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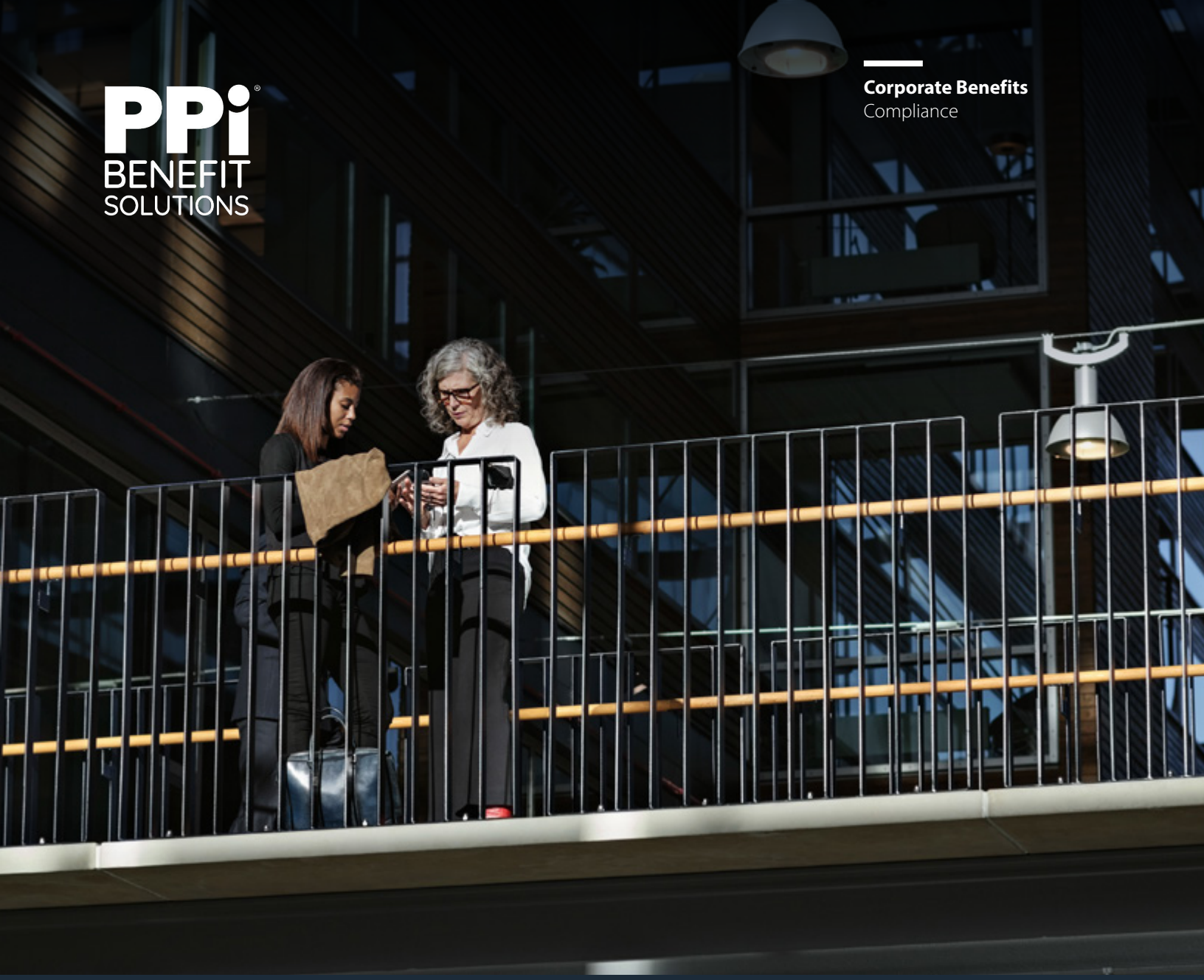


COBRA:

A Guide for Employers

Even when an employer outsources COBRA administration to a third-party administrator (TPA), such as a COBRA vendor, the plan administrator continues to hold direct responsibility for COBRA compliance.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers that sponsor group health plans to offer continuation coverage to employees, their spouses, and their dependent children in certain circumstances under which they would otherwise lose that coverage. Note that group health plans must designate a plan administrator, typically named in the plan documents. If no plan administrator is named, the role defaults to the employer sponsoring the plan.

This guide provides an overview of the essential COBRA compliance considerations for employers. It notes the coverage types that are subject to COBRA and explains how to identify COBRA qualified beneficiaries and COBRA qualifying events and durations, including special rules that apply to domestic partners. In addition, it describes the rules for calculating COBRA premiums and distributing time-sensitive initial notices, election notices, and COBRA open enrollment packets. Finally, it examines some of the special COBRA administrative considerations related to mergers and acquisitions, deferred losses of coverages, required group health plan notices, and international and retiree benefits. Employee lawsuits seeking to enforce COBRA rights are common, and employers should consult with legal counsel for specific advice regarding COBRA's application to their benefit plans.

At a Glance:

1. Employers Subject to COBRA

COBRA generally applies to private sector group health plans maintained by employers with at least 20 employees and plans sponsored by state and local government employers, regardless of the number of employees. COBRA does not apply to church plans. Importantly, even if an employer has fewer than 20 employees and is not subject to federal COBRA, they may nonetheless be subject to state continuation coverage laws. These laws, often referred to as mini-COBRA laws, generally mirror some or all of federal COBRA's requirements and typically apply only to fully insured plans.

2. Plans Subject to COBRA

COBRA applies to employer-sponsored group health plans that provide "medical care." Medical care is defined as the diagnosis, cure, mitigation, treatment, or prevention of disease affecting any structure or function of the body. This encompasses fully insured and self-insured medical plans (including HRAs and health FSAs, both of which reimburse expenses for medical care) along with coverage for prescription drugs, dental care, vision care, and certain point solution programs. HSAs are not group health plans and therefore are not subject to COBRA.

3. Qualified Beneficiaries

A group health plan must offer COBRA continuation to "qualified beneficiaries." A qualified beneficiary is an employee (or former employee, including retiree), spouse (including ex-spouse immediately following a divorce), or dependent child who was covered under the group health plan on the day before the occurrence of a COBRA qualifying event (i.e., a triggering event that results in a loss of coverage). A child born to or adopted by a COBRA participant during the COBRA maximum duration period is also a qualified beneficiary. Each qualified beneficiary has independent COBRA election rights, meaning they have the right to elect their own individual continuation coverage when the employee's coverage ends.

4. COBRA Qualifying Events

A COBRA qualifying event requires employers to offer COBRA continuation coverage to qualified beneficiaries. COBRA lists seven events (referred to as triggering events) that constitute qualifying events if they result in a loss of coverage for a qualified beneficiary: termination of employment, reduction of hours, divorce or legal separation, death of employee, dependent child ceasing to be a dependent under the plan, entitlement to Medicare, and employer's bankruptcy (for retirees and their dependents).

5. COBRA Initial Notice and SPD Disclosures

A group health plan subject to COBRA must provide written notice of COBRA rights and notification obligations to covered employees and their covered spouses when they begin coverage under the plan. While the DOL regulations call this notice the "general notice," it is typically called the "initial notice" in practice. ERISA plans must also provide each covered participant and beneficiary with an SPD, which explains their rights and obligations under the benefit plan, including a description of COBRA rights and obligations.

6. COBRA Election Process

Qualified beneficiaries who experience a qualifying event must be given the opportunity to elect COBRA. There are three stages in the COBRA election process: 1) notice of the qualifying event by the qualified beneficiary to the plan administrator; 2) delivery of the election notice by the plan administrator to qualified beneficiaries; and 3) election of coverage and payment of the initial premium by qualified beneficiaries to the plan administrator. Qualified beneficiaries will generally have 60 days to elect COBRA, where the election window is measured from the latter of the date the plan coverage terminates or the date the election notice was provided. They then have at least 45 days from the date of their election to make the initial COBRA premium payment.

7. COBRA Premiums

The COBRA premium for a month's coverage cannot be more than 102% of the total cost of coverage, including both employer- and employee-paid premiums. In the limited case of an SSA disability extension, employers may charge the disabled qualified beneficiary up to 150% of the total cost of coverage during the 11-month extension.

8. Duration of COBRA Coverage

The maximum period of COBRA continuation coverage is 18 months for termination of employment or reduction of hours and 36 months for death of employee, divorce or legal separation, loss of dependent status under the plan, or employee enrollment in Medicare. Plan sponsors can terminate COBRA continuation coverage earlier for certain reasons, including failure to pay premiums or a qualified beneficiary's enrollment in Medicare after electing COBRA, among other reasons. Following a termination of employment or reduction of hours qualifying event, the maximum COBRA continuation coverage period of 18 months can be extended in two circumstances: 1) another qualifying event occurs; or 2) a qualified beneficiary is determined by the SSA to be disabled.

9. Open Enrollments and HIPAA Special Enrollments During COBRA Periods

COBRA requires employers to offer qualified beneficiaries the opportunity to continue the same coverage that was in place on the day before the qualifying event. Additionally, when an open enrollment period is available for similarly situated employees under the plan, or when a qualified beneficiary experiences a HIPAA special enrollment event, the qualified beneficiary may make coverage changes consistent with the election changes available to active employees. Ahead of the open enrollment effective date, plan administrators must notify COBRA qualified beneficiaries of any coverage changes, including any carrier, plan design, or rate changes and the availability of any new group benefits.

