Chapter 27
COBRA Continuation of Coverage

Introduction

The continuation of coverage provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct.

While COBRA ensures that people who lose their health insurance coverage can continue it for up to 36 months in some cases, it does not require employers or unions to continue paying for this insurance; the entire health insurance premium must be paid by the persons electing COBRA. Those who utilize their right to COBRA coverage often find it to be surprisingly expensive (see the section “Who Pays for COBRA,” below).

Who Qualifies?

All employees and their dependents covered by an employment-based group health plan (provided by a private-sector employer with at least 20 employees) on the day before a qualifying event are eligible for COBRA. Employees covered by church plans are not necessarily covered by COBRA since their employer is not required to provide continuation of coverage. Employees of states and any political subdivision, agency, or instrumentality of such states, and federal employees (and their dependents) are covered by provisions identical to those of COBRA.

Under legislation that took effect in December 2002, certain people certified as having lost their jobs due to international trade, and who lost employment-based health coverage as a result, may be eligible for a new, second COBRA sign-up period (in addition to the traditional sign-up period described below), as well as tax credits covering 65 percent of the cost of their COBRA premiums.

What Constitutes a “Qualifying Event”?

For active employees and their dependents:

- Voluntary or involuntary termination of employment (other than for gross misconduct) or reduction in hours. (For example, a qualifying
event can occur because of a strike, lockout, layoff, or when an employee fails to work the minimum number of hours required for health plan coverage for instance, because of a disability).

**For retired employees and their dependents:**
- The employer’s filing for bankruptcy.

**For dependents of active or retired employees:**
- The employee’s death.
- Divorce or legal separation.
- The employee’s entitlement to Medicare benefits.
- A dependent child ceasing to be a dependent under applicable plan provisions.

**Duration of Coverage**

When a covered employee is terminated or his or her hours of work are reduced, the employee and qualified beneficiaries must be given the option of electing COBRA coverage for up to 18 months. In cases involving the employee’s death, divorce, legal separation, Medicare entitlement, or loss of a child’s dependency status, either initially or at any time during the continuation of coverage period, the qualified beneficiary must be allowed to elect COBRA coverage for up to a maximum of 36 months from the first qualifying event.

Only in the case of a retiree losing retiree health coverage in the event of a bankruptcy may the COBRA coverage period be longer than 36 months from the initial qualifying event for the retiree and his or her dependents.

**Rights and Costs**

COBRA coverage must be the same as that provided to other similarly situated employees covered under an employment-based health plan (except for medical savings accounts, long-term care plans, and in certain cases, flexible spending accounts) for which a qualifying event has not taken place, and may not be conditioned on evidence of insurability. For example, if the employment-based health plan offers dental benefits as a separate plan option, a COBRA beneficiary must be allowed to separately elect dental coverage under the same conditions as active employees.

Each COBRA beneficiary (except for a new spouse of a COBRA eligible employee, as explained below) may elect his or her own health plan coverage at the time of each qualifying event and open enrollment season. COBRA
beneficiaries have the same right as active employees. For example, COBRA beneficiaries must be allowed to participate in all scheduled open-enrollment seasons and have the same coverage of benefits as active employees participating in the same health plan.

A new spouse of an employee on COBRA may receive the same coverage as the employee, but cannot make any elections on his or her own. The new spouse does not qualify for additional continuation of coverage availability (e.g., in the event of his or her spouse’s death or a divorce from his or her spouse). In contrast, children who are born or adopted during the covered employee’s continuation period are treated as qualified