COBRA

FAQs About COBRA Continuation Health Coverage

What is COBRA continuation health coverage?
Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

What does COBRA do?

COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. The coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage.

Who is entitled to benefits under COBRA?
There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plan coverage, qualified beneficiaries, and qualifying events.

Plan Coverage – Group health plans for employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year are subject to COBRA. Both full and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

Qualified Beneficiaries – A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is either an employee, the employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events – Qualifying events are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer period of continuation coverage.

Qualifying Events for Employees:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

Qualifying Events for Dependent Children:

- Loss of dependent child status under the plan rules
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

How does a person become eligible for COBRA continuation coverage?

To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you worked and the health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.

What group health plans are subject to COBRA?

The law generally covers health plans maintained by private-sector employees with 20 or more employees, employee organizations, or state or local governments.

What process must individuals follow to elect COBRA continuation coverage?

Employees must notify plan administrators of a qualifying event within 30 days after an employee's death, termination, reduced hours of employment or entitlement to Medicare. A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.

Plan participants and beneficiaries generally must be sent an election notice not later than 14 days after the plan administrator receives notice that a qualifying event has occurred. The individual then has 60 days to decide whether to elect COBRA continuation coverage. The person has 45 days after electing coverage to pay the initial premium.

How do I file a COBRA claim for benefits?

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures must be described in the summary Plan Description. You should submit a claim for benefits in accordance with the plan's rules for filing claims. If the claim is denied, you must be given notice of the denial in writing generally within 90 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim, and procedures for appealing the denial. You will have at least 60 days to appeal a denial and you must receive a decision on the appeal generally within 60 days after that.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. There can be charges up to 20 cents a page for copies of the rules.

Can individuals qualify for longer period of COBRA continuation coverage?

Yes, disability can extend the 18 month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours. To qualify for additional months of COBRA continuation coverage, the qualified beneficiary must:

- Have a ruling from the Social Security Administration that he or she became disabled within the first 60 days of COBRA continuation coverage.
- Send the plan a copy of the Social Security ruling letter within 60 days of receipt, but prior to expiration of the 18-month period of coverage.

If these requirements are met, the entire family qualifies for an additional 11 months of COBRA continuation coverage. Plans can charge 150% of the premium cost for extended period of coverage.

Is a divorced spouse entitled to COBRA coverage from their former spouses' group health plan?

Under COBRA, participants, covered spouses and dependent children may continue their plan coverage for a limited time when they would otherwise lose coverage due to a particular event, such as divorce (or legal separation). A covered employee's spouse who would lose coverage due to a divorce may elect continuation coverage under the plan for a maximum of 36 months. A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation. After being notified of a divorce, the plan administrator must give notice, generally with 14 days, to the qualified beneficiary of the right to elect COBRA continuation coverage.

Divorced spouses may call their plan administrator or the EBSA Toll-Free number, 1.866.444.EBSA (3272) if they have questions about COBRA continuation coverage or their rights under ERISA.

If I waive COBRA coverage during the election period, can I still get coverage at a later date?

If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period. A beneficiary may then elect COBRA coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Under COBRA, what benefits must be covered?

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, for the same coverage that the qualified beneficiary had immediately before qualifying the continuation coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

When does COBRA coverage begin?

COBRA coverage begins on the date that health care coverage would otherwise have been lost by reason of a qualifying event.

How long does COBRA coverage last?

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. Coverage begins on the date that coverage would otherwise have been lost by reason of a qualify event and will end at the end of the maximum period. It may end earlier if:

- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- After the COBRA election, coverage is obtained with another employee group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

- After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

Although COBRA specified certain periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from offering continuation heath coverage that goes beyond the COBRA periods.

Some plans allow participants and beneficiaries to convert group health coverage to an individual policy. If this option is generally available from the plan, a qualified beneficiary who pays for COBRA coverage must be given the option of converting to an individual policy at the end of the COBRA continuation coverage period. The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.

Who pays for COBRA coverage?

Beneficiaries may be required to pay for COBRA coverage. The premium cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not incurred a qualifying event, including both the portion paid by employees and any porting paid by the employer before the qualifying event, plus 2 percent for administrative costs.