10. Consequences of COBRA Noncompliance

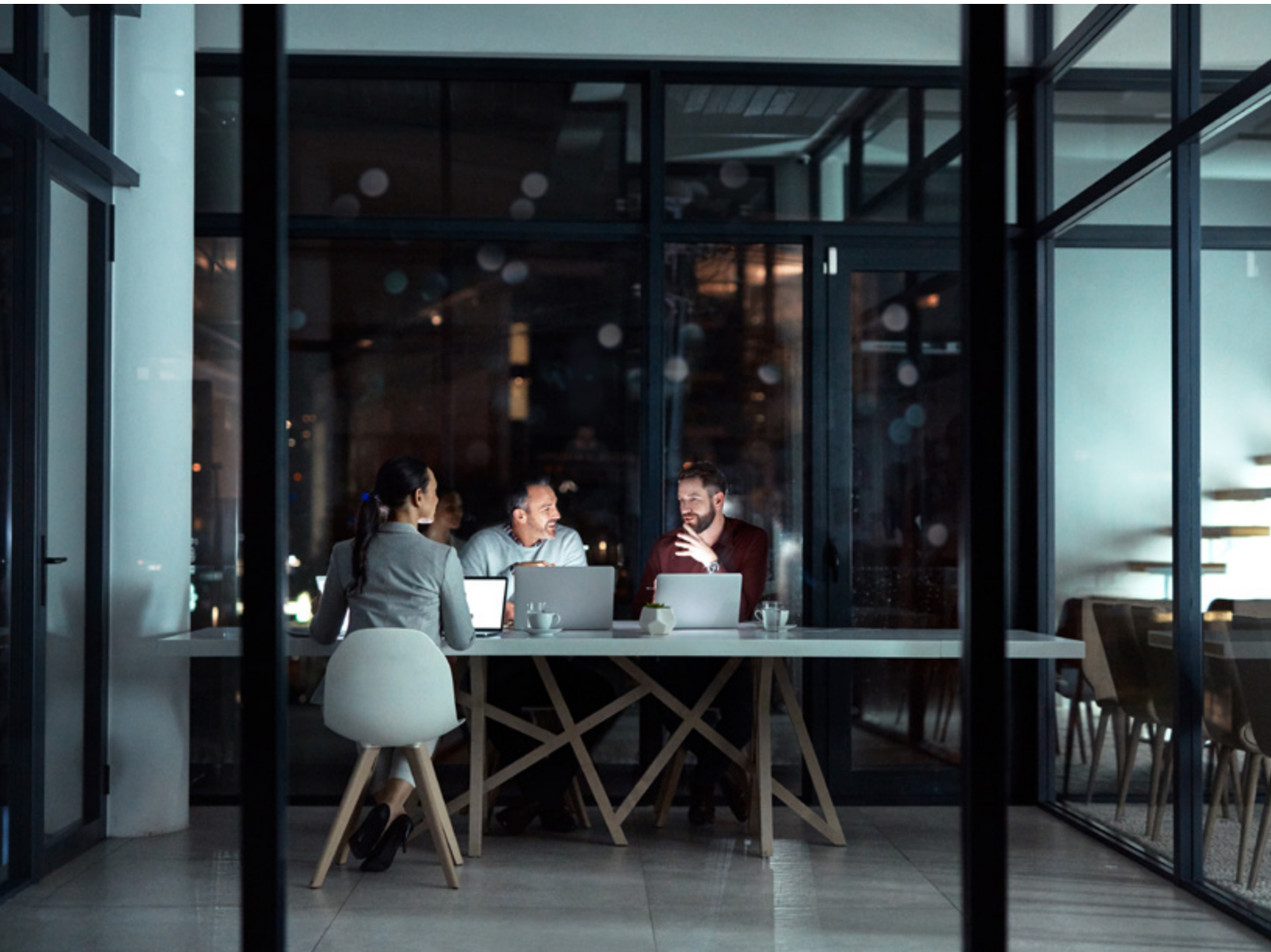
Employers must remember that they have ultimate responsibility for COBRA compliance, regardless of whether they use a COBRA TPA or administer the requirements in-house. Common COBRA administration mistakes include failing to provide initial notices or election notices, failing to offer COBRA on all benefits that provide medical care, failing to extend open enrollment rights to COBRA qualified beneficiaries, and failing to charge the correct COBRA premium. These shortcomings can result in significant penalties and costly participant lawsuits. Employers that suspect a COBRA compliance violation should discuss the specific risk and potential liability with legal counsel as soon as possible.

11. Additional Issues in COBRA Administration

This guide addresses special COBRA administration issues related to mergers and acquisitions, deferred losses of coverage, required group health plan notices, international settings, and retiree coverage.

12. Summary

13. Resources



1. Employers Subject to COBRA

COBRA generally applies to private sector group health plans maintained by employers with at least 20 employees. All employees are counted for this purpose, not just plan participants. Part-time employees are counted as a fraction of an employee based on the number of hours an employee must work to be considered full-time by the employer (not to exceed eight hours per day or 40 hours per week). Controlled group rules under Internal Revenue Code Section 414 apply, meaning all full- and part-time employees of all related employers under common control must be counted. In addition, employees outside the US, including those who are not receiving US source income, are included in the count. Note that the counting rule under COBRA departs from counting rules under the Affordable Care Act (ACA) employer mandate and the Family and Medical Leave Act (FMLA).

COBRA requirements also apply to plans sponsored by state and local government employers, regardless of the number of employees. COBRA does not apply to church plans or plans sponsored by the federal government. The law is unclear on whether Indian Tribal plans are subject to COBRA. Such plans should seek legal counsel.

Note that the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides protected military service leave with the opportunity for the employee to elect continuation coverage under a group health plan for themselves and any covered dependents. USERRA applies to all employers, regardless of size. If an employee loses coverage under a group health plan as a result of military service leave, the employee will generally be entitled to rights under USERRA and also, if applicable, under COBRA.

Small Employer Exception

A benefit plan is not subject to COBRA if the employer had fewer than 20 employees on more than 50% of its typical business days during the preceding calendar year. This is known as the small employer exception. Employers with fluctuating workforce counts above and below the 20-employee threshold must carefully track when the small employer exception no longer applies. If an employer's employee count reaches or exceeds 20 on more than 50% of its typical business days in a given calendar year, the employer will be subject to COBRA for the entire following calendar year, regardless of whether the employee count subsequently drops below 20 during that time.

Our Observation	COBRA rules are unclear regarding whether an employer that loses its "small employer" status due to an acquisition becomes subject to COBRA requirements as of the transaction date or the first day of the subsequent calendar year. Since employers are free to provide greater protections than COBRA specifically affords (assuming the carrier(s), including any stop-loss carriers, agree), the cautious approach is for the acquired entity to comply with COBRA requirements immediately following the transaction.

Employers should clearly communicate changes in COBRA obligations to employees. If an employer's workforce count fell below 20 employees in a previous calendar year and the employer wants to take advantage of the small employer exception, the plan administrator should notify employees of the loss of federal COBRA rights. Note that if an employer's workforce count newly falls below 20 employees such that they are not subject to COBRA in the following calendar year, employees whose triggering events occurred when the employer was still subject to COBRA retain those COBRA rights, even if their COBRA commencement date falls in the following calendar year.

Whenever an employer experiences a change in its COBRA obligations, the plan documents, Summary Plan Description (SPD), and all other employee communications regarding COBRA rights should be updated and employees should be advised accordingly. Without such clear notice, a previously qualified beneficiary may assume they are entitled to COBRA based on a prior promise (e.g., via a COBRA initial notice, SPD, or other plan communication); or, conversely, a newly qualified beneficiary may not be aware of their COBRA entitlement.

Our Observation	Employers whose workforce size tends to fluctuate above and below the 20-employee threshold for federal COBRA rights should consider modifying their COBRA initial notice, SPD, and other plan communications to inform employees that new COBRA continuation coverage rights will not be available in a year the employer qualifies for the small employer exception (based on the previous year's employee count).

Employers should consult with legal counsel on whether the small employer exception applies to them. The consequences for non-compliance can be significant, including participant lawsuits and penalties. In addition, if an employer extends COBRA rights to an employee beyond what COBRA requires, their carrier (stop-loss if self-insured) may deny any related claims, leaving the employer uninsured for that COBRA participant's claims.

State Mini-COBRA Laws

Importantly, even if an employer satisfies the small employer exception to federal COBRA, they may nonetheless be subject to state continuation coverage laws. These laws, often referred to as mini-COBRA laws, generally mirror some or all of federal COBRA's requirements. Typically, mini-COBRA laws apply only to fully insured plans. This is because ERISA (the federal law that governs many private group health plans) preempts state law from governing ERISA plans. However, state laws regulate insurers, which is how state insurance laws apply indirectly to fully insured plans.

While some states (notably, Vermont and Louisiana) have passed mini-COBRA laws that attempt to reach self-insured (including level-funded) plans, a reviewing court could find the law is preempted by ERISA. Because of this uncertainty, small self-insured or level-funded employers should confirm whether their stop-loss carriers interpret the applicable state mini-COBRA law as applying to their self-insured plan.

Some mini-COBRA laws also apply to larger fully insured group health plans that are simultaneously covered by federal COBRA, and in some cases, they provide more generous benefits. For example, California and New York generally require fully insured group health plans of all sizes to extend continuation coverage for medical benefits (but not dental or vision benefits) to 36 months (inclusive of the 18-month federal COBRA requirement). Some states (such as New York) have additional requirements in the event a covered individual no longer qualifies as a dependent. Others (such as Massachusetts and Louisiana) have very specific provisions for divorced spouses and surviving spouses.

Our Observation	State mini-COBRA laws vary and fall outside the scope of this publication. Some state mini-COBRA laws provide protections only to employees who reside in that state and are covered under a policy issued in that state. Other state mini-COBRA laws are extraterritorial, meaning the protections apply to residents of that state covered under a policy issued in another state. Even though carriers largely bear the burden of mini-COBRA compliance under state law, carrier agreements may shift certain requirements, such as distributing employee notices and processing election forms, to employers. Employers with mini-COBRA obligations should closely review state continuation requirements with their carriers.

2. Plans Subject to COBRA

COBRA applies to employer-sponsored group health plans that provide "medical care." Medical care is defined as the diagnosis, cure, mitigation, treatment, or prevention of disease affecting any structure or function of the body. This encompasses fully insured and self-insured medical plans (including HRAs and health FSAs) along with coverage for prescription drugs, dental care, and vision care. HSAs are not group health plans and therefore are not subject to COBRA.

As noted on the following chart, some coverage types require case-by-case scrutiny to determine whether they include medical care and are thereby subject to COBRA rules.

What Coverage Is Subject to COBRA?

Coverage Type	Subject to COBRA	Coverage Type	Subject to COBRA
Medical	Yes	Disability (STD/LTD)	No
Dental	Yes	Group Term Life	No
Vision	Yes	AD&D	No
Prescription Drug	Yes	Fixed Indemnity	No
HRA (including ICHRA and EBHRA)	Yes	Long-Term Care	No
Health FSA	Yes	HSA	No
Disease-Specific	Maybe**	Dependent Care FSA	No
Wellness Program	Maybe**		
EAP	Maybe**		
Point Solution Program	Maybe**		

*Health FSAs may qualify for a special limited COBRA obligation.
**This coverage must be scrutinized for whether it includes medical care.

