislation, Litigation, IRS and DOL rulings, Compliance consultants**
- ✓ **Copies of Notices**
- ✓ **COBRA Premium calculations**
- ✓ **Corporate Compliance Philosophy (i.e. receive a less than significantly short payment)**
- ✓ **Exception Practices (who can make exceptions)**
- ✓ **Proof of Training**
- ✓ **Tracking System – established, monitored and updated**
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- ✓ **Activity Standards (i.e. what to do if a lawyer calls . . .)**

# COBRA and HIPAA PROCEDURE MANUAL

## PROCEDURE MANUAL (cont)

### ✓ **Proof of Training**

The IRS monitors the training schedule of the personnel responsible for your company's COBRA and HIPAA activities. Training should be received at least once a year – while the law may not change every year, frequent litigation gives us clarification of the laws.

### ✓ **Tracking System – established, monitored and updated**

How does your company discover a COBRA or HIPAA compliance event has occurred? Is there a delay in information flowing from payroll to the HR department? If your company has satellite offices, what is the timeline from the satellite office to corporate?

### ✓ **Audit Record**

The IRS expects companies to audit their compliance activities and program at least once a year.

### ✓ **Activity Standards (i.e. what to do if a lawyer calls . . .)**

**EVERY** employee of your company should know what to do if a lawyer, government official, or the press calls on their phone line.

### **COBRA and HIPAA Procedure Manual**

- ✓ **Basics of the Laws**
- ✓ **Update Sources (Legislation, Litigation, IRS and DOL rulings, Compliance consultants**
- ✓ **Copies of Notices**
- ✓ **COBRA Premium calculations**
- ✓ **Corporate Compliance Philosophy (i.e. receive a less than significantly short payment)**
- ✓ **Exception Practices (who can make exceptions)**
- ✓ **Proof of Training**
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- ✓ **Audit Record**
- ✓ **Activity Standards (i.e. what to do if a lawyer calls . . .)**

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

## PURPOSE

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law by President Clinton on August 21, 1996. The law defines its primary purpose as “improving the portability and continuity of health insurance coverage in the group and individual markets.”

### HIPAA - PURPOSE

“To improve Portability and Continuity of Health Insurance Coverage in Group and Individual Markets”

- ACCESS and RENEWABILITY
- PORTABILITY

## WHO MUST COMPLY?

Employers with two or more employees on their group insurance plan must comply with the HIPAA regulations. The law defines a group health plan as “an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.”

### WHO MUST COMPLY?

- Two or more in a Health Plan
- Federal Government – EXEMPT
- OPT OUT OPTION FOR Self-Funded Non-Federal Government Entities

WHO CAN OPT OUT – self-funded, non-federal government plans (state, county, municipality, school district . . .)

## HOW IT WORKS

Improved access is provided through Guarantee Issue and Special Enrollment provisions for those that may opt out of the group plan.

HIPAA Portability is accomplished by limiting exclusions for pre-existing medical conditions and providing credit for prior medical coverage. This credit is verified by Certificates of Creditable Coverage.

### HOW IT WORKS

- GI and Special Enrollment opportunities
- LIMIT and GIVE CREDIT for Pre-existing Medical Conditions

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

## CERTIFICATES OF CREDITABLE COVERAGE

As proof of prior coverage, employers are responsible for issuing or giving notice that the participant is eligible to receive a Certificate of Creditable Coverage when coverage is lost.

Certificates should be mailed to the last known address of the participant that has lost coverage.

Certificates for dependents residing in a different household from the employee must be mailed to that different address.

### CERTIFICATES of COVERAGE

- For ANY loss of coverage
- Catch-up certificates 7-1-96
- On-going Certificates 7-1-97
  
- Dependents different address – separate notice as of 6-1-98
  
- PENALTY - \$100 A DAY

## CREDITABLE COVERAGE

Creditable Coverage is limited to comprehensive HEALTH coverage – group, individual, COBRA, Medicare, Medicaid or public health plans. It does not include disease specific or limited coverage plans such as cancer, dental, vision or hospital indemnity benefits (\$100 a day while in the hospital).

### CREDITABLE COVERAGE

- HEALTH ONLY
  
- NO Disease specific or limited policies

## HIPAA CHANGES

When groups became HIPAA groups (Anniversary Date on or after July 1, 1997) the pre-existing condition clause of the contract changed. The clock begins on the ENROLLMENT DATE; the LOOK BACK is limited to 6 months prior to the enrollment date; the LOOK FORWARD period is limited to 12 months (except for late enrollees); pregnancy is not included in the pre-existing condition definition. The program must now allow special enrollment opportunities.

### NEW DEFINITIONS

- ENROLLMENT DATE
- 6 Month Look Back
- 12 Month Look Forward
  
- No Pre-X on Maternity

## 63 DAY GAP

The Certificate of Creditable Coverage is only good for 63 days from the time coverage ends to the time an individual policy is effective or the participant is employed – 1<sup>st</sup> day of the waiting period. If a significant gap in coverage occurs, no pre-existing credit must be given.

### 63 DAY GAP

- From end of coverage to ENROLLMENT Date –date of hire

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

## PRE-X CLOCK BEFORE HIPAA

Before HIPAA the pre-existing condition clock began with the DATE OF COVERAGE. A normal pre-existing condition exclusion period was 12 months. This provided a full 12 months of premium to be collected before the program began to pay for pre-existing conditions.

PRE-X CLOCK – BEFORE
<ul style="list-style-type: none"><li>Begins with <span style="border: 1px solid black; padding: 2px;">Date of Coverage</span></li></ul>
Hire --Wait-- <span style="border: 1px solid black; padding: 2px;">Cov</span> -Pre – X

## PRE-X CLOCK AFTER HIPAA

HIPAA changed the beginning date of the pre-existing condition clock from the date of coverage to the ENROLLMENT DATE (date of hire in an eligible for insurance job) and normally ends 12 months from the date of hire.

HIPAA PRE – X CLOCK
<ul style="list-style-type: none"><li>CHANGED Begins with <span style="border: 1px solid black; padding: 2px;">DATE OF HIRE</span></li></ul>
<span style="border: 1px solid black; padding: 2px;">Hire</span> –Wait – Cov -- Pre-X

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

## ENROLLMENT OPPORTUNITIES

Every employer has two types of employees – those that enroll in the insurance program and those that do not. Employers must have an application on file for BOTH types of employees.

## OPEN ENROLLMENT

Some states have their own laws concerning enrollment opportunities and mandate annual open enrollments. Normally, only FULLY INSURED groups must abide by state laws. Self-funded groups can ignore most state laws but must abide by ERISA and FEDERAL LAWS. HIPAA is a Federal Law. It does NOT require an open enrollment provision. However, many plans have this option in their program. An open enrollment provision is normally coordinated with the program's anniversary date and allows participants previously declining group insurance to enroll in the insurance program.

Plans without an open enrollment provision have provided ONE "Everybody In" enrollment opportunity. This enrollment was for people that had been previously declined coverage because of their medical condition or never applied because they thought they would have been declined. This guideline was not put in place until January 98.

## LATE ENROLLEE

The HIPAA law regarding enrollment provisions for LATE ENROLLEES has changed since the law passed. There are now two late enrollee options

- 1) Allow late enrollees to enroll at anytime subject to an 18 month pre-existing condition waiting period.
- 2) Allow late enrollees to enroll during an annual enrollment period.

## TYPES OF EMPLOYEES

- On the Coverage
- Not on the Coverage
  - have other coverage
  - just don't want it

## OPEN ENROLLMENT

- Is it required?
- Is it an option?
- Everybody In Enrollment – Jan 98

## LATE ENROLLEE

- Enroll anytime - 18 month pre-x
- Annual Enrollment

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

## SPECIAL ENROLLMENT OPPORTUNITIES

The HIPAA law requires special enrollment provisions be included in all HIPAA contracts. Some persons may have previously declined coverage because of having other coverage. Should they LOSE that coverage, this creates a special enrollment opportunity.

SPECIAL ENROLLMENT
<ul style="list-style-type: none"> <li>• LOSE ??? other Coverage</li> </ul>

## SPECIAL ENROLLMENT OPPORTUNITIES

For employees that originally declined coverage, marriage, birth and adoptions also trigger special enrollment opportunities for the employee, new spouse or child. All participants must apply for coverage within 30 days of the event.

ENROLLMENT OPPORTUNITIES
<ul style="list-style-type: none"> <li>• Marriage</li> <li>• Birth or Adoption</li> </ul>

## HIPAA CHANGES COBRA

The HIPAA legislation amended parts of the COBRA continuation law. These changes were effective January 1, 1997.