For qualified beneficiaries receiving the 11 month disability extension of coverage, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage. COBRA premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay premiums on a monthly basis if you ask to do so, and the plan may allow you to make payments at other intervals (weekly or quarterly).

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the plan.

If premiums are not paid by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate coverage retroactively to the beginning of the period of coverage.

If the amount of the payment made to the plan is made in error but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period

(for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to co-payments and deductibles, and are subject to catastrophic and other benefit limits.

If I elect COBRA, how much do I pay?

When you were an active employee, your employer may have paid all or part of your group health premiums. Under COBRA, as a former employee no longer receiving benefits, you will usually pay the entire premium amount, that is, the portion of the premium that you paid as an active employee and the amount of the contribution made by your employer. In addition, there may be a 2 percent administrative fee.

While COBRA rates may seem high, you will be paying group premium rates, which are usually lower than individual rates.

Since it is likely that there will be a lapse of a month or more between the date of layoff and the time you make the COBRA election decision, you may have to pay health premiums retroactively-from the time of separation from the company. The first premium, for instance, will cover the entire time since your last day of employment with your former employer. You should also be aware that it is your responsibility to pay for COBRA coverage even if you do not receive a monthly statement.

Although they are not required to do so, some employers may subsidize COBRA coverage.

Can I receive COBRA benefits while on FMLA leave?

The Family and Medical Leave Act, effective August 5, 1993, requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee notifies an employer of his or her intent not to return to work. Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, U.S. Department of Labor, Employment Standards Administration.

What is the Federal government's role in COBRA?

COBRA continuation coverage laws are administered by several agencies. The Departments of Labor and Treasury have jurisdiction over private-sector health group health plans. The

Department of Health and Human Services administers the continuation coverage law as it affects public-sector health plans.

The Labor Department's interpretive and regulatory responsibility is limited to the disclosure and notification requirement of COBRA. If you need further information on your disclosure or notification rights under a private-sector plan, or about ERISA generally, telephone EBSA's Toll-Free number at: 1.866.444.3272, or write to:

U.S. Department of Labor
Employee Benefits Security Administration
Division of Technical Assistance and Inquiries
200 Constitution Avenue NW, Suite N-5619
Washington, DC 20210

The Internal Revenue Service, Department of the Treasury, has issued regulation on COBRA provisions relating to eligibility, coverage and premiums in 26 CFR Part 54, Continuation Coverage Requirements Applicable to Group Health Plans. Both the Departments of Labor and Treasury share jurisdiction for enforcement of these provisions.

The Center for Medicare and Medicaid Services offers information about COBRA provisions for public-sector employees. You can write them at this address:

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C1-22-06
Baltimore, MN 21244-1850
Tel 1.877.267.2323 x61565

Am I eligible for COBRA if my company closed or went bankrupt and there is no health plan?

If there is no longer a health plan, there is no COBRA coverage available. If, however, there is another plan offered by the company, you may be covered under that plan. Union members who are covered by a collective bargaining agreement that provides for a medical plan also may be entitled to continued coverage.

How do I find out about COBRA coverage and how do I elect to take it?

Employers or health plan administrators must provide an initial general notice if you are entitled to COBRA benefits. You probably received the initial notice about COBRA coverage when you were hired.

When you are no longer eligible for health coverage, your employer has to provide you with a specified notice regarding your rights to COBRA continuation benefits.

Employers must notify their plan administrators within 30 days after an employee's termination or after a reduction in hours that causes and employee to lose health benefits.

The plan administrator must provide notice to individual employees of their right to elect COBRA coverage with 14 days after the administrator has received notice from the employer.

You must respond to this notice and elect COBRA coverage by the 60th day after the written notice is sent or the day health care coverage ceased, whichever is later. Otherwise, you will lose all rights to COBRA benefits.

Spouses and dependent children covered under your heath plan have an independent right to elect COBRA coverage upon your termination or reduction in hours. If, for instance, you have a family member with an illness at the time you are laid off, that person alone can elect coverage.