Certain arrangements, such as HRAs, health FSAs, point solution programs, and disability, life, AD&D, fixed indemnity, and disease-specific plans, require some special considerations:

HRAs

HRAs are self-insured group health plans and therefore subject to COBRA. Typically, HRAs are only offered to employees along with major medical coverage (i.e., via integration with the group major medical plan) to satisfy the ACA requirement to cover preventive services without cost-sharing and the prohibition on annual dollar limits for essential health benefits. Under this common bundled arrangement, COBRA continuation coverage on the HRA is limited to qualified beneficiaries who also elect continuation coverage on the major medical plan. Employers may also allow qualified beneficiaries the option to waive the HRA and only elect COBRA continuation coverage on the major medical plan, thereby reducing the cost of the COBRA premium.

ICHRAs and EBHRAs are also subject to COBRA. An ICHRA sponsor must ensure that a COBRA qualified beneficiary has individual health insurance during any period of COBRA coverage. If the individual coverage is lost, then the COBRA coverage must terminate.

Health FSAs

COBRA coverage continuation rights only apply to "underspent" health FSAs (i.e., when the participant's remaining balance – their annual election minus reimbursed claims – exceeds the maximum health FSA COBRA premium that can be charged through the end of the plan year). Health FSAs may be subject to a special limited COBRA obligation to restrict the continuation period on underspent health FSAs to the end of the plan year in which COBRA is triggered if they meet the following three conditions:

1. The maximum benefit payable under the health FSA does not exceed the greater of: a) two times the participant's salary reduction for the plan year; or b) the participant's salary reduction for the plan year, plus $500.
2. Other group major medical coverage must be available to health FSA participants under the same eligibility conditions as the health FSA.
3. The maximum COBRA premium that may be charged for the health FSA must equal or exceed the maximum health FSA benefit for the plan year.

Most health FSAs (e.g., those funded solely with salary reduction dollars) will satisfy these three conditions.

Employees with underspent health FSAs at the time of the qualifying event need to elect COBRA continuation coverage on the health FSA in order to retain access to their year-to-date salary reductions.

Point Solution Programs

Certain "point solution" programs, which are typically designed as specific services that add value to an employer's major medical plan (e.g., programs related to fertility, musculoskeletal conditions, weight management, or mental health), are subject to COBRA (as well as ERISA, HIPAA, and the ACA) if the program provides medical care. While the analysis turns on the particular services provided through each unique point solution program, it essentially boils down to whether the program provides individualized diagnosis, treatment, or prescription services as opposed to a program that provides just behavioral coaching, education, broad-based exercise, or other general health recommendations. If the point solution is more broad-based in nature, i.e., beneficial to the general health and well-being of an individual, then it is unlikely to be considered medical care. Conversely, if a licensed medical practitioner is providing diagnoses, treatment, or prescriptions related to an individual's specific condition, then the program is providing medical care and would be subject to COBRA. For further information about point solution programs, see the PPI publication **Point Solution Programs: A Guide for Employers**.

Disability, Life, AD&D, Fixed Indemnity, and Disease-Specific Plans

Disability, group term life, and AD&D plans generally do not provide "medical care"; therefore, no COBRA obligation extends to these benefits. In addition, indemnity coverage that pays a fixed amount based on a particular event unrelated to an individual's medical expenses (e.g., hospital admission) and is not coordinated with major medical coverage is not subject to COBRA. By contrast, any cancer or other disease-specific insurance plan that provides medical care is subject to COBRA.

Our Observation	Some AD&D and fixed indemnity plans include an additional coverage component (e.g., as a rider to the plan or embedded within it) that provides medical care. Disease-specific plans, EAPs, and wellness programs must be scrutinized for whether they provide medical care, just like point solution programs. The medical care coverage component of the plan would be subject to COBRA. Employers should review their specific plan designs with legal counsel to confirm adherence to COBRA compliance, especially because carriers might not be sufficiently attentive to this consideration.

3. Qualified Beneficiaries

A group health plan must offer COBRA continuation to "qualified beneficiaries." A qualified beneficiary is an employee (or former employee, including retiree), spouse (including ex-spouse immediately following a divorce), or dependent child who was covered under the group health plan on the day before the occurrence of a COBRA qualifying event (i.e., a triggering event that results in a loss of coverage). A child born to or adopted by a COBRA participant during the COBRA maximum duration period is also a qualified beneficiary. By contrast, a spouse gained by a COBRA participant during the COBRA period can be enrolled in the plan but is not a qualified beneficiary. Each qualified beneficiary has independent COBRA election rights, meaning they have the right to elect their own individual continuation coverage when the employee's coverage ends.

Domestic Partners

Many states recognize domestic partnerships and give domestic partners substantially similar rights and privileges as married individuals. Additionally, many group health plans offer benefits to employees' domestic partners. However, even legally recognized domestic partners (i.e., according to state or local domestic partner registries) are not qualified beneficiaries under COBRA because COBRA specifically limits qualified beneficiaries to employees, spouses, and dependent children. (Note that some states extend continuation coverage rights to domestic partners via their mini-COBRA laws, which fall outside the scope of this publication.)

While domestic partners do not have independent COBRA rights, an employee who loses coverage due to termination or reduction of hours has the right to elect to continue coverage for a domestic partner if the domestic partner is covered under the plan on the day prior to the employee's qualifying event. This is because an employee who loses coverage for either of those reasons has the right to elect the same coverage that was in place on that day, which may include coverage for the employee's domestic partner.

In addition, an employee who elects COBRA has the right to add a domestic partner during a subsequent open enrollment period if similarly situated active employees are permitted to do the same. Employers that offer health coverage to domestic parties (a domestic partner or the child(ren) of a domestic partner) should also be aware that HIPAA special enrollment rights protect an employee's right to add any dependent who is eligible under the plan, including a domestic party, due to a relevant loss of coverage event. By contrast, however, life event special enrollment rights do not grant employees the right to enroll a newly qualified domestic partner outside of the employer's open enrollment period, as attaining domestic partnership status is not comparable to marriage for purposes of triggering a HIPAA special enrollment right.

Further, because COBRA doesn't provide a definition for "dependent child," any child who is a dependent under the terms of a plan, including children of domestic partners who are not themselves qualified beneficiaries, will be a "dependent child" – and thus a "qualified beneficiary" – for purposes of COBRA continuation coverage. On the other hand, if children of domestic partners are not included in the definition of dependent children under a plan, they would not be independent COBRA qualified beneficiaries. Employers should review relevant plan terms with their carriers and legal counsel to establish consistent COBRA administration practices, with clear communication to plan participants.

Our Observation	COBRA sets minimum standards for the continuation of group health coverage. Employers that offer domestic partner health coverage can design their health plans to offer domestic partners COBRA-like healthcare continuation benefits, provided the carrier agrees and the provision is included in the plan document. Such provisions can allow an employer to offer COBRA-like coverage to an employee's former domestic partner upon timely notice of the termination of the domestic partnership; similarly, such provisions can allow an employer to offer COBRA-like coverage to a new domestic partner or spouse of the employee's former domestic partner if a subsequent qualifying event occurs during the continuation period. Employers that choose to extend these COBRA-like benefits to domestic partners generally follow the same COBRA notification and premium rules as would otherwise apply to COBRA qualified beneficiaries. Employers that offer domestic partner health coverage and engage a TPA for COBRA services should carefully review their administrative practices (including the COBRA election packet) to ensure that any references to domestic partner continuation coverage are consistent with their intended policy, plan documents, and benefit communications.

For more information about domestic partner benefits, including criteria for establishing a definition of domestic partnerships and methods for imputing income associated with domestic partner benefits, see the PPI publication **Domestic Partner Benefits: A Guide for Employers**.

4. COBRA Qualifying Events

A COBRA qualifying event requires employers to offer COBRA continuation coverage to qualified beneficiaries. As explained above, qualified beneficiaries are covered individuals who experience a loss of coverage because of a triggering event. Losses of coverage include any change in the terms or conditions of coverage (e.g., reduction in benefits), not only complete termination of coverage. Both active and former employees can be qualified beneficiaries, as can their spouses (including ex-spouses following a divorce) and dependent children, depending upon the qualifying event.

COBRA lists seven events (referred to as triggering events) that constitute qualifying events if they result in a loss of coverage for a qualified beneficiary. Triggering events that do not result in a loss of coverage are not considered COBRA qualifying events. Likewise, losses of coverage for reasons that are not recognized triggering events are not considered COBRA qualifying events.

In simple terms: **Triggering Event + Loss of Coverage = COBRA Qualifying Event**.

Triggering Events

1. **Termination of Employment:** Termination of employment is a triggering event. This includes voluntary terminations (e.g., employee-initiated resignation or retirement), involuntary terminations such as firings, layoffs, and other employer-initiated discharges, and labor-related terminations such as strikes and lockouts.

   Other than terminations for "gross misconduct," the facts and circumstances surrounding a termination are irrelevant for purposes of determining whether a triggering event or the corresponding qualifying event occurred; if an employee's termination of employment results in a loss of coverage, then the employee has experienced a qualifying event and is a qualified beneficiary, as are the employee's covered spouse or dependent children. As explained above, while domestic partners are not COBRA qualified beneficiaries with independent COBRA rights, an employee who loses coverage due to termination or reduction of hours has the right to elect to continue coverage for an enrolled domestic partner.

Our Observation	Termination for "gross misconduct" is the only exception to the rule that employment termination triggers COBRA continuation coverage rights. However, the COBRA regulations do not define "gross misconduct," and courts have not fashioned a uniform definition. Without a clear standard to apply, employers that deny COBRA coverage for gross misconduct risk the imposition of retroactive coverage and other penalties in the event a court invalidates their determination. As a result, except for egregious circumstances where an employee's termination is for substantial and willful disregard of the employer's interests (as analyzed by legal counsel), employers should generally avoid relying on their perception of gross misconduct as a basis for denying COBRA coverage.

2. **Reduction of Hours:** A covered employee's reduction of hours is a triggering event. If the reduction of hours results in a loss of coverage for the employee and/or the employee's spouse or dependents, then it is a qualifying event. (As discussed above, a loss of coverage includes any change in the terms or conditions of coverage such as a reduction in benefits.) Reductions of hours can result from an employee moving from full-time to part-time, temporary furloughs, unpaid leaves of absences, strikes, or lockouts.

   Reductions of hours include leaves of absence (i.e., a reduction to zero hours of work). The qualifying event occurs when coverage is lost under the eligibility terms of the plan during the leave of absence, such as following the expiration of any FMLA protected leave. Note that if an employee declines coverage on FMLA leave (or fails to pay the required premiums) and does not return to work following the end of the FMLA leave period, a COBRA qualifying event occurs on the last day of the FMLA leave or the date coverage is lost, if later. If an employee provides earlier unequivocal notice that they will not return to work, then the date of that notice is considered the last day of the FMLA leave, and the COBRA qualifying event

occurs on the date the FMLA leave ends or the date coverage is lost, if later. Importantly, employers should consult with employment law counsel before terminating FMLA leave early based on an employee's notice of their intention to not return, as this impacts significant employment rights.