- Expanded the eligibility for COBRA 11 month disability extension to participants whose date of SS disability was in the first 60 days of COBRA coverage.
- Extension eligible for not only the person with the disability but, all Qualified Beneficiaries of the family.
- Established newborn or newly adopted child added to COBRA coverage as a qualified beneficiary.
- Clarified that COBRA coverage should cease when a Qualified Beneficiary satisfies the pre-existing condition waiting period on a newly acquired insurance plan.

HIPAA CHANGES TO COBRA
<ul style="list-style-type: none"> <li>• Date of SS Disability in the first 60 days of COBRA coverage</li> <li>• Family members also eligible for the 11 month extension</li> </ul>

OTHER CHANGES
<ul style="list-style-type: none"> <li>• New Qualified Beneficiaries – newborn or newly adopted</li> <li>• COBRA coverage ends when new coverage is gained</li> </ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### SIMPLE LAW

The COBRA law is actually a very simple law. It identifies *Qualified Beneficiaries* (employees and dependents active on the coverage the day before the COBRA qualifying event). Should a Qualified Beneficiary lose insurance benefits because of certain specified reasons (*qualifying events*) they are allowed to continue the same insurance benefits as the non-COBRA participants. These benefits will be provided on a self-pay basis. This premium may also include a 2% administrative fee.

While the concept of the law is simple, the administration is much more difficult. Strict timelines for notices, elections, and payments are specified in the law.

Stepping outside, or not following the provisions of the law, could result in the employer totally self-insuring a claim situation or risking discrimination or litigation.

Again, this is an employer law. If the employer stays within the letter of the law, the carrier or third party administrator must abide by the law. But, if the employer steps outside the letter of the law, they will likely be stepping outside by themselves – the carrier is not required to support the “outside of the law” activity.

### COBRA CONTINUATION

- Continuation of coverage
- Loss of coverage due to specified Qualifying Events
- 102% premium

### LETTER OF THE LAW

- Employer Law
- Carriers or TPAs support only by the letter of law
- Exceptions or Non-compliance situations outside the letter of the law may become the total responsibility of the employer

# COBRA CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

**WHO MUST COMPLY**

COBRA is an IRS and DOL law. This explains why the employee count “test” is determined on a Jan 1 to Dec 31 time frame.

All health plan-sponsoring employers having 20 or more employees over half of the typical business days in the preceding calendar year, must comply with COBRA continuation provisions for participant losing insurance during the next calendar year. The only employer exceptions are:

- The Federal Government
- Church Plans (as defined in section 414 (e) of the IRS Code)

WHO MUST COMPLY
<ul style="list-style-type: none"> <li>• 20 or more employees</li> <li>• over ½ the working days in the PREVIOUS calendar year – offer COBRA during ALL of the current calendar year</li> <li>• Exceptions                             <ul style="list-style-type: none"> <li>– Federal Govt</li> <li>– Churches – 414 (e) IRS Code</li> </ul> </li> </ul>

**EMPLOYEE COUNT**

The employee count process changed with the 2001 Final Guidelines but, still maintains this premise – this is a basic employee count - eligibility for insurance is not a determining factor.

The 2001 Final Guideline employee definition includes all full-time and part-time employees, officers and owners. In the 1987 proposed guideline, this was a simple “body count” however; the 2001 guidelines use a full-time equivalency formula when counting part-time employees.

EMPLOYEE COUNT
ALWAYS COUNT
<ul style="list-style-type: none"> <li>• Full-time</li> <li>• Part-time – by full-time equivalency formula</li> </ul>
$\frac{\# \text{ hours worked as PT}}{\# \text{ hours required to be FT}} = \text{full-time equivalent ratio}$

# **COBRA CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT**

## **HOW MANY EMPLOYERS**

The COBRA law relies on other laws such as ERISA and DOL to define employers. The law includes special COBRA compliance provisions in instances of common ownership, multi-employer plans and multiple employer plans. It is critical that a plan understand their specific identity when determining their compliance liabilities.

## **COMMON OWNERSHIP PROGRAMS**

If companies are commonly owned by an individual or individuals, it is likely that the companies should be viewed as one when determining a COBRA compliance obligation. An example of this would be when determining the employee count.

For Example: Two companies with one owner, two tax ID numbers, 15 employees each. Even though they appear as two companies, the common ownership brings them together when making a COBRA determination. The result is an employer with 30 employees and both employers are COBRA Plans.

<b>COMMON OWNERSHIP</b>	
<b><u>A Place</u></b>	<b><u>B Place</u></b>
<ul style="list-style-type: none"><li>– both owned by Joe</li><li>– both with 15 employees</li><li>– two different insurance plans</li></ul>	
Both A and B Place are COBRA Plans	

<b>COBRA</b> <b>CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT</b>
---

**MULTI-EMPLOYER PROGRAMS**

A Multi-Employer Plan is a plan to which more than one employer is required to contribute (i.e. collective bargaining agreement plans). In most instances, it is the employer that has the COBRA compliance responsibilities – however, in multi-employer plans, it is the plan that must comply. While each employer is looked at individually, if ONE employer meets the “20+ employee test, the entire plan (ALL employers) become COBRA Plans.

<b>MULTI-EMPLOYER PLAN</b>
If even just ONE employer in the program is a COBRA required plan, then the entire multi-employer plan becomes a COBRA program.

**MULTIPLE-EMPLOYER PROGRAMS**

Often times, multiple employers come together to gain the pricing and negotiating advantage of “numbers” (i.e. associations or MEWAs). These multiple-employer plans are viewed differently from a multi-employer plan when the COBRA test is given. Each employer plan is looked at individually when making the COBRA determination.

<b>MULTIPLE-EMPLOYER PLAN</b>
Each employer is looked at individually for COBRA determination. Compliance requirements for one employer have no effect on other employers in the plan.

# **COBRA**

## **CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT**

### **WHO MUST BE OFFERED COBRA**

The original COBRA law gave us a “new” language with words like qualified beneficiary and qualifying events. A qualified beneficiary is an individual covered under the employer’s health plan the day before the COBRA qualifying event. The law defines a qualified beneficiary as a covered employee, covered spouse of the employee, covered dependent child of the employee or, as provided for by the HIPAA law, any child born to, or placed for adoption with, the covered employee during the period of continuation coverage.

Each Qualified Beneficiary has their own individual right to continuation. Nothing is contingent upon the employee continuing.

Qualified Beneficiaries have a number of other special benefits through the COBRA law. These benefits will be discussed later.

The COBRA law also provides benefits for NON-Qualified Beneficiaries. These are dependents (other than newborns or adopted children) added to COBRA coverage after it has begun. Domestic Partners may also fall into this category. Continued eligibility for non-qualified beneficiaries IS contingent upon the original COBRA beneficiary remaining eligible and continuing coverage.

<b>QUALIFIED BENEFICIARY</b>
<ul style="list-style-type: none"><li>• Effective on coverage the day BEFORE the qualifying event</li><li>• Employee and dependents</li><li>• Newborn or adopted child added to COBRA coverage</li><li>• Each has their OWN ELECTION RIGHT</li></ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### **WHAT PLANS MUST BE OFFERED**

For COBRA purposes, “a *group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have employment –related connection to the employer or employee organization or to their families.*”

Many people mistakenly interpret the “health plan” wording of the law to mean that only health insurance plans must be offered under COBRA. This is incorrect. The law goes on to clarify that “health plan” includes plans that reimburses medical expenses through a health, dental, vision, prescription drug programs, flexible spending accounts and /or some Employee Assistance Programs.

The law also explains that employer contribution is NOT a requirement – “a *group health plan is maintained by an employer or employee organization even if the employer or employee 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*”.

### **WHAT PLANS MUST BE OFFERED**

- Health
- Dental
- Vision
- Rx
- FSA – Medical Reimbursement Account
- EAP

### **WHAT PLANS MUST BE OFFERED**

- Employer contribution is NOT a requirement
- Is same coverage available at same cost on an individual basis?

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### **WHAT PLANS MUST BE OFFERED** **(cont)**

In addition to the group plan, employers must review all plans providing COBRA eligible benefits to determine any possible COBRA obligation.

#### **Portable Individual Payroll Deduct Plan**

Some payroll deduct plans are truly portable individual plans. When an employee leaves, they take the policy with them and simply change the billing address to their home. If your plan is of this type, it is truly portable. Since no coverage has been lost, there is no COBRA obligation.

#### **COBRA Required Payroll Deduct Plan**

However, some payroll deduct plans are actually group plans and eligibility is based on employment or employee organization membership. In these plans, loss of eligibility results in loss of coverage. Your question should be – “can they take it with them at the same price and the same benefit level?” If the answer is “NO” - there is a COBRA obligation.