A discussion of FMLA protections is outside the scope of this publication, as are state and local employment laws that may provide additional job and benefit protections for certain types of leaves. Employers should consult with their human resources consultant or employment law counsel to ensure their leave, PTO, and other personnel policies satisfy all FMLA and applicable state and local employment laws.

3. **Divorce or Legal Separation:** Entry of a divorce decree or legal separation (by court order) is a qualifying event for the spouse and any dependent children (such as stepchildren) who lose health coverage as a result. While divorce almost always makes a covered spouse ineligible for coverage, legal separation may not result in loss of coverage if the plan document deems separated spouses to be eligible for coverage. Employers should review their plan document to determine if legal separation triggers a loss of coverage.

   Anticipation of Qualifying Event Rule: The COBRA regulations include a special "anticipation of qualifying event" rule that addresses the situation in which an employee drops a spouse's coverage (e.g., during open enrollment) in advance of a divorce or legal separation. Specifically, if a covered employee eliminates or reduces a spouse's coverage in anticipation of a divorce, then upon receiving notice of the divorce (required within 60 days of the entry date of the divorce decree), the plan must make COBRA continuation coverage available as of the date of the divorce, even if the employee or spouse was no longer covered at that time.

Our Observation	From an administrative perspective it may be difficult to determine whether an employee has dropped a spouse's coverage in anticipation of a divorce. Employers will make this determination based on the facts and circumstances of any given situation (e.g., an employee mentions a pending divorce when inquiring about spousal coverage). To avoid the risk of a coverage dispute, employers should ensure that plan information clearly relays this rule to employees, seek legal counsel on any uncertain scenarios, and consult with carriers (including stop-loss carriers) to confirm coverage rules.

4. **Death of Employee:** The death of a covered employee is a triggering event for any covered spouse and covered dependent children of the employee.
5. **Dependent Child Ceases to Be a Dependent Under the Plan:** A covered dependent child experiences a qualifying event when they lose coverage based on the plan's age restrictions (also known as "aging out"). This typically occurs at age 26 due to the ACA's requirement for plans to cover adult children up to age 26, if the plan covers children at all. Employers have discretion to establish aging-out rules that result in loss of coverage either on the dependent child's birthday, the end of the month, or the end of the calendar year in which the child reaches the limiting age, so employers should ensure that the COBRA qualifying event aligns with the plan's benefit end date rules.
6. **Entitlement to Medicare:** COBRA includes entitlement to Medicare (i.e., enrollment) as a triggering event. However, this is rarely a qualifying event because employers with group health plans subject to COBRA (due to having 20 or more employees) are also subject to Medicare Secondary Payer (MSP) rules (also due to having 20 or more employees), which prevent employers from terminating an active employee's coverage because of Medicare entitlement. However, employers may terminate health coverage for retired employees who become entitled to Medicare without violating MSP rules, and retirees' spouses and covered dependents may be entitled to COBRA.
7. **Bankrupt:** An employer's bankruptcy can be a triggering event for retirees and their dependents if a loss of coverage results from the bankruptcy. These retiree qualified beneficiaries will have the right to elect COBRA continuation coverage following the bankruptcy if the employer or any member of its controlled group (as defined in Section 414) continues to offer any group health plan. Note that bankruptcy alone is not a COBRA triggering event for active employees or their dependents.

5. COBRA Intial Notice and SPD Disclosures

Initial Notice

A group health plan that is subject to COBRA must provide written notice of COBRA rights and notification obligations to covered employees and their covered spouses when they begin coverage under the plan. While the DOL regulations call this notice the "general notice," it is typically called the "initial notice" in practice and includes information related to: plan and COBRA administrator contacts; qualifying events; qualified beneficiaries; COBRA rights; directions on how to elect and deadlines for making elections; consequences of failing to elect; description of the benefits that may be continued; duration of continuation coverage; premium amounts and payment procedures; and the importance of notifying the administrator of any qualified beneficiary address changes. While the initial notice can take many forms, the DOL provides a model initial notice which most plans adopt. Any deviation from the DOL's model initial notice should be reviewed by an employer's legal counsel. A copy of the DOL model initial notice can be found here: DOL Model COBRA Initial Notice.

The plan must provide the initial notice to covered employees and covered spouses within the first 90 days of coverage. This means that if a spouse enrolls later than the employee (such as due to a HIPAA special enrollment), they must be provided their own initial notice. Importantly, because COBRA rights are only available to plan participants, not to all employees merely eligible for coverage, the initial notice should only be provided to covered participants.

Our Observation	Because COBRA rights are available exclusively to plan participants, not to all employees merely eligible for coverage, initial notices should not be distributed through open enrollment guides or new hire packets. Distributing initial notices to employees who are not enrolled for coverage is misleading (i.e., it provides employees with information regarding rights they do not yet have and will never have if they waive coverage). In addition, open enrollment guides or new hire packets are not a suitable vehicle for delivering initial notices to covered spouses.

Generally speaking, plan administrators have a choice in how to deliver COBRA initial notices, though certain delivery methods (like first-class mail) are more reliable than others. If a plan administrator chooses to send initial notices via second- or third-class mail, return/forwarding postage must be guaranteed, and address correction must be requested. In addition, plan administrators must be able to prove the initial notice was mailed to covered employees and covered spouses, sometimes years later. Like COBRA election notices, proof of mailing COBRA initial notices may be established with USPS records (e.g., Certificates of Mailing) or business records. For more information, see the Proof of Delivery discussion in the COBRA Election Process section below. There is no requirement to distribute the COBRA initial notice to dependent children.

Our Observation	Neither COBRA vendors nor carriers routinely assume responsibility for providing the initial notice to covered employees and covered spouses within the first 90 days of coverage. Plan administrators (typically employers), who have ultimate responsibility for compliance with COBRA requirements, should address this requirement with TPAs to ensure that the initial notice requirement is timely satisfied by an identified party.

SPD Disclosures

ERISA plans must provide each covered participant and beneficiary with an SPD, which explains their rights and obligations under the benefit plan. The SPD must be written in plain language that the average participant can understand. In addition to plan eligibility requirements, a summary of benefits, applicable claim procedures, and ERISA rights and obligations, the SPD must include a description of COBRA rights and obligations, including information concerning qualifying events, qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.

For more information on SPD disclosures and an overview of ERISA compliance, see the PPI publication **ERISA Compliance Considerations for Health and Welfare Benefit Plans**.

Our Observation	The DOL's COBRA regulations technically permit a plan administrator to satisfy the initial notice requirement via an SPD if the SPD meets certain specifications. Under this approach, the SPD must include all the information required in the initial notice and must be delivered to covered employees and covered spouses within the first 90 days of coverage. But, there are several reasons why distributing a stand-alone initial notice is preferable: it is more likely to be read; it simplifies proof of delivery recordkeeping; and the cost of distributing it via first-class mail is less than for the much lengthier SPD.

6. COBRA Election Process

Qualified beneficiaries who experience a qualifying event must be given the opportunity to elect COBRA. There are three stages in the COBRA election process:

1. **Notice of the qualifying event** by the qualified beneficiary to the plan administrator
2. **Delivery of the election notice** by the plan administrator to qualified beneficiaries
3. **Election of coverage and payment** of the initial premium by qualified beneficiaries to the plan administrator

Although most employers use a third party to administer the COBRA election process, employers (as plan administrators) have ultimate responsibility for compliance.

Stage 1: Notice of Qualifying Event to the Plan Administrator

The plan administrator must be advised of a potential qualifying event before it can deliver COBRA election notices to qualified beneficiaries. The responsibility to notify the plan administrator lies either with the employer, covered employee, or qualified beneficiary, depending upon the type of triggering event.

Employer Responsibility for Notice. COBRA's language technically requires employers to provide notice to the plan administrator of any of the following events within 30 days of their occurrence:

- Termination or reduction of hours of the covered employee
- Death of the covered employee
- Covered employee's enrollment in Medicare (only a qualifying event if group coverage is lost, which is rare due to MSP rules)
- Employer's bankruptcy (causing a substantial elimination of retiree coverage)

For single employer plans, under which the employer and the plan administrator are usually the same entity, the employer is effectively allowed a combined period of 44 days to provide election notices to qualified beneficiaries — 30 days for the employer's notice to the plan administrator, plus 14 days for the plan administrator's notice to the qualified beneficiaries.

Covered Employee/Qualified Beneficiary Responsibility for Notice. Covered employees and qualified beneficiaries are responsible for providing notice to the plan administrator of a divorce or legal separation, or when a child loses dependent status under the plan. The notice should generally be provided within 60 days of the later of the triggering event or the resulting loss of coverage. The timeframe for covered employees and qualified beneficiaries to provide notice to the plan administrator should be set forth in the initial notice. An employer's failure to provide a timely COBRA initial notice to covered employees and covered spouses may prevent the plan from enforcing these notice deadlines against qualified beneficiaries.

The plan must establish reasonable procedures for covered employees and qualified beneficiaries to provide notice of a triggering event, including all of the following:

- Describing the procedure in the plan's SPD
- Specifying the individual or entity designated to receive notices and how notices should be provided
- Describing the information regarding the qualifying event necessary to provide continuation coverage rights
- Complying with regulatory requirements regarding reasonable timeframes for providing the notice, reasonable notice content, and who may provide the notice

Stage 2: Election Notice to Qualified Beneficiaries

The election notice provides key election information to qualified beneficiaries and starts the clock running on the COBRA election period. The plan administrator is responsible for satisfying election notice content requirements and timely delivery to qualified beneficiaries.

Content of the Election Notice. The election notice must contain specific information related to COBRA rights and election processes, including: plan and COBRA administrator contacts; qualifying events; qualified beneficiaries; COBRA rights; directions on how to elect and deadlines for making elections; consequences of failing to elect; description of the benefits that may be continued; duration of continuation coverage; directions on how to provide notice of a second qualifying event; premium amounts and payment procedures; and the importance of notifying the administrator of any qualified beneficiary address changes. (See the DOL's An Employer Guide to Group Health Continuation Coverage Under COBRA for a full list of these required items.)

Any COBRA election notice that does not include these required items would be considered deficient and could subject the employer to a lawsuit by COBRA qualified beneficiaries and/or a DOL investigation and penalties. Helpfully, the DOL provides a model election notice, which most plans adopt. Because COBRA compliance is ultimately the employer's responsibility (when they serve as plan administrator), employers that rely on a third party to provide COBRA election notices should routinely ensure that the notice, as provided, includes all the elements required under the COBRA regulations. Using the DOL Model COBRA Election Notice helps to ensure compliance.

Delivery of the Election Notice. The plan administrator has 14 days from its receipt of notice of a qualifying event to send election notices to qualified beneficiaries. Where it is the employer's responsibility to give notice of the event and the employer is also the plan administrator (i.e., in the events of employment termination, reduction of hours, death of covered employee, covered employee's enrollment in Medicare, or employer bankruptcy for covered retirees), the employer generally has 44 days from the triggering event to deliver election notices to qualified beneficiaries. (As noted above, this technically consists of 30 days for the employer's notice to the plan administrator, plus 14 days for the plan administrator's notice to the qualified beneficiaries.) The date the election notice is sent to the qualified beneficiary, irrespective of any date on the COBRA election notice itself or the date the qualified beneficiary receives the notice, is key in assessing timely delivery.

Our Observation	Despite generally being allowed 44 days to send the election notice to qualified beneficiaries, employers should ensure election notices are provided as quickly as possible. Because coverage often ends within days of the qualifying event, qualified beneficiaries can sometimes experience gaps in coverage that are not always easily remedied when continuation coverage is reinstated retroactively (e.g., when scheduled medical care was put on hold). Additionally, undue delay may lead to disputes regarding timely delivery of election notices.

The election notice must be sent to each qualified beneficiary's last known address. One election notice may be sent to all qualified beneficiaries residing at the same address, addressed to the covered employee, spouse, and any dependents. The qualified beneficiaries covered by the notice must be clearly identified, with an explanation of their independent rights to elect COBRA continuation coverage. Employers are not required to address election notices to covered dependent children if they reside with a covered employee and/or spouse to whom the election notice is addressed. However, the election notice must identify each qualified beneficiary covered by the notice (including any dependent children) and explain that each qualified beneficiary has independent COBRA election rights. Separate notices are required when qualified beneficiaries do not reside together.

Our Observation	Employers should establish routine procedures to maintain current addresses for covered employees, spouses, and dependents and to ensure that the addresses they maintain internally in their payroll or human resources database match addresses on file with their insurers and TPAs. This may include requiring qualified beneficiaries to promptly notify the employer of any address changes. Since job changes (i.e., employment termination, whether voluntary or involuntary) often coincide with address changes, such procedures may also include requiring departing employees to confirm their current addresses. In addition, employers that rely on COBRA TPAs to handle their election notices should adopt reliable procedures (such as electronic file feeds) to ensure the vendors are routinely notified of qualified beneficiary address changes.

Proof of Delivery. Generally speaking, plan administrators have a choice in how to deliver COBRA election notices (by hand, mail, or e-delivery), but certain methods are more reliable than others. First-class mail is an approved delivery method. If a plan administrator chooses to send election notices via second- or third-class mail, return/forwarding postage must be guaranteed, and address correction must be requested.

Hand delivery of COBRA election notices is not recommended, as it is difficult to retain proof of hand delivery. Furthermore, because the election notice must be sent to all qualified beneficiaries, including covered spouses and dependents, hand delivering election notices to a covered employee will not fully satisfy the notice requirements if there are any covered spouses or dependents. Similarly, while electronic delivery of COBRA election notices is permitted, it is not recommended. Again, electronic delivery to a covered employee alone will be insufficient if there are covered spouses or dependents who must receive the election notice.

While a plan administrator does not have to guarantee delivery of an election notice, in the event a qualified beneficiary claims the election notice was not received, the plan administrator must be able to prove an adequate election notice was sent to that individual to their last-known address, using a reasonable delivery method. Testimony that the election notice was sent may not be sufficient proof; the plan administrator will usually be required to produce records that support the assertion (e.g., written procedures for sending election notices, copies of actual sent election notices, and any other evidence of mailing such as USPS documentation or business records).

Our Observation	While first-class mail is an acceptable method of delivery under the COBRA rules, employers must also retain proof that the election notice was mailed. First-class mail with a USPS Certificate of Mailing provides the sender with a mailing receipt including the identity and address of the sender and the recipient(s) and a postmark with the mail date. Because it provides proof of mailing on a certain date from an independent source, USPS first-class mail with Certificate of Mailing is generally considered a best practice for mailing COBRA election notices. Alternatively, business records may serve as proof of mailing first-class mail, without the added USPS expense. Courts have accepted business records as sufficient proof of first-class mailing when those records were created at the time of mailing, under routine procedures, and supported by individual testimony. Plan administrators should also maintain copies of mailed election notices, or other evidence to prove the mailed contents. Note that proof of delivery (via delivery receipt or other confirmation) is not required. However, plan administrators that are notified delivery was unsuccessful are likely obligated under COBRA and ERISA to remedy the situation (i.e., re-send the notice or investigate why the delivery failed).

Remember that while group health plans often engage a third party to provide COBRA administrative services to the plan, the plan administrator (typically the employer sponsoring the plan) remains responsible for satisfying COBRA's requirements, including timely sending adequate election notices using a reasonable delivery method.

Employers should adopt suitable record retention policies, keeping in mind that they may be called upon to prove specific election notices were sent to specific individuals years after the COBRA qualifying event. Eight years is the general rule of thumb for retaining ERISA plan records. However, given the particularly significant legal exposure on proving COBRA election notices were sent, and the varying statutes of limitations, plan administrators should consult with their legal counsel regarding how long they should maintain these records.

Notice of Unavailability

If the plan administrator, after receiving notice of a qualifying event, determines that the individual is not eligible for COBRA coverage, the plan administrator must provide a notice of unavailability of COBRA continuation coverage to that individual. Specifically, a notice of unavailability must explain why COBRA continuation coverage is not available (e.g., employee was terminated for gross misconduct, notice of a divorce was not timely delivered to the plan administrator, a divorce has not yet been finalized, or the plan was terminated) in a manner calculated to be understood by the average plan participant. The DOL has not provided a model for the notice of unavailability of COBRA continuation coverage, due to the wide variety of circumstances under which COBRA continuation coverage may not be available. The distribution rules for the notice of unavailability mimic those for the COBRA election notice.

Stage 3: COBRA Election and the Initial Premium Payment by Qualified Beneficiaries

Calculating the Election Period: Date Sent vs. Date Received. Qualified beneficiaries will generally have at least 60 days to elect COBRA coverage, where the election window is measured from the latter of: 1) the date the plan coverage terminates; or 2) the date the election notice was provided. Generally, the election notice is considered to be provided as of the date it is sent (not necessarily the date on the election notice). However, some courts, in reviewing whether a COBRA election was timely made, have considered the date the COBRA notice was delivered via mail (i.e., the date received) as the date the notice was provided. With this potential interpretation in mind, plan administrators should be cautious in denying COBRA elections when they exceed the 60-day window by only a few days. These are delicate decisions for plan administrators to make in close consultation with legal counsel and carriers, including stop-loss carriers.

Our Observation	Generally speaking, COBRA regulations set forth minimum requirements. In many aspects, such as election windows, plans may be more generous. In any event, plan documents and other COBRA communications should clearly and consistently state a plan's election deadlines. Any decision to provide more generous COBRA terms should be made in consultation with a plan's TPAs and carriers, including stop-loss carriers, and should be applied uniformly to all qualified beneficiaries.

Persons Able to Elect COBRA on Behalf of a Qualified Beneficiary. Each qualified beneficiary has independent COBRA election rights, although a covered employee or their spouse can generally elect coverage on behalf of other qualified beneficiaries. However, a spouse may not decline coverage for the other spouse, nor can the covered employee or their spouse decline coverage for adult dependent children. COBRA elections for qualified beneficiaries who are minor children are made by the covered employee or spouse.

Note that an incapacitated or deceased qualified beneficiary's legal representative, estate, or spouse may make the election on behalf of a qualified beneficiary. Some courts have found an ERISA fiduciary obligation to reasonably assume (based on the specific facts) that an incapacitated qualified beneficiary would have elected COBRA continuation coverage, if not incapacitated. As with evaluating narrowly missed COBRA election windows, these are delicate decisions to be made in close consultation with legal counsel and carriers, including stop-loss carriers.

Available Initial Coverage. COBRA requires employers to offer qualified beneficiaries the opportunity to continue the same coverage in place on the day before the qualifying event. In most instances, this requires employers to extend offers of COBRA coverage for the benefit components in which the qualified beneficiaries were enrolled. These can include any of the benefits discussed in the above section on Plans Subject to COBRA.

Children who become qualified beneficiaries as a result of being born or adopted to a COBRA participant during the COBRA period are subject to a special rule. While these children are qualified beneficiaries, they did not technically have coverage on the day before the qualifying event. However, these children may select any of the same benefits that are available to dependent children of active employees as of the date of the child's birth or adoption.

Timing of Initial Premium Payment. Qualified beneficiaries have at least 45 days from the date of their election to make their initial COBRA premium payment. COBRA premiums are considered to be made on the date the payment is sent to the plan (e.g., postmark date). The initial premium payment covers the period from the loss of coverage through the end of the month preceding the month in which the initial premium payment deadline falls. Plans do not have to provide the elected COBRA coverage until the initial premium payment is made, and employers that extend COBRA coverage prior to receipt of the initial COBRA premium payment do so at their own risk. Once the initial premium payment is made, coverage must be reinstated retroactive to the qualifying event (i.e., the date coverage was lost).

7. COBRA Premiums

Calculation of Premiums

The COBRA premium for a month's coverage cannot be more than 102% of the "applicable premium." Note that the applicable premium (also referred to as the premium equivalent) incorporates the total cost of coverage, including both employer- and employee-paid premiums.

In the case of a Social Security Administration (SSA) disability extension, employers may charge the disabled qualified beneficiary up to 150% of the applicable premium for their coverage tier during the 11-month extension (i.e., after the first 18 months of COBRA continuation), as opposed to the normal 102%. (For more information on this extension, see the discussion below on disability determinations by the SSA.)

Premium Calculation for Fully Insured Plans. For fully insured plans, the COBRA applicable premium is the insurance premium paid to the insurer.