### **WHO WILL STAND BY YOU IN COURT?**

COBRA is an *employer law*, and many areas of compliance should be determined with the help of legal counsel; confirm with your carrier their interpretation of the law. Of course, you must ask an accurate question to get a correct answer. And, be sure to get that interpretation in writing!

#### **VOLUNTARY PLAN TEST**

- Is it a COBRA benefit
- Is ANYONE paying for coverage?
- Is it portable?
- At the same benefit level?
- At the same price?

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### WHAT PLANS MUST BE OFFERED

#### One Plan – Separate Plans

Employers should also examine the number of “plans” offered. While a controversial area, it is a critical step of compliance to determine “one” plan or “multiple” plans. For example, if an employer offers a package health plan and dental plan, must a COBRA participant elect both health and dental, or can they continue either plan?

From the 2001 Final Regulations we find that a plan will *constitute one health plan, unless –*

- 1) *It is clear from the instruments governing an arrangement to provide health care benefits under separate plans;*
- 2) *The arrangement or arrangements are operated pursuant to such instruments as separate plans”*

Many employers have determined that programs administered through separate contracts or policies, are separate “governing instruments” and COBRA participants can pick and choose between plans. However, benefits provided through one “governing instrument” (dental benefits as a rider to a health contract – integrated plan) require the plan be continued as one.

The 1987 proposed regulations even provided core and non-core wording to identify options available, but the 1999 Final Regulations eliminated this provision.

HOW MANY PLANS
<ul style="list-style-type: none"> <li>• One Plan – COBRA participant must elect the benefits as a package</li> <li>• Separate Plans – COBRA participants can choose between the plans</li> <li>• Good Guide - benefits provided through one contract or multiple contracts?</li> <li>• Language of the law - “instruments governing an arrangement” I</li> </ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### WHAT PLANS MUST BE OFFERED

#### COBRA and FSAs

Health Flexible Spending Accounts, as defined by the IRS, are self-funded health plans and COBRA eligible.

If FSA plan can qualify for an exception, COBRA continuation is not required to be offered. This provision is confusing and the best advice may be - contact your 125 administrator for guidance in determining a COBRA obligation.

#### Qualifying for the Exception

To qualify for the exceptions, the health FSA must meet the following two conditions:

- 1 – The health FSA must be exempt from HIPAA; (HIPAA Exemption) a two prong test
  - a) The maximum benefit under the health FSA cannot exceed two times the employee’s salary reduction for the year or, if greater, the amount of the employee’s salary reduction plus \$500 – maximum benefit condition.
  - b) The employee must have other coverage available under the group health plan of the employer and the other coverage cannot be limited to benefits which are excepted benefit under HIPAA – availability condition
- 2 – The maximum annual COBRA premium chargeable for health FSA continuation coverage must equal or exceed the maximum annual health FSA coverage amount (Premium Exemption).

EXCEPTION QUALIFICATION
<p style="text-align: center;">Benefits Under the FSA Are Exempted from HIPAA</p> <ul style="list-style-type: none"> <li>• Maximum Benefits Condition</li> <li>• Availability Condition</li> </ul>
<p style="text-align: center;">Annual COBRA Premium Equals or Exceeds the Annual Coverage Amount</p> <ul style="list-style-type: none"> <li>• In most instances the cost will be equal to or less than 102%</li> </ul>

# **COBRA**

## **CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT**

### **WHAT PLANS MUST BE OFFERED**

COBRA and FSAs (cont)

If your plan cannot qualify for the exemptions, the Un-reimbursed Medical Expense Account portions of your Flexible Spending Account may result in a COBRA obligation.

To make the COBRA determination, the status of the Un-reimbursed Medical Expense Account must be reviewed.

Many employers do not understand the reasoning behind the COBRA offering but, electing COBRA may be the only way reimbursement can be received for a health FSA claim incurred after a qualifying event.

The 2001 Final COBRA Regulations provide a formula for determining the employer's COBRA obligation. If the account has been overspent, no COBRA offering must be made.

### **FSA FORMULA**

If the remaining benefit available is less than the amount left to pay until the end of the benefit plan year, then no COBRA offering should be made.

However, if the benefit available is MORE than the amount left to pay, there is a COBRA obligation.

### **FSA COBRA FORMULA**

If the health FSA account has been overspent, a COBRA offering is not required

If a COBRA offering is required, it must be offered only through the end of the Plan year

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### WHAT PLANS MUST BE OFFERED (cont)

#### REGION SPECIFIC COVERAGE

Qualified Beneficiaries need only be offered the coverage in effect prior to their qualifying event. However, COBRA coverage is not just benefits, it is also the other parts of the benefit program. Qualified beneficiaries are eligible for benefits, open enrollment opportunities, adding dependents . . .

A good rule to remember is “anything an active participant can do, a COBRA participant can do, plus a little more”.

The regulations make special mention of qualified beneficiaries and region-specific benefit programs. What if a qualified beneficiary moves from the region - specific service area? Can they change plans? They have the same rights as a non-COBRA participant.

*If a qualified beneficiary participates in a region-specific benefit package that will not service his or her needs in the area to which he or she is relocating, 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 only offers a region-specific plan, the regulations specify that the employer’s COBRA obligation remains, even if the coverage option is of little or no use to the qualified beneficiary.

Anything an active participant  
can do, a COBRA participant  
can do

+

a little more

# **COBRA**

## **CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT**

### **ALTERNATE COVERAGE**

Insurance benefits are not required to be totally lost for a COBRA Qualifying Event to occur - simply a difference in the way benefits were provided. For instance, a number of employers allow retirees to remain on the insurance plan until they reach Medicare Entitlement.

Some would say, this retirement is NOT a COBRA qualifying event – coverage was not lost. However, the 1999 Final Regulations discuss instances where an employer may have a COBRA obligation.

Is the contribution the same? If the retiree is required to pay a larger portion of the premium, then there has been a COBRA Qualifying Event.

The retiree has a decision:

- COBRA – pay 102% premium for 18 months or as long as eligible
- Retiree coverage – employer pays a portion for as long as there is a retiree plan

Should the retiree plan be cancelled, the employer must review each participant in the retiree program. Any participant on the retiree plan for less than 18 months (the time they would have had COBRA), the coverage must be continued for the remainder of the 18 – month period.

Dependents may still experience 2<sup>nd</sup> qualifying events during the alternate plan period should retiree plan cancel.

<b>ALTERNATE COVERAGE</b>
<ul style="list-style-type: none"><li>• Benefit or contribution difference can trigger a COBRA event</li><li>• Retiree should be given a choice – COBRA or Retiree coverage</li><li>• 2<sup>nd</sup> Qualifying Events may still occur</li></ul>

<h1 style="margin: 0;">COBRA</h1> <h2 style="margin: 0;">CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT</h2>
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**QUALIFYING EVENTS REQUIRE A COBRA OFFERING**

The COBRA law specifies that COBRA continuation be offered only if coverage is lost as the result of specific Qualifying Events. The law defines loss of coverage to mean *ceases to be covered under the same terms and conditions as in effect immediately before the Qualifying Event*. The event determines the length of continuation.

QUALIFYING EVENTS
<ul style="list-style-type: none"> <li>• Loss of Coverage due to QE</li> <li>• 18 Month Events</li> <li>• 36 Month Events</li> </ul>

**18 - MONTH EVENTS**

18 - Month Events provide a continuation opportunity for the employee and dependents.

- Termination – Voluntary or Involuntary (Exception - Gross Misconduct)
- Reduction in hours
- Layoff

Terminations due to Gross Misconduct seem to be the most contentious. There is no clear definition of gross misconduct – not in the COBRA law or any other Federal labor law. Many an employer has found that their definition of gross misconduct has not been communicated sufficiently. Unfortunately, this discovery is made by way of a court case.

18 MONTH EVENTS
<ul style="list-style-type: none"> <li>• Termination               <ul style="list-style-type: none"> <li>- Voluntary or Involuntary</li> <li>- Exception</li> <li>- Gross Misconduct</li> </ul> </li> <li>• Reduction in hours</li> <li>• Reduction in hours</li> <li>• Layoff</li> <li>• Layoff</li> </ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### FAMILY MEDICAL LEAVE ACT

In 1993 a Federal law was put in place for employers of more than 50 employees – the Family Medical Leave Act (FMLA). This provides employees the opportunity of leave of absence due to family medical situations. FLMA is NOT a COBRA Qualifying Event. However, an event could occur if the employee does not return to work at the end of the FLMA period.

FMLA
<ul style="list-style-type: none"><li>• Employers 50+</li><li>• FMLA is NOT a COBRA Event</li><li>• Could be a COBRA event if they do not return</li></ul>

### FMLA – WHO MUST PAY

The employer must continue insurance coverage during the leave under the same conditions as before the leave including the payment arrangement. Employer pays 100% for an active employee, this same contribution is continued during the FMLA leave.

If the program is a contributory plan, the employer may *request* the employee contributions be continued during the leave. But, even if the employee fails to make the proper contribution during the leave, when the employee returns to work after the leave, they must be placed back on the insurance program as if they never left. This includes without being subject to waiting periods.

If they do not return to work after the leave, a COBRA event may occur but, not until the FMLA leave is exhausted.

FMLA – WHO MUST PAY
<ul style="list-style-type: none"><li>• Employer pays 100% Must continue</li><li>• Contributory Plan May request payment but . . .</li></ul>

# **COBRA**

## **CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT**

### **ON the JOB INJURY LEAVE**

In some states, workers compensation law requires the employer to continue the health plan coverage. And some employers may even have a corporate policy that provides coverage during this leave. Depending on the policy, a “reduction in hours” qualifying event may have occurred.

<b>On the JOB INJURY</b>
<ul style="list-style-type: none"><li>• Does the State require health plan coverage to continue</li><li>• Does the employee meet the health plan definition of an eligible participant</li></ul>

### **LEAVE and COBRA**

It is critical that employers review their Employee Handbook to ensure the leave policies described in the handbook are supported by the insurance contracts.

For example, an Employee Handbook provides for an additional 12 weeks of medical leave available after FMLA is exhausted. And yet, this is not supported by the definition of an eligible participant in the insurance contract. An employer may find themselves self-insuring any claims in the additional 12-week medical leave period.

<b>REVIEW LEAVE POLICIES</b>
<ul style="list-style-type: none"><li>• Employee Handbook</li><li>• Insurance Contracts</li><li>• Are you sure leave policies are supported by contract language?</li></ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### **36 - MONTH EVENTS**

36 - Month Events entitle only the dependents the opportunity to continue coverage.

- Death of the Employee
- Employee's Medicare Entitlement
- Legal Separation or Divorce
- Dependent child no longer meets dependent definition

Again, these events are not as simple as they seem.

For instance, would an *active* employee lose insurance benefits simple because they became entitled to Medicare? That would surely be an illegal program.

However, should a COBRA participant gain other coverage (including Medicare entitlement), this could be a second qualifying event for other qualified beneficiaries on the COBRA coverage. This will be discussed later as we review the 1998 Supreme Court Ruling.

Another difficult area is the Legal Separation or Divorce event. Often times employees will simply tell the employer to drop the dependent and not reveal the reason. It is critical that the employer be "nosey" – depending on the reason, the employer may have a COBRA obligation. Of course, this information could put the employer in the middle of a divorce!

<b>36 MONTH EVENTS</b>
<ul style="list-style-type: none"> <li>• Death of the Employee</li> <li>• Employee's Medicare Entitlement</li> <li>• Legal Separation or Divorce</li> <li>• Dependent child no longer meets the eligible dependent definition</li> </ul>

<b>Any Loss of Coverage</b>
<ul style="list-style-type: none"> <li>• KNOW WHY!</li> <li>• The Employer must determine if there is a COBRA obligation</li> </ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### 36-month Events (cont)

The 1999 Final Regulations provide that if coverage is *reduced or eliminated in anticipation of a qualifying event, the elimination or reduction is disregarded in determining whether the event causes a loss of coverage*. The primary purpose of this provision is to protect the employer when an employee eliminates a spouse's coverage in anticipation of a divorce.

While the coverage may be dropped, the qualifying event and COBRA offering will not occur until the "true qualifying event" has occurred – the legal separation or divorce.

Unfortunately, the law provides no "event must occur within a certain time frame" language. In difficult divorce situation, this could leave the employer with a pending COBRA obligation for a number of months. And yet, because of these situations, "time frame" language could not be included.

The "gap" goes against the "covered on the day before the qualifying event" provision of the law.

And, what if the employee drops the spouse in anticipation of the divorce and then they reconcile. When can the spouse be added back on the plan? Probably not until the next open enrollment or special enrollment event.

#### IN ANTICIPATION OF AN EVENT

- Drop Spouse before Divorce is Final
- How Long Before
- Gap in Coverage
- What if They Reconcile

#### Protect Your Plan

- Premium run through a 125 plan – cannot drop until divorce is final!
- Check divorce decree – CAN they drop the dependent?

# **COBRA**

## **CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT**

### **SUPREME COURT RULING**

**June 98**

In June 1998, the Supreme Court ruled in *Geissel vs. Moore Medical* to clarify COBRA eligibility for participants with other coverage in place prior to a COBRA qualifying event. Prior to this ruling, some employers limited COBRA offerings if the participant was already covered by another insurance plan.

The Supreme Court ruled that “other coverage (including Medicare entitlement) in place PRIOR to the election of COBRA coverage should be ignored when determining COBRA eligibility.”

Let’s confirm the definition of Medicare Entitlement – actually participating in Medicare – either Part A or B.

A qualified beneficiary’s COBRA coverage should cease when they gain other coverage (including Medicare entitlement) and satisfy the pre-existing condition waiting period on that new coverage.

#### **COVERAGE PRIOR TO COBRA ELECTION**

- Ignore Other Coverage in Place Prior to the Election of COBRA Continuation

#### **COVERAGE GAINED AFTER COBRA ELECTION**

- Coverage Gained After COBRA Election May Limit COBRA Continuation Rights

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### EXTENSION OF COBRA COVERAGE

Situations may occur that extend COBRA continuation coverage past the original 18 – month period.

There are two types of extensions:

1) Second Qualifying Event – allows qualified beneficiaries already on COBRA to extend their COBRA coverage up to 36 months due to another qualifying event

2) Social Security Disability Extension – allows eligible participants and other family members up to an 11-month extension.

#### Second Qualifying Event

At times, COBRA participants may experience another COBRA qualifying event. Only certain qualified beneficiaries (dependents on coverage prior to the original qualifying event) are eligible for second qualifying event extensions. For example, should a couple divorce while on COBRA, this is a second qualifying event and the dependent is eligible for COBRA continuation for up to 36 months – not an additional 36 months of coverage – but calculated from the original qualifying event.

Only 36-month qualifying events result in second qualifying events. 18-month events cannot be stacked for additional coverage.

EXTENSION OF COBRA
<ul style="list-style-type: none"><li>• Second Qualifying Event</li><li>• Social Security Disability Extension</li></ul>

SECOND QUALIFYING EVENTS
<ul style="list-style-type: none"><li>• Only Qualified Beneficiary dependents are Eligible</li><li>• Coverage Period is Calculated From the Original Qualifying Event Date</li></ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### EXTENSION OF COBRA COVERAGE (cont)

#### Social Security Disability Extension

The COBRA law provides Certified Social Security Disabled participants and their families up to an 11-month extension of COBRA coverage. The extension is meant to fill the gap left from the original 18 months of COBRA and 29-month waiting period for Medicare benefits – under the age of 65. The HIPAA legislation amended parts of the COBRA continuation law effective 1-1-97.

Eligibility for the extension is contingent upon the following:

- The original qualifying event must be termination of employment or reduction in work hours
- The Qualified Beneficiary's date of disability, as determined Social Security, must prior to or anytime within the first 60 days of COBRA coverage
- The Qualified Beneficiary must notify the plan administrator within 60 days of the Social Security determination date and before the end of the original 18-month period.

The extension of coverage applies not only to the person with the disability but, also to all qualified beneficiaries. During the 11-month extension, 150% of the applicable premium can be charged if the person with the disability is on the coverage.

SS DISABILITY EXTENSION CRITERIA
<ul style="list-style-type: none"> <li>• Original Qualifying Event is termination or reduction in hours</li> <li>• Date of Disability, as Certified by SS, must be prior to or within the first 60 days of COBRA coverage</li> <li>• Notification to Plan Administrator must be provided within 60 days of SS determination and prior to the end of the original 18-month period</li> </ul>

COBRA and SS DISABILITY Timelines
<u>COBRA</u> QE + 18 months + 11 months
<u>SS Disability</u> 5 months + 24 months

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### **BANKRUPTCY**

Filing a bankruptcy proceeding under Title 11 constitutes a qualifying event if it causes certain qualified beneficiaries to lose group health plan coverage. In these instances, the definition of qualified beneficiary is expanded to include covered employees and dependents that retired on or before the date of a substantial elimination of coverage.

In this context, a loss of coverage includes a substantial elimination of coverage within one year before or after the date that the bankruptcy proceeding was commenced.

COBRA participants may be eligible for continuation as long as the employer sponsored plan is active.