Premium Calculation for Self-Insured Plans. For self-insured plans, the applicable premium is calculated using the actuarial method or the past-cost method. While fully insured plans are subject to the specific premium that is imposed by the carrier (and the carrier assumes all claims risk), self-insured plan claims are paid out of the plan sponsor's general assets. As such, there is not a specific premium for self-insured plans; instead, plan sponsors must calculate the applicable premium. The IRS allows sponsors of self-insured plans to use two different methods to calculate the COBRA applicable premium — the actuarial method and the past-cost method.

Our Observation	This publication only discusses COBRA premium calculations at a high level. Employers with self-insured (including level-funded) plans should calculate COBRA premiums in consultation with an actuary. Because there is a lack of guidance on how to correct a COBRA premium calculation error (i.e., resulting in overcharging or undercharging qualified beneficiaries), employers should discuss appropriate remedies with legal counsel.

- **Actuarial Method:** Under the actuarial method, the plan must identify which similarly situated beneficiaries are most closely related to the particular qualified beneficiary and charge the qualified beneficiary an amount equal to a reasonable estimate of the cost of providing coverage to an individual in that group. This method requires an actuary. Generally, the actuary uses all of the following plan information to conduct the analysis:
    - The 12-month COBRA determination period (typically the plan year)
    - Plan claims data for a prior period (commonly referred to as the review period) with respect to all individuals covered by the plan
    - Information about administrative costs, stop-loss premiums, and stop-loss reimbursements
    - An estimate of the average number of covered lives (including participants, spouses, dependents, and COBRA qualified beneficiaries) for each month of the determination period
- **Past-Cost Method:** The past-cost method is only available if there has been no significant change in either the coverage offered or the number of employees on the plan in the current plan year. Under the past-cost method, the applicable premium equals the cost to the plan for the immediately preceding plan year (including claims costs, administrative expenses, stop-loss premiums, and stop-loss reimbursements) as adjusted by the percentage increase (or decrease) in a cost-of-living index. In general, the past cost equals the total cost for the employer divided by the number of participants.

Our Observation	If the cost of stop-loss coverage is factored into the applicable premium such that participants (COBRA or active) contribute towards the stop-loss coverage, then the stop-loss coverage is considered a plan asset. Under that approach, the stop-loss coverage should be in the name of the plan to reimburse the plan (not the employer) and reflected in the plan documents and Form 5500 Schedule A. Alternatively, if the stop-loss coverage is segregated from the applicable premium rates, the policy belongs to the employer rather than the plan and would not be factored into the COBRA premium calculation.

Premium Calculation for HRAs. HRAs are self-insured plans that present unique COBRA administration issues, including calculating the applicable premiums (i.e., the cost of providing coverage). Similar to other self-insured plans, there are generally two methods that may be used to determine the COBRA applicable premium for HRAs: the actuarial method and the past-cost method (discussed above). For obvious reasons, new HRAs with insufficient past-cost history must rely on the actuarial method. In general, employers with HRAs should calculate COBRA premiums in consultation with an actuary.

Our Observation	Unfortunately, there is not clear guidance on calculating the COBRA premium for a new HRA, outside of hiring an actuary. However, in informal IRS comments, an IRS official noted that it would be improper to set the annual COBRA premium for the first year of an HRA equal to the annual coverage amount, suggesting that first-year expected costs, which tend to be 75% to 80% of annual coverage for HRAs, is a good rule of thumb.

Premium Calculation for Health FSAs. Health FSAs are self-insured plans that present unique COBRA administration issues, including calculating the applicable premiums (i.e., the cost of providing coverage). As discussed in the above section on Plans Subject to COBRA, COBRA coverage continuation rights only apply to underspent FSAs (i.e., the participant's remaining balance – their annual election minus reimbursed claims – exceeds the maximum COBRA premium that can be charged through the end of the plan year). As illustrated in the following example, the health FSA applicable monthly premium (before the 2% administrative surcharge) for the remaining months of the plan year is the maximum coverage amount available to the employee for the year divided by 12. Note that health FSA carryover amounts are not factored into the COBRA applicable premium.

> *Example:* Calculating the premium for "underspent" Health FSAs. Employer maintains a calendar year cafeteria plan under which it offers fully insured medical coverage and a health FSA option to employees. Employee, who is single, enrolls in medical coverage and the health FSA. For the health FSA, Employee makes an annual coverage election of $2,400 and contributes $200 a month. Employee terminates employment on June 30. Employee has contributed $1,200 to the health FSA and has not submitted any claims. In accordance with the COBRA rules, Employee's health FSA is "underspent," and Employee has a right to elect COBRA. Employee's COBRA premium for the health FSA would be $204 a month: the coverage amount available to the employee for the year ($2,400) divided by 12, plus 2% (allowable COBRA administration surcharge).

Premium Calculation for Point Solution Programs. The DOL has not provided formal guidance on how to calculate COBRA premiums for point solution programs structured as a reimbursement. In the absence of guidance, HRAs are the closest analogy. Keeping in mind the general rule that the COBRA applicable premium is based on the total cost of coverage to provide the benefit to similarly situated non-COBRA beneficiaries, the COBRA applicable premium would be based on all individuals with access to the program, not just those who receive reimbursements from the program.

Changing COBRA Rates

Both fully insured and self-insured plans must determine the applicable premium for each 12-month COBRA determination period before the beginning of the period and cannot increase the applicable premium during the determination period. In other words, plan sponsors that experience rate changes during a 12-month determination period (e.g., if the policy year and determination period start and end at different times) generally will not be able to pass along rate increases to COBRA participants during the determination period.

Our Observation	The 12-month determination period runs at the plan level, not the participant level. This means a COBRA participant who begins continuation coverage in the middle of a plan year may be subject to a new rate when the plan's next 12-month determination period begins, even if the participant had COBRA coverage for fewer than 12 months as of the start of the new determination period.

There are only three instances in which a plan may increase the COBRA premium charged to a qualified beneficiary during the 12-month determination period:

- If the qualified beneficiary qualifies for a disability extension, the rate can be increased to 150% of the applicable premium during the 11-month extension.
- If the plan is not currently charging the maximum allowable amount (102% of the applicable premium), the rate can be raised to that maximum allowable amount as determined at the beginning of the determination period.
- If a qualified beneficiary elects a different benefit package during the determination period (such as due to a HIPAA special enrollment right), the plan can use the applicable premium for the different benefit package as determined at the beginning of the determination period.

Our Observation	It may be permissible for employers to select a new COBRA determination period if the decision is supported by a business reason or significant plan change (e.g., short plan year or change in policy coverage period), so long as the employer intends to use the new 12-month determination period indefinitely. However, an employer's decision to modify its determination period because of higher-than-expected costs contradicts COBRA's 12-month determination period requirement. Given the lack of definitive guidance, employers should consult with legal counsel before adjusting a 12-month determination period.

Timing of Subsequent Premium Payments

Plans must allow COBRA participants to make payments in monthly installments, though the parties can mutually agree to other frequencies (e.g., quarterly). The due date for subsequent premium payments is typically the first day of the month for a period of coverage. However, qualified beneficiaries must be granted 30-day grace periods for all COBRA premiums payable after the initial premium. As with the initial premium payment, subsequent premium payments are considered to be made on the date the payment is sent to the plan (e.g., the postmark date if the remittance is not made electronically).

Our Observation	Employers should closely track receipt of COBRA premium payments and should terminate benefits if premium payment is not made by the end of the grace period, as COBRA participants are not otherwise required to notify employers or COBRA TPAs (except passively by non-payment of premium) that they are discontinuing their COBRA benefits prior to the end of the maximum COBRA period. By contrast, employers are required to notify COBRA participants regarding termination of COBRA coverage prior to the end of the maximum COBRA period, as described further under Notice of Early Termination below.

8. Duration of COBRA Coverage

Maximum Duration Periods Generally

The maximum period of COBRA continuation coverage is generally either 18 or 36 months from the qualifying event date, depending upon the type of event. For termination of employment or reduction of hours, the maximum period of COBRA continuation coverage is 18 months. For death of the employee, divorce or legal separation, loss of dependent child status under the plan, or employee enrollment in Medicare, the maximum period of COBRA continuation coverage is 36 months. COBRA coverage must be continuous; in other words, it cannot be elected, dropped, and then later resumed.

When an active employee experiences a termination or reduction of hours that results in a loss of coverage within 18 months after Medicare enrollment, the employee's spouse and dependent children are entitled to COBRA coverage for up to 36 months after the employee's Medicare enrollment. By contrast, the employee is only entitled to the usual 18 months from their qualifying event. For example, if a covered employee enrolls in Medicare 8 months before the date their employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for their enrolled spouse and children must be available for up to 28 months (36 months minus 8 months).

Employer bankruptcy as a qualifying event for retirees is subject to a special rule that may result in a much longer maximum duration for the retiree qualified beneficiaries. Specifically, in the event of a Chapter 11 employer bankruptcy, a covered retiree is entitled to COBRA continuation coverage for life. The retiree's covered spouse and dependent children are entitled to COBRA continuation coverage for the longer of the life of the covered retiree or 36 months following the retiree's death.

Note that a COBRA participant's voluntary termination of their COBRA enrollment before the end of the maximum duration period (such as when an employer-sponsored subsidy ends) does not constitute a HIPAA special enrollment right or election change event that allows the participant to join a group health plan midyear (whether with their own current employer or that of a spouse or domestic partner). However, the end of an employer-sponsored subsidy may give rise to a Marketplace special enrollment period. For further information about midyear election change events, see the PPI publication **Midyear Election Change Events: A Guide and Matrix for Employers**.

Events that Shorten the Maximum Duration Period

Plan sponsors may terminate COBRA continuation coverage earlier than the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis.
- The employer (including successor employers and other employers in a Section 414 controlled group) ceases to maintain any group health plan.
- A qualified beneficiary becomes covered (not merely eligible) under another group health plan after electing COBRA.

Our Observation	Given the administrative burden of consistently monitoring COBRA participants' enrollment in another group health plan, many employers may opt not to apply this termination event; employers should consult with their legal counsel and carriers (including stop-loss carriers) regarding the specific application of this termination event.

- A qualified beneficiary enrolls in Medicare after electing COBRA.
- A qualified beneficiary engages in conduct that would justify terminating coverage of a similarly situated non-COBRA participant (e.g., submitting fraudulent claims).

Before terminating COBRA coverage for failure to timely pay a premium in full, employers should be mindful of the "insignificant shortfall" rule. Under this rule, when a COBRA premium payment is short by an amount less than or equal to the lesser of $50 or 10% of the COBRA premium required by the plan, the employer must either deem the payment adequate or notify the qualified beneficiary of the shortfall amount and provide a reasonable period of time (typically 30 days) for the qualified beneficiary to cover it.