Courts have held that circumstances resulting in the termination of a plan are sufficient to terminate an employer's COBRA obligations. For example, cessation of an employer's legal existence, with no successor employer, has been held to terminate an employer's group health plan.

BANKRUPTCY
<ul style="list-style-type: none"><li>• Title 11 bankruptcy may result in an extension of COBRA coverage</li><li>• Bankruptcy expands the qualified beneficiary to any participant with a substantial elimination of coverage 1 year prior to bankruptcy proceedings</li><li>• Coverage will remain in effect as long as an employer sponsored plan is in place</li></ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### **MILITARY LEAVE and COBRA**

To understand an employer's COBRA liability involving employee and military service, one must compare the COBRA law to the Uniformed Service Employment and Reemployment Rights Act of 1994 (USERRA). USERRA was introduced as a result of the Gulf War and created new health plan continuation coverage rights for persons who are "absent from their position of employment by reason of service in the uniformed services."

Of course, COBRA would establish some of the same rights under a reduction of work hours qualifying event. However, USERRA continuation affords the employee and their dependents greater rights than COBRA continuation. Should an employer choose to designate a COBRA qualifying event, the maximum continuation period is not extended – USERRA and COBRA continuation run concurrently.

### **USERRA – It's the Same and It's Different**

***SAME – both Health Plans eligible for continuation and the 18-month coverage period.***

USERRA and COBRA
<ul style="list-style-type: none"><li>• Absent from their position by reason of service in the uniformed services</li> <li>• Compare COBRA and USERRA – whichever provides the greater benefit</li> <li>• SAME - 18 – month continuation</li></ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### COBRA and USERRA DIFFERENCES

- USERRA applies to ALL employers – no small employer, government or church plan exceptions
- Premium – 102% except for a person who performs service in the uniformed services for less than 31 days – in these instances the premium cannot exceed the employee’s share – the same as they were paying as an active employee
- Termination of Coverage – only ONE instance allows termination prior to the maximum 18-month continuation period – *“the day after the date on which the person fails to apply for or return to a position of employment.”* Return to work deadlines are specified in the USERRA law and range from 8 hours to 90 days after military leave ends
- Coverage cannot be terminated for gaining other coverage or nonpayment of premium. Actually USERRA is silent regarding premium payments
- USERRA requires an “election” of continuation. Technically, COBRA does not. While dependents can receive continuation rights through the employee, they have no independent election rights under USERRA

USERRA
<ul style="list-style-type: none"><li>• Applies to ALL employers</li><li>• Same premium as active for less than 31 days of service</li><li>• Only termination reason – they do not return to work within specified time</li><li>• Requires an election</li></ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

- USERRA has no formal “notice” requirement or timeline – continuation rights must be explained in the summary plan document. The employer should inform the employee of their USERRA rights when they are notified of the military leave
- USERRA does not require an extension of the 18-month coverage period for any reason
- Notice – COBRA requires notice be provided. The notice must include explanation of independent election rights, payment grace periods and reasons coverage may be terminated. Must the employer identify the areas where USERRA benefits are greater?
- Premium Payments – since USERRA provides no premium payment guidelines, can coverage be cancelled due to nonpayment?
- Should the employer-sponsored plan cease to exist, can USERRA coverage end?

USERRA
<ul style="list-style-type: none"> <li>• No formal notice</li> <li>• No SS Disability Extension</li> <li>• Questionable - if employer must explain difference in COBRA and USERRA</li> <li>• Questionable – can USERRA be cancelled for non-payment</li> <li>• Questionable – if employer sponsored plan is cancelled, what happens to continuants</li> </ul>

Obviously, USERRA’s silence in some areas is not meant to require continuation beyond reasonable limits. A recommendation is to follow COBRA premium payment and coverage guidelines established in the COBRA law.

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### BUSINESS REORGANIZATIONS Mergers and Acquisitions

The 1999 Proposed Regs gave the first official guidelines for buy/sell situations. While this was the first mention, guidance came from precedent setting court cases. The 2001 Final Regs set everything in INK and provided rules for mergers and acquisitions AFTER January 1, 2002.

Simple Explanation of the Law – no one will lose COBRA opportunity because of a merger or buy out.

The law allow for two options -

The 2 lawyers discuss it and decide who will offer COBRA - that never happens. OR

#### DEFAULT

If the seller still sponsors an insurance plan - then the current COBRA participants and those losing insurance benefits because of the merger or buy out, should remain the COBRA obligation of the seller.

If the seller no longer exists or no longer sponsors a group health plan, then the BUYER just bought not only the company, but also any of the current COBRA participants and has a COBRA obligation to anyone that loses insurance benefits because of the buyout or merger.

#### BUSINESS REORGANIZATIONS

- Basic Concept – no one loses a COBRA option because of a merger or acquisition
- Two options --
- Lawyers agree on continuation obligation
- Default Provisions –
- Seller continues to sponsor a plan – all COBRA obligation stays with seller
- Seller no longer sponsors a plan – all COBRA obligations revert to the buyer



# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### TRADE ACT 2002

The 2002 Trade Act provides COBRA tax credit and new second election periods for certain displaced workers.

On August 6, 2002, President Bush signed into law the Trade Act which expands COBRA benefits available to **workers displaced by import competition or shift of production to other countries**. This provision is simply an expansion of the 1974 Trade Adjustment Assistance provisions that were scheduled to expire September 30, 2001 – now they have been extended to September 30, 2007.

**GOVERNMENT SUBSIDY** - The Act provides eligible participants with a 65% government subsidy (tax credit for participants and their families) for certain types of medical premiums including COBRA premiums. The tax credit are available to eligible participants December 1, 2002 and is on a month-by-month basis with the following limitations

- The taxpayer must be an eligible individual
- The taxpayer is paying premiums for qualified health insurance
- The taxpayer and family members do not have other specified coverage
- The taxpayer is not in prison

#### TRADE ACT 2002

- Worker displaced by import competition or job function is sent to another country
- Sunset provision - September 30, 2007
- 65% Government Subsidy
- NEW Second COBRA Election Period

#### TAX CREDIT

- Eligible December 1, 2002
- Month-by-Month basis

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### TRADE ACT 2002 cont

ELIGIBILITY – an individual is eligible for the tax credit if

- Eligible for Trade Adjustment Assistance
- A PBGC pension recipient (an individual at least 55 years of age and receiving pension benefits paid by the Pension Benefit Guaranty Corporation).

QUALIFIED HEALTH PLANS – the ACT specifies qualified health plans

- COBRA or other continuation
- NOT for Flex Plan or HIPAA exempt plans

#### OTHER SPECIFIED COVERAGE

EXEMPTIONS – the credit is NOT available for taxpayers who have other specified coverage including

- Other coverage for taxpayer or spouse if an employer or former employer pays at least 50% of the cost of the coverage – NOTE: coverage paid for by the taxpayer on a pre-tax basis under a cafeteria plan, is considered employer-paid!
- Medicare
- Medicaid

ADVANCED PAYMENTS – No later than August 1 2003, the Treasury Department must establish a program for making premium payments direct to the insurance providers. Providers will also need to file information returns listing participants eligible for the advance credit and the amount of the credit.

TAX CREDIT
<ul style="list-style-type: none"> <li>• Restricted Eligibility</li> <li>• Qualified Health Plans</li> <li>• Other Coverage Restrictions</li> <li>• Advanced Payment --- August 1, 2003 --- How do we get \$\$\$ together?</li> <li>• Reporting to who??</li> <li>• Direct to Insurance Provider – what if self-insured – what if outsourced</li> </ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### TRADE ACT cont

EFFECTIVE DATE – tax Credit provision is effective for

- Taxable years beginning after December 31, 2001?
- Eligible credit months – months beginning more than 90 days after the date of the enactment (August 6, 2002)
- TRUE first credit month – December 1, 2002

TAX CREDIT
<ul style="list-style-type: none"> <li>• First eligible month – DECEMBER 1, 2002</li> </ul>

SECOND ELECTION PERIOD – the Act provides a second 60-day election period for eligible workers not already electing COBRA. This second election period is restricted to

- Those eligible for trade adjustment assistance and job loss eligible under the Trade Act
- Failed to elect COBRA during the regular COBRA election period
- Coverage elected during the new second election period commences on the first day of the NEW second election period – no retro-active coverage between initial loss and first day of second election period – will COBRA still end 18, 29 or 36 months from original loss?
- Loss of coverage to the first day of the the second election period will not count toward the HIPAA pre-existing credit 63-day “gap”

SECOND ELECTION PERIOD
<ul style="list-style-type: none"> <li>• Allows an additional 60 day election period</li> <li>• If elected, coverage effective the 1<sup>st</sup> day of SECOND election period</li> <li>• Will leave a gap in coverage from original loss</li> <li>• Gap will NOT count toward 63-day HIPAA pre-existing condition gap</li> <li>• How does this effect the original COBRA time period???</li> </ul>

**WHO - Eligible for individuals with respect to whom petitions for certification for trade adjustment assistance are filed on or after November 4, 2002.**

# **COBRA**

## **CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT**

### **COBRA COVERAGE ENDS**

Qualified Beneficiaries are not eligible to continue their COBRA coverage the earliest of the following:

- The time period expires (18, 29 or 36 months)
- Timely payment is not made
- The date on which the QB becomes covered under another group health plan (including entitled to Medicare) that does not contain a pre-existing condition limitation or that pre-existing condition period has been satisfied
- The employer ceases to maintain any group health plan.

### **COBRA PREMIUMS**

Employers are allowed to charge up to 102% of the cost of non-COBRA participant coverage – up to 150% during the SS Disability extension. This simple calculation is not as simple as it appears. For instance, self-insured plan costs include more than the contribution to the expected claims fund; stop loss premium, administrative costs . . .

One continuing participant, whether an employee or dependent, should be charged the applicable individual cost. Two or more participants, are charged according to the plans pricing structure.

#### **COBRA COVERAGE ENDS**

- The time period expires
- Timely payment is not made
- The date on which the QB becomes covered under another group health plan (including entitled to Medicare) that does not contain a pre-existing condition limitation or that pre-existing condition period has been satisfied.
- The employer ceases to maintain any group health plan.

#### **COBRA PREMIUM**

- 1 continuant – individual rate
- 2 or more participants – same as applicable active participants

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### Less Than Significantly Short Payments

The 1999 Proposed COBRA Regulations provided a provision for *less than significantly short* COBRA payments. However, it was not until the 2001 Final Regs that this term was defined – the lesser of 10% or \$50.

If a COBRA payment is received meeting this criteria, the employer has two options:

- Waive the Shortage – actually pay it for them; or
- Bill for the Shortage – should the employer elect to bill, they must give the participant an additional 30 day grace period to pay the shortage amount

Controversy continues as to whether coverage can be cancelled if the less than significantly short payment is not received. Many contend that the term “less than significantly short” was purposeful – the majority of the payment was received. Is this really a “waive it now or waive it later” provision?

LESS THAN SIGNIFICANTLY SHORT PREMIUM
<ul style="list-style-type: none"> <li>• The lesser of 10% or \$50</li> <li>• Waive shortage OR</li> <li>• Bill for it – allow an additional 30 day grace period to pay the shortage</li> <li>• What if shortage is never paid?</li> <li>• Each payment stands of its own</li> </ul>

### NSF PAYMENTS

A more concerning problem is the entire payment being a NSF check. The COBRA law is silent regarding NSF payments. This leaves the situation to the guidelines of each State’s NSF procedures.

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### NSF cont

The silence in the law also eliminates a communication requirement from the employer or administrator advising the participant of the NSF payment – the bank will take care of that.

So what does the employer do? It depends – when did they receive notification of the NSF payment? The COBRA law states that payment (good payment) must be sent by the end of the grace period. If the NSF situation is discovered BEFORE the end of the grace period, the participant has until the end of the grace period to make the payment good.

If the NSF situation is discovered AFTER the grace period, the participant has no opportunity to make good payment and coverage should be cancelled retro-active to the last date of premiums received.

Again, the COBRA law does not require the employer or administrator notify the participant of the NSF. If the NSF situation occurs before the end of the grace period, some employers or administrators make it a practice to advise the participant and remind them that if payment is not made by the end of the grace period, coverage will be cancelled. This is not a requirement, simply a gesture – but remember, a notice sent once is a new procedure for all.

NSF PREMIUM
<ul style="list-style-type: none"><li>• Silent in the law</li><li>• GOOD payment by grace period</li><li>• No communication requirement</li></ul>

# COBRA

## CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

### COBRA PENALTIES

There are many penalties for non-compliance with the COBRA law – IRS excise tax, ERISA penalty, claim payments, damages and attorney fees.

Failure to provide notice of COBRA continuation options can result in a \$100 per day (\$200 two or more QB) excise tax. The IRS may waive the penalty if the employer gives notification within 30 days of notice of violation.

ERISA Penalties can be assessed at \$110 per day of non-compliance, per qualified beneficiary and per violation.

IRS and ERISA penalties may not be the result of a complaint but, simple the result of a random compliance audit.

Obviously, employers will not find themselves in court for a COBRA violation unless there are claims costing more than the premium owed. Claim Cost, Damages and Attorney Fees can add to the non-compliance expense.

PENALTIES
<p>IRS PENALTIES</p> <ul style="list-style-type: none"> <li>• \$100 Per Day Per Violation - or \$200 a Day if more than one qualified beneficiary</li> <li>• OOPs clause</li> </ul>
<p>ERISA PENALTIES</p> <ul style="list-style-type: none"> <li>• \$110 Per Day, Per Qualified Beneficiary, Per Violation</li> </ul>
<p>CLAIM COSTS</p> <ul style="list-style-type: none"> <li>• Make the Person Whole</li> </ul>
<p>DAMAGES</p> <ul style="list-style-type: none"> <li>• To the Judges Discretion</li> </ul>
<p>ATTORNEY FEES</p>

# COMPLIANCE COMMUNICATIONS

## **COMPLIANCE COMMUNICATIONS**

The COBRA and HIPAA laws require that employees and eligible dependents be notified of the opportunities provided under these laws upon employment and coverage becoming effective as well as when coverage is lost.

Failure to send any one of the communications properly can result in non-compliance penalties, fines and litigation.

### **COBRA and HIPAA NOTIFICATIONS**

- Initial Right Notices - Upon employment and coverage effective
- Event Notices – Upon Loss of coverage

## **HIPAA INITIAL NOTIFICATION**

Newly hired employees should immediately be sent a HIPAA Initial Notice. This notice explains two major points concerning the group health insurance program:

- Explains the right to receive credit for pre-existing conditions through a Certificate of Creditable Coverage
- If the employee does not enroll in the group health insurance program when it is initially offered, enrollment opportunities may be limited.

### **HIPAA INITIAL NOTICE**

- All New Hires and their eligible dependents
- Receive pre-existing condition credit
- Limited enrollment opportunities

# COMPLIANCE COMMUNICATIONS

## **COBRA INITIAL NOTIFICATION**

COBRA Initial Rights Notifications should be sent only to those employees and dependents that become effective on the insurance program. This includes not only newly enrolled employees but, also new dependents as they are added.

This notification gives details of the COBRA provisions including eligibility requirements, Qualifying Events, the responsibility of notification, and a timeline for notification and payments.

### **COBRA INITIAL NOTICE**

- When coverage becomes effective
- Qualifying Events
- Election time periods
- Explains notification responsibilities
- Payment timelines
- Secondary Qualifying Events
- Social Security Disability Extension of Coverage
- Possible Right of Conversion
- Contact Information if there are any questions

# COMPLIANCE COMMUNICATIONS

## **HIPAA CERTIFICATE OF COVERAGE**

A HIPAA Certificate of Creditable Coverage should be sent within 14 days to any employee or dependent that loses health insurance benefit for any reason.

### **HIPAA CERTIFICATE**

- Employee or dependent
- Loss of coverage for ANY reason
- 14 days

## **COBRA ELIGIBILITY NOTIFICATION**

The COBRA eligibility notification should be sent within 14 days of the loss of coverage or notification. This notice is primarily the same as the initial COBRA notification but, now it specifies the amount due to continue coverage.

### **COBRA ELIGIBILITY NOTICE**

- Employee or dependent
- Loss of coverage due to a Qualifying Event
- 14 days

## **HOW TO SEND COMMUNICATION**

Both the COBRA and HIPAA laws specify that the minimum communication method should be 1<sup>st</sup> Class Mail – but how does an employer prove they sent something 1<sup>st</sup> class mail? While many rely on the costly Certified Mail process, recent court cases have shown this method to have loop holes. Proof of Mail (certificate of mail) methods provide a more cost effective, fail safe mailing method.

### **HOW TO SEND COMMUNICATION**

- Law says 1<sup>st</sup> class mail
- Certified Mail Problems
- Proof of Mail

## **CURRENT COBRA CASE LAW REFERENCE GUIDE**

While many concern themselves with the IRS imposed penalties of the COBRA and HIPAA laws, a greater concern should be directed to the possibility and reality of litigation. To gain a full understanding of the provisions of the laws, one must be knowledgeable of not only the law and its guidelines, but also of the lawsuits.

The old adage of “learning from your mistakes” is a true one. But, reviewing lawsuits provides true compliance understanding and betters the adage – we learn from other people’s mistakes.