Notice of Early Termination

A plan administrator must provide a notice of termination of COBRA coverage "as soon as practicable" to any qualified beneficiary whose coverage will be terminated before reaching their maximum coverage period, including if the coverage is terminated for non-payment of COBRA premiums by the end of the grace period. The DOL has not provided a model for the notice of termination but does require that the notice be written in a manner calculated to be understood by the average plan participant. Specifically, the notice of termination must include all of the following:

- The reason for the early termination of coverage
- The date coverage will terminate
- A statement of any rights that the qualified beneficiary may have under the plan or under applicable law to elect alternative group or individual coverage, including any conversion rights

The distribution rules for the notice of termination mimic COBRA's election notice distribution rules.

Events that Extend the Maximum Duration Period

Following a termination of employment or reduction of hours qualifying event, the maximum COBRA continuation coverage period of 18 months can be extended in two circumstances: 1) another qualifying event occurs; or 2) a qualified beneficiary is determined by the SSA to be disabled.

Multiple Qualifying Events. The maximum duration of COBRA continuation coverage can be extended to a total of 36 months (inclusive of the original COBRA period) if a second qualifying event occurs within the initial 18-month period (or 29-month period under an 11-month disability extension). There are two conditions that must be satisfied for an individual to qualify for this extension. First, the second qualifying event must be either the death of the covered employee, the divorce or legal separation of the covered employee and spouse, the covered employee's Medicare enrollment (this is rare, due to MSP rules), or the loss of dependent child status under the plan. Second, the second qualifying event must cause a loss of coverage in the absence of the first qualifying event.

The extension only applies to qualified beneficiary spouses and dependents receiving COBRA coverage at the time of the second qualifying event and does not apply to covered employees. While it is the qualified beneficiary's responsibility to notify the plan of a second qualifying event, the plan's SPD and the COBRA initial notice should provide the specific rules for how to provide notice. The time limit for providing notice cannot be shorter than 60 days from the latest of:

1. The date on which the second qualifying event occurs
2. The date on which the qualified beneficiary would have lost coverage under the plan if this were a first qualifying event
3. The date on which the qualified beneficiary is informed of their responsibility to notify the plan of the second qualifying event and the procedures to give such notice

Disability Determination by the SSA. The maximum duration of COBRA continuation coverage can be extended to 29 months in the event a qualified beneficiary is determined by the SSA to be disabled. There are two conditions that must be satisfied for an individual to qualify for this extension. First, the qualified beneficiary's initial COBRA triggering event must be the employee's termination of employment or reduction of hours. Second, the SSA must determine that the qualified beneficiary (covered employee, spouse, or child) is disabled at any time during the first 60 days of COBRA coverage. Note that the qualified beneficiary's disability determination date (i.e., when the disability began) may have occurred before the COBRA effective date.

The qualified beneficiary or employee must timely notify the plan administrator of their disability determination. The plan's SPD and the COBRA initial notice should specify the rules for providing notice. The time limit for providing notice cannot be shorter than 60 days from the latest of:

1. The date of the disability determination
2. The date on which the qualifying event occurs
3. The date on which the qualified beneficiary would have lost coverage under the plan if this were a first qualifying event
4. The date on which the qualified beneficiary is informed of their responsibility to notify the plan of the second qualifying event and the procedures to give such notice

If all of these conditions are met (including timely notice from the qualified beneficiary), the maximum COBRA continuation coverage period extends by 11 months to a total of 29 months. The extension applies to all qualified beneficiary family members, even if the disabled qualified beneficiary does not elect COBRA. The employer may charge for the disabled qualified beneficiary's enrollment tier (e.g., individual or family coverage) up to 150% of the premium or premium equivalent (as opposed to the normal 102%) during the 11-month COBRA extension. However, if the disabled qualified beneficiary did not elect COBRA, the other qualified beneficiary family members can only be charged up to 102% of the premium through the 11-month extension.

9. Open Enrollments and HIPAA Special Enrollments During COBRA Periods

COBRA requires employers to offer qualified beneficiaries the opportunity to continue the same coverage that was in place on the day before the qualifying event. Additionally, when an open enrollment period is available for similarly situated employees under the plan, or when a qualified beneficiary experiences a HIPAA special enrollment event, the qualified beneficiary may make coverage changes consistent with the election changes available to active employees. This means that qualified beneficiaries can enroll dependents on a midyear basis because of marriage, birth, adoption, or loss of other health plan coverage. HIPAA special enrollment rights only arise for qualified beneficiaries receiving COBRA coverage, not for former qualified beneficiaries who failed to timely elect coverage following a qualifying event.

Generally, any family members added during open enrollment or due to a HIPAA special enrollment event do not become independent qualified beneficiaries. The one exception to this rule is children born to or placed for adoption with the covered employee during a period of COBRA continuation coverage. Those children are considered independent qualified beneficiaries, but the maximum duration of their COBRA continuation coverage is tied to their parent's initial qualifying event.

Each qualified beneficiary has independent open enrollment rights as if they were an active employee. Importantly, plan administrators must notify COBRA qualified beneficiaries of any coverage changes, including any carrier, plan design, or rate changes and the availability of any new group benefits, ahead of the open enrollment effective date. All coverage options (including any coverage modifications) available to similarly situated active employees during open enrollment must also be made available to qualified beneficiaries. This means that qualified beneficiaries must be allowed to add, change, or drop coverage types (e.g., add medical, even if enrolled only in dental as of the COBRA qualifying event) and must be allowed to switch elections within a coverage type (e.g., change from a PPO plan to an HDHP or vice versa) and add or drop family members, to the extent that active employees are given these choices.

Our Observation	COBRA vendors that agree to provide open enrollment information to COBRA qualified beneficiaries often charge a separate flat fee or per-packet charge for this service and require annual confirmation of the open enrollment details. Employers should address these COBRA open enrollment administrative details with their vendors to ensure that the COBRA qualified beneficiaries are given the appropriate opportunity to make elections for the upcoming plan year.

10. Consequences of COBRA Noncompliance

Common COBRA administration mistakes include:

- Failing to provide initial notices or election notices.
- Failing to offer COBRA continuation coverage on point solutions, disease-specific plans, EAPs, or wellness programs that offer medical care.
- Failing to offer the same open enrollment rights to COBRA qualified beneficiaries as are offered to active employees.
- Failing to correctly calculate COBRA premiums or failing to charge the correct COBRA premium amount.

Employers must remember that they have ultimate responsibility for COBRA compliance, regardless of whether they use a COBRA TPA or administer the requirements in-house.

As with many compliance failures, the general rule for correcting COBRA compliance failures is to return the qualified beneficiary to the position they would have been in had the compliance failure not occurred. Note that qualified beneficiaries interested in maintaining health coverage are particularly incentivized to file complaints with the DOL or sue to enforce their COBRA rights. Employers that suspect a COBRA compliance violation should discuss the specific risk and potential liability with legal counsel as soon as possible.

Failing to meet COBRA's many requirements can result in significant penalties and costly participant lawsuits (which may include awards of attorneys' fees and interest against employers). Employers can also be held liable for any medical costs incurred by a participant during a period that a qualified beneficiary should have been offered COBRA continuation coverage. If a COBRA notice failure is not corrected within 30 days of discovery, then the employer may need to self-report the violation on IRS Form 8928 with assessable civil penalties of $100 per day. Failure to provide a complete initial notice or election notice at the required times to the required recipients could also put an employer at risk for legal action brought by participants and ERISA fines of up to $110 per day per participant. Class actions based on alleged COBRA notice failures have become more prevalent in recent years.

In addition to the possible statutory penalties and lawsuits, a plan that fails to provide initial notices will not be able to enforce notice deadlines against qualified beneficiaries, thereby potentially extending COBRA coverage for those qualified beneficiaries. For example, an employer that fails to comply with the initial notice requirement related to spouses could not impose the 60-day notification period following a divorce for an ex-spouse electing COBRA coverage. If the spouse was never informed of the obligation to notify the plan within 60 days of the divorce to preserve their COBRA rights, the employer might be responsible for offering the full measure of coverage regardless of when they are notified of the divorce. Further, a carrier (including a stop-loss carrier) could deny coverage because of the initial notice failure, which would leave the employer paying out-of-pocket for an ex-spouse's claims.

When an employer discovers a COBRA initial notice compliance failure, a generally accepted best practice is to distribute the initial notice to all currently enrolled employees and spouses, implement a compliant procedure going forward, and consult with legal counsel on additional corrective actions. The initial notice boilerplate may need to be tailored to the situation to prevent confusion among participants receiving a particularly late notice of their COBRA rights and obligations.

Like initial notice failures, failing to properly send election notices is a common COBRA mistake that exposes employers to potentially substantial liability. Considering the general goal is to put the participants in the same position they would have been in had the COBRA election notice been timely provided, one potential remedy for election notice failures is to offer retroactive COBRA coverage (with carrier approval). In that case, the qualified beneficiary should be allowed to choose the duration of retroactive COBRA coverage in between the date of the qualifying event and the time of remedy, but the employer may have to cover the COBRA premium for any retroactive period. This is because the DOL generally frowns upon requiring COBRA beneficiaries to pay for retroactive COBRA, which may be a substantial sum depending on how much time has passed.

Another potential option is to offer *prospective* COBRA coverage. Prospective coverage goes beyond what COBRA requires but addresses complaints by those who may have declined or postponed medical care they would have otherwise pursued had COBRA coverage been offered.

While offering a qualified beneficiary either retrospective or prospective coverage is not a complete remedy for a COBRA notice failure, such voluntary corrective actions can stop the clock on penalties and offer partial relief to qualified beneficiaries, thereby limiting potential damages. Any proposed remedy to a COBRA notice failure should be tailored to the unique facts of the situation in close consultation with legal counsel and approved by the carriers (including any stop-loss carriers).

11. Additional Issues in COBRA Administration

COBRA in the Mergers and Acquisitions Context

In the context of mergers and acquisitions (M&As), the COBRA regulations provide default rules regarding COBRA responsibilities. The parties in these transactions are generally free to negotiate COBRA liability (and health plan obligations), provided COBRA qualified beneficiaries receive any required offers of continuation coverage. Such COBRA qualified beneficiaries, often referred to as "M&A qualified beneficiaries," may include those receiving COBRA coverage under the seller's plan at the time of the transaction, as well as individuals whose employment is terminated or who lose benefits eligibility with the new employer as a result of the transaction. If COBRA is not addressed in the transaction agreement, then the default COBRA rules apply.

COBRA Qualifying Event. In the acquisition context, the triggering event is typically a termination of employment. With stock transactions, if all employees continue employment with the buyer after the stock sale, there is no COBRA qualifying event. In such a case, the employees of the acquired division may experience a loss of coverage under the seller's plan but are not necessarily entitled to an offer of COBRA as a COBRA triggering event did not occur. (These employees would instead be entitled to continue coverage as active employees under the buyer's plan, and therefore would not suffer a loss of coverage.) However, if some benefits-enrolled employees are terminated or suffer a reduction in hours below the benefits eligibility threshold because of the sale, those individuals would experience a COBRA qualifying event and thus must be offered COBRA.

By contrast, employees who lose group health coverage due to an asset sale typically experience a COBRA qualifying event. In other words, the employees have a termination of employment with the seller, even if hired (and offered coverage) by the buyer. For example, assume a seller sells one of several divisions to a buyer and the buyer hires all the division's employees and offers them coverage under the buyer's group health plan. Those employees (and their spouses or domestic partners and dependents) who were previously covered under the seller's plan immediately prior to the transaction date would be entitled to an offer of COBRA.

Party with COBRA Obligation. Regardless of whether the transaction is an asset or stock transaction, the COBRA liability generally defaults to the seller. Specifically, if the seller (as defined on a Section 414 controlled group basis) maintains any group health plan after the sale, then the seller must make COBRA coverage available to covered employees, spouses, or domestic partners and dependents who lost coverage because of the sale (and also to the current COBRA participants). Sellers that maintain a plan after the sale (either as an individual entity or within a controlled group) should consult with their carriers (including stop-loss carriers) to ensure the M&A COBRA qualified beneficiaries will be covered, even if they were not previously enrolled in the seller's remaining plan.

By contrast, different COBRA obligation rules apply to asset versus stock transactions if the seller ceases to provide any group health plan. In a stock sale, a group health plan maintained by the buyer has the obligation to make COBRA coverage available, but only if the cessation of the seller's plan was "in connection with the sale." The determination of whether a plan cessation is in connection with a sale is based upon all facts and circumstances. Thus, even if the plan termination occurs after the actual sale date, the termination can still be considered "in connection with" the sale (assuming the facts and circumstances support such a finding).

In an asset sale, the buyer's group health plan may also be obligated to make COBRA coverage available if the seller ceases to maintain any plan in connection with the sale. However, this responsibility arises only if the buyer continues the business operations associated with the purchased assets without interruption or substantial change. In such a case, the buyer is considered a successor employer. The buyer's obligation as a successor employer should be satisfied if the buyer offers active coverage under the buyer's group health plan to the acquired employees of the seller, and if the buyer also makes COBRA coverage available to the M&A qualified beneficiaries under the buyer's plan.

If COBRA liability attaches to the buyer, the obligation to make coverage available begins on the later of: 1) the date that the seller ceases to provide any group health plan; or 2) the date of the sale. The buyer's obligation extends only to the COBRA

beneficiaries with respect to the transaction (i.e., the COBRA beneficiaries related to the purchased entity, but not to other entities owned by the seller).

COBRA Disclosure Obligations. The parties should be closely attentive to COBRA disclosure obligations related to the transaction. If the seller maintains a group health plan for a period after the acquisition date, then the seller is responsible for providing COBRA election notices to the COBRA qualified beneficiaries who became employees of the buyer. If the seller ceases to provide any group health coverage, the seller must provide a notice of cessation of coverage (e.g., a Summary of Material Reduction or an SBC) to any remaining active employees. If COBRA liability attaches to the buyer, the buyer is responsible for sending the COBRA election notices. Additionally, the existing COBRA participants under the seller's plan must be notified of the change in the group health plan coverage (including any change in the COBRA administrator and premium payments).

The buyer has the obligation to provide SBCs and SPDs to hired employees and qualified beneficiaries (including COBRA participants) offered coverage under the buyer's group health plan. The buyer must also provide newly hired employees with a COBRA initial notice for the buyer's plan.

For more information about the numerous health and welfare benefit compliance issues that arise during business reorganizations, see the PPI publication **Health Benefits Compliance Considerations in Mergers and Acquisitions: A Guide for Employers**.

Deferred Losses of Coverage

While most losses of coverage occur soon after a triggering event, some coverage losses may not occur until well beyond the triggering event, such as during leaves of absence (see item 2 in the Triggering Events subsection of the COBRA Qualifying Events section above for more information on leaves of absence as qualifying events), under look-back measurement stability periods (used for determining which variable-hour employees must be offered coverage under the ACA employer mandate), or through severance agreements. Any extension of coverage must be consistent with the plan's eligibility terms and approved by the carriers (including stop-loss carriers). Because a COBRA qualifying event does not arise until after a triggering event produces a loss of coverage, COBRA continuation coverage should not be offered until the eventual loss of coverage occurs. Further, to produce a COBRA qualifying event, the eventual loss of coverage must occur within the time period from the triggering event through the COBRA maximum coverage period (18 or 36 months).

Required Group Health Plan Notices

Many periodic group health plan notice requirements, such as SPDs, Summaries of Material Modifications or Reductions, Summaries of Benefits and Coverage, Summary Annual Reports, and Medicare Part D Creditable/Non-Creditable Coverage Disclosure notices, extend to COBRA participants as well as active employees. For further information about required group health plan notices, see the PPI publications **Required Group Health Plan Notices Chart** and **Required Group Health Plan Notices Overview**.

International Considerations and COBRA

There is a lack of specific guidance on COBRA administration in international settings. Questions related to COBRA in international settings often relate to applicability: which non-US citizen employees may be qualified beneficiaries and which international plans are subject to COBRA. First, if a non-US citizen is not receiving US source income during their active coverage period, then neither they nor their enrolled dependents are qualified beneficiaries. Second, if a group health plan is maintained outside the US primarily for the benefit of non-US citizen employees, then it is not subject to COBRA. This is true even if a US citizen is covered by the plan. Employers sponsoring international group health plans that cover non-US citizen employees with no US source income should review their covered employee population with legal counsel to determine their COBRA obligations.

COBRA Considerations for Retiree Coverage

Retirement (assuming it involves termination of employment) is a COBRA qualifying event that allows retiring employees and their covered spouses or dependents ("retiree beneficiaries") to elect COBRA. Employers offering retiree coverage – either through the active plan or a separate retiree plan – must also comply with COBRA regarding the retiree plan offering. However, the application of COBRA rules differs based on whether the retiree coverage is alternative to active coverage or identical to active coverage.

Alternative Retiree Coverage. An employer provides alternative coverage when they offer retirees non-COBRA continuation of coverage that varies from active coverage in cost or benefits. This offering might be through the active plan or through a separate retiree-only plan. Either way, employers that offer alternative retiree coverage upon retirement must generally provide a simultaneous offer of COBRA to the retiree beneficiaries. Such COBRA qualified beneficiaries should receive COBRA election paperwork and have the entire 60-day election period to choose between the retiree coverage and COBRA.

Employers offering retiree coverage as an alternative to COBRA often require COBRA qualified beneficiaries to waive their right to COBRA in exchange for taking the alternative coverage. This waiver of COBRA should be clearly communicated such that qualified beneficiaries understand that they will not have a right to an offer of COBRA once the alternative coverage ends.

Our Observation	A spouse or dependent enrolled in alternative retiree coverage would normally experience a qualifying event that would allow them to elect COBRA continuation coverage if they lose the alternative retiree coverage due to any of the regular COBRA triggering events (i.e., death of the retiree, divorce from the retiree, the retiree's entitlement to Medicare, or dependent aging off the plan). Employers that seek to avoid the requirement to offer COBRA continuation coverage to spouses or dependents upon the occurrence of post-retirement COBRA qualifying events would need to design their offering such that these events do not trigger a loss of coverage (i.e., the alternative coverage is offered for a set period of time such that what triggers the loss of coverage is the lapse of time rather than a recognized COBRA triggering event).

Identical Retiree Coverage. If an employer offers retiree beneficiaries the opportunity to remain on the active plan following retirement, the coverage provided is considered identical if there are no differences in the cost (including employer contribution), benefits, or plans offered to active employees and their dependents. If that is the case, and the retiree beneficiaries have the option to remain on the plan, then the retiree beneficiaries do not experience a loss of coverage. If coverage is not lost, then COBRA is not triggered and would not need to be offered at retirement.

Whether COBRA would have to be offered at the end of the identical plan coverage period will depend on how long the identical coverage was provided. If the identical coverage period equals or exceeds the COBRA maximum duration period, then the retiree beneficiaries would not be due an offer of COBRA when coverage ends. However, if the identical coverage period is less than the COBRA maximum duration period, then the retiree beneficiaries must be offered COBRA for the remainder of the maximum duration period. Note that any change to or termination of the identical coverage, including any plan design or participant cost-share contribution changes that are imposed differently for retirees than for active employees, would be considered a COBRA triggering loss of coverage for purposes of producing a COBRA qualifying event.

Our Observation	Due to the complex nature of COBRA rules in the retiree context, employers sponsoring retiree plans should consult with legal counsel for assistance in drafting and implementing retiree coverage. Plan sponsors should ensure that plan documents are carefully drafted to represent the employer's desired retiree coverage obligations, including any intended obligations to surviving spouses or dependent children following the death of the retiree. To avoid disputes concerning the continued coverage of retirees, plan sponsors should also notify their carrier (if fully insured) or their TPA and/or stop-loss provider (if self-insured) of their intended retiree plan design.

12. Summary

Employers that are subject to COBRA regulations (generally all private sector employers with at least 20 employees) should familiarize themselves with the range of COBRA compliance obligations that pertain to their group health plans, including:

- Proper identification of COBRA covered benefits, qualified beneficiaries, qualifying events, and continuation coverage durations.
- Accurate calculation of COBRA premiums.
- Timely delivery of notices (e.g., initial notices and election notices) and COBRA open enrollment packets.

Special COBRA administration issues arise in the context of mergers and acquisitions, deferred losses of coverages, required group health plan notices, and international and retiree benefits.

In their role as plan administrators, employers bear responsibility for proper COBRA administration even if they delegate certain operational functions to a TPA. PPI client copies of PPI publications from the PPI Client Help Center. For further information regarding PPI's full range of services, see **ppibenefits.com**.

13. Resources

An Employer's Guide to Group Health Continuation Coverage Under COBRA (dol.gov)

COBRA | CMS

DOL Model Initial Notice

DOL Model Election Notice

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