Over the years, several hundred lawsuits have made their way into the federal court system. An untold number of cases are settled out of court each year. Now that the COBRA law has been finalized, the number of court cases and the dollars awards is certain to increase.

Lawsuits provide clear understanding of gray areas of the law, clarify administrative responsibilities and can actually increase compliance responsibilities.

As with any litigation, there is never a financial win. Even if the court rules in your favor, the financial burden of that win is costly. An ever-constant vigil of proactive awareness of all aspects of the law is the best defense to compliance.

The following pages may begin your “Current COBRA Case Law Reference Guide”.

## CURRENT COBRA CASE LAW REFERENCE GUIDE

**Degrise v. Sprint Corporation, 2002 U.S. App. (5th Cir. 2002)**

**This case is a recent reversal of certified mail cases. In this instance Sprint sent the COBRA election notice by certified mail. It was returned undeliverable. The 5<sup>th</sup> Circuit Court of Appeals ruled that Sprint do not know the reason the letter was not delivered and they had performed their “good faith effort” to provide the notice.**

The plan administrator in this case sent a COBRA election notice by certified mail, return receipt requested, to an employee who had been terminated a week earlier. The post office twice attempted to deliver the notice to the employee, who was out of town on a three-week honeymoon. The post office left the employee a notice that there was a certified letter for him at the post office. The post office's notice apparently did not indicate who had sent the certified mail. When the employee sought on two occasions to retrieve the letter, postal workers could not find it and advised him to check again. The post office later located the letter but sent it back to the plan administrator marked "undelivered." This occurred less than three weeks after the COBRA notice was originally sent, which means that the plan administrator knew for several weeks before the 60-day COBRA election period expired that the employee had not received his COBRA election notice.

The issue in the qualified beneficiary's lawsuit for COBRA coverage was whether "a company meets its notification duty under COBRA by sending a letter by 'certified mail' to an individual's last known address even when the company knows that the individual did not actually receive the letter." The Fifth Circuit Court of Appeals held that COBRA requires no more than a "good faith" attempt to provide the required election notice. The court found that mailing the notice by certified mail—a type of first-class mail--satisfied the plan administrator's obligation to make such a good faith effort. The return of the letter as "undelivered" did not change the outcome because the plan administrator did not know why the letter was not delivered and was not responsible for the letter's going undelivered. "Therefore, [the plan administrator] did nothing to undermine the presumption of 'good faith' established under the case law once it attempted to notify [the employee] of his COBRA benefits by certified mail."

The reason we are so stunned by this unusual decision from this Court is the fact that this same Court reached an opposite decision against American Airlines less than a year ago – this facts were almost a mirror case – except the qualified beneficiary made American Airlines aware they had not received their COBRA notice within the 60 day election period.

## **CURRENT COBRA CASE LAW REFERENCE GUIDE**

### **SUPREME COURT RULING – JUNE 1998**

**This case is gave clarification to COBRA and Other Coverage eligibility situations including enhancing COBRA eligibility for Medicare entitled participants.**

In *Geissal v. Moore Medical Corporation*, the Supreme Court ruled that employers must provide COBRA continuation coverage to individuals who have other group health plan coverage before the date of their COBRA election.

While employed, Geissal was covered under Moore's group health plan as well as under the health plan provided by his wife's employer. After Geissal's employment was terminated, he was offered and elected COBRA. After six months of premium payments, the employer informed him that there had been a mistake. According to the employer, since Geissal had been covered by another group health plan on the date of his COBRA election, he was not entitled to COBRA coverage. Geissal issued, charging that Moore violated COBRA.

The lower court sided with the employer, ruling that since group health plan coverage was in effect at the time of the COBRA election, Geissal was ineligible for COBRA coverage. The Court of Appeals for the Eighth Circuit agreed. The Supreme Court heard the case to resolve a conflict among the federal circuits on whether ERISA §602(2)(D)(i) allows employers to deny COBRA continuation coverage to qualified beneficiaries who are covered under another group health plan at the time of the COBRA election.

Under ERISA §602(2)(D), COBRA coverage may cease on:

...[t]he date on which the qualified beneficiary first becomes, after the date of the election (i) covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, or (ii) entitled to benefits under title XVIII of the Social Security Act.

Moore claimed that Geissal's coverage under his wife's employer group health plan defeated the claim for COBRA coverage after his election to receive it. The employer argued that the deciding factor is whether, at any time after the election, the beneficiary is covered by another group health plan. In addition, the employer argued that Geissal was not covered under his wife's employer plan until after his COBRA election, since that was when that coverage became primary.

**continued**

## **SUPREME COURT RULING – JUNE 1998 (cont.)**

The Supreme Court ruled that the employer's interpretation did not square with the plain meaning of the statute. The statute does not excuse the employer if the beneficiary "is" covered or "remains" covered on or after the date of the election.

In addition, the statute does not suggest that it matters which plan is primary. Instead, §602(2)(D)(i) speaks in terms of "becom[ing] covered," and this event is significant only if it "first" occurs "after the date of the election." Since Geissal was covered under his wife's employer group health plan continuously — before, during and after the date of his COBRA election — the employer could not cut off his COBRA coverage.

The court rejected the employer's argument that the first moment of coverage on the day following the COBRA election is the moment the beneficiary "first becomes" covered after the date of the election.

The court also rejected the "significant gap" argument adopted by some other courts. This argument makes a case for COBRA eligibility in the case of a "significant gap" between the coverage offered by the employer's plan and that offered by the beneficiary's other group health plan. The court ruled that there was no statutory support for this position. Instead, the statute provides that coverage under a later-acquired group health plan will not terminate COBRA rights if that plan limits or excludes coverage for a preexisting condition of the beneficiary.

The Supreme Court acknowledged that its ruling will allow individuals who obtain coverage under a group health plan (as an employee or otherwise) between the date of the qualifying event and the COBRA election to elect continued coverage. So if a COBRA beneficiary gets a new job with health coverage (with no exclusion or limitation for his condition) in the interim between the qualifying event and the election, he is eligible for COBRA. If the new job and coverage come after the election date, he is not.

A further consequence of the court's interpretation of the statute is that a plan may not deny COBRA coverage merely because the beneficiary becomes entitled to Medicare benefits before the date of his election for COBRA coverage.

The Supreme Court's decision in Geissal is contrary to proposed Treasury regulation 1.162-26, Q&A #38. However, the IRS noted the Treasury Department's intention to reverse its position effective June 8, 1998 (the date of the court's decision). The IRS also said that it will not assess excise taxes under Code §4980B for any period before June 8, 1998, during which a plan sponsor relied on the proposed regulation.

## CURRENT COBRA CASE LAW REFERENCE GUIDE

### **BOWERMAN v. Wal-Mart Stores, Inc. -- 7<sup>th</sup> Cir. 2000**

**This case gave clarification to the employer responsibility of explaining insurance benefits to a rehired employee. However, please remember, this situation began in 1995, before HIPAA pre-existing condition credit and no pre-existing condition wait for maternity was allowed. The reason we include this case in the guide is because it is an excellent example of the problems that can result from an employer's attempt to "give advise" instead of giving facts and allowing the participant to make their own decision.**

Ms. Bowerman was covered under the Wal-Mart Stores Inc. insurance group health plan. She quit her job and her coverage ended on her last day of work. During her exit interview, she was given her COBRA election materials. A few days later, she visited her doctor and discovered she was pregnant. She elected COBRA coverage and her 45-day payment deadline was October 9, 1995.

She went to work for another company but, she didn't like the job, so she quit and returned to work at Wal-Mart exactly one month after she had originally left Wal-Mart employment.

Shortly after she returned to Wal-Mart, she met with the person in charge of plan enrollment for her department. While discussing re-enrollment in the plan, she asked the enrollment representative if she needed her COBRA coverage. Her told her that she didn't. The Wal-Mart election packet also included a discontinuance form. Instead of paying her COBRA premium, she returned the form and noted her reason for discontinuance as "I went back to work . . . so my insurance is still in effect." The Wal-Mart program included a rehire provision allowing employees terminated and then rehired within 12 months to have the normal 90-day waiting period waived. However, rehires are still subject to the plan's 12-month pre-existing condition waiting period. Again, had this situation occurred after HIPAA legislation, the pregnancy could not have been treated as a pre-existing condition.

The employee immediately began to incur pregnancy-related medical expenses and receiving notice of denied claims. Over the course of the next few weeks, both the employee and her doctor contacted the plan numerous times but, never received a satisfactory reason for the denials. Even the explanation of benefits failed to provide conditional rational for the denial. In a recorded phone call, the company's representative emphasized that all of the expenses occurred after the employee's rehire date and Ms. Bowerman was told, "I will get this fixed for you, OK?"

**continued**

**BOWERMAN v. Wal-Mart Stores, Inc. -- 7<sup>th</sup> Cir. 2000 (cont)**

Very significant to the case was the fact that this phone call occurred well before the October 9 COBRA premium deadline. However, it was not until 5 months later that the employee was first told that her claims were being denied because of a pre-existing condition. Had she been advised of this upon her original inquiry, she could have avoided the conflict by paying for COBRA coverage during her one-month gap – then she would have had continuous coverage.

Not only Ms. Bowerman been advised incorrectly (even though the information was received informally), the court found that the company's SPD and COBRA materials were also ambiguous due to their failure to explain that electing COBRA coverage would "bridge the gap" in coverage for a rehired employee and possibly prevent application of a pre-existing condition waiting period. incorrect information been told

## CURRENT COBRA CASE LAW REFERENCE GUIDE

### **WRIGHT v. Anthem Life Ins. Co. - U.S. District Court Miss. 2000**

*This case resulted in conversion coverage being extended to an ineligible participant because of incorrect information being relayed.*

**The COBRA law provides that COBRA beneficiaries be advised of any conversion rights available to them within 6 months of their COBRA coverage being exhausted. Shortly before the end of his COBRA coverage, Mr. Wright contacted his insurer to inquire about alternative coverage. He was told that if he continued paying his premiums, he would automatically become covered by an individual conversion policy when his COBRA coverage ended. Mr. Wright continued to pay and the insurer accepted the premium for several months after the COBRA coverage was exhausted.**

During this time, Mr. Wright was in a serious automobile accident and made claim for reimbursement under his policy. His claims were denied based on the fact that the insurer's COBRA plan did not provide a conversion right for a qualified beneficiary.

The court was asked to determine whether the insurer's representation and acceptance of premiums should bind the insurer notwithstanding the insurer's position that the qualified beneficiary had no actual conversion rights under the plan document. The court concluded that the insurer could be equitably estopped from denying the coverage, because the COBRA plan's description of the conversion coverage option was ambiguous, and this allowed the qualified beneficiary to rely on the insurer's interpretation of the provision given in his original inquiry.

This case is not final – the court has questioned the insurer's "conversion discrimination against qualified COBRA beneficiaries." The COBRA law requires that a qualified beneficiary whose has exhausted his or her COBRA maximum coverage period be provided with a conversion option if that option is "otherwise generally available" under the plan. The insurer argued that since the insurance policy expressly excluded qualified beneficiaries from eligibility for conversion policies, those policies were not generally available within the meaning of the statutory rule. The court does not agree.

## CURRENT COBRA CASE LAW REFERENCE GUIDE

### **MARSH v. Omaha Printing Co. – 8<sup>th</sup> Circuit 2000**

**This case involves a delayed Social Security Disability Certification that resulted in a COBRA participant losing eligibility for the 11-month extension of COBRA coverage. This emphasizes the importance of receiving Social Security Disability Certification within the original 18 months of COBRA coverage.**

COBRA law provides the opportunity for Social Security Disability Certified participants to extend the 18-month COBRA coverage to 29-months. The law specifies specific eligibility provisions for the extension – the date of disability must be before or at a maximum, within 60 days of the beginning of the original 18-month COBRA period; the Qualified Beneficiary must provide the Administrator a copy of the Social Security Disability Certification form within 60 days of the determination; Social Security Disability Certification must be received within the original 18-month COBRA period.

Mr. Marsh terminated employment and elected COBRA coverage in July 1995 when he suffered a heart attack that left him permanently disabled. He applied for Social Security Disability benefits in August 1995 but, never received certification. At the end of his 18-months period, he applied for the 11-month extension but, since he had never received Social Security Disability approval, his request for the extension was denied. He then suffered another heart attack and incurred approximately \$80,000 in medical expenses.

In August 1998, more than 3 years from his original application, Social Security determined that Mr. Marsh had been disabled since July 1995. Mr. Marsh again attempted to obtain the 11-month extension of his COBRA coverage. But, the court dismissed his claim. On appeal, the employee argued that his doctor's determination of disability made within the original 18 month of COBRA should have been sufficient to allow the extension. The Eighth Circuit denied the appeal quoting that the COBRA statute plainly required a disability determination from the Social Security Administration within the original 18-month period.

## CURRENT COBRA CASE LAW REFERENCE GUIDE

### **PHILLIPS v. Saratoga Harness Racing, Inc. – New York 2000**

**This case determined that a foreign divorce decree that had been determined null and void by a U. S. Court was not a COBRA qualifying event and did not require the employer to offer COBRA continuation. Even though the employer won in court, this case creates the question of documentation required to determine a proper COBRA qualifying event.**

An employee divorced his spouse in the Dominican Republic without his spouse's knowledge. He presented the Dominican divorce decree to the administrator and advised them that he wanted to drop his ex-spouse and add his new spouse. The administrator dropped the spouse as requested and provided the covered employee with a CORBA election notice that the employee was supposed to give to his purported ex-spouse.

Seventeen months after the Dominican court entered the divorce decree, a New York State court declared the decree null and void because the spouse had not been given adequate notice of the divorce nor the opportunity to be heard. During the past months, she had incurred significant medical expenses.

The spouse claimed she had never received a COBRA election notice. The court dismissed her case for lack of matter jurisdiction. The court explained that for the purposes of COBRA, the "finalization" of the divorce must occur. And, since the court had declared the Dominican divorce null and void, there had been no COBRA qualifying event.

The employer is actually lucky that the Dominican divorce was declared null and void and not a COBRA qualifying event. If it had been, the employer would have likely lost the case for COBRA coverage because proper COBRA notification had not been given. But still, this case brings a question of required documentation. Should, in divorce and legal separation situations, an employer give notice of COBRA eligibility but, explain that if the divorce decree is later invalidated, COBRA coverage may be negated? Maybe instances of this type is what caused the new "dropped in anticipation of a qualifying event" provision.

## CURRENT COBRA CASE LAW REFERENCE GUIDE

### McKNIGHT v School District of Philadelphia – U. S. District Court 2000

**While the COBRA law has never (and likely never will) defined gross misconduct, this case looks to another source to determine a definition – the applicable state’s unemployment insurance law that includes “willful misconduct” wording.**

A teacher was charged with criminal sexual assault against a former student. The charges were later dismissed. The plaintiff was fired and the school district did not offer COBRA continuation because of the gross misconduct dismissal. Mr. McKnight brought suit against the school district for a number of issues related to his firing including the school’s failure to offer COBRA continuation.

The school made motion to dismiss the non-offering of COBRA stating the plaintiff had been fired for gross misconduct and was not entitled to COBRA continuation. The court denied the school district’s motion to dismiss. The court held that whether an arrest and subsequent dismissal of criminal charges constituted gross misconduct was an issue of fact to be determined at trial. The plaintiff provided evidence that he was fired not because of gross misconduct but because he had been arrested. He emphasized the point that he had been awarded unemployment insurance benefits because the school district failed to establish willful misconduct by the plaintiff.

*Once again we emphasize, when involved in a gross misconduct firing, the least of your concerns should be whether to offer COBRA continuation or not – be sure your firing sticks.*

## CURRENT COBRA CASE LAW REFERENCE GUIDE

### **Brown v Neely Truck Line, Inc. – U. S. District Court for the Middle District of Alabama 2001**

**This case involves the inability of the employer to prove a COBRA notice had been provided and resulted in Neely Truck Line paying \$25,000 in claims and over \$5000 in penalties (\$10 per day for each day the notice was not provided – with interest).**

Earl Brown and his wife Linda were covered through the Neely Truck Line. Insurance was critical to the family because of Mrs. Brown's diabetes. However, on September 6, 1991, Mr. Brown terminated Neely truck Lines employment in order to begin work at All State Packaging. After a 90-day employment waiting period, the couple was covered for insurance benefits through the All State Packaging plan. The new plan included a pre-existing condition waiting period. During this pre-existing condition waiting period, Mrs. Brown incurred approximated \$25,000 in medical expenses.

The Browns contend that Neely Truck Lines never made a COBRA offering to them. Though Neely Truck Line contends they sent a COBRA election form to Mr. Brown, they were unable to provide proof and convince the court such notice had been provided. For this reason, they lost the court case and paid over \$34,000 in claims and penalties. A 75¢ Certificate of Mail would have been a good investment.

Of course, had this situation occurred after 1997, the HIPAA portability provisions would have allowed Mrs. Brown the opportunity of pre-existing condition credit and she would have likely never been out the medical expense. However, Neely Truck Lines would have still lost the COBRA case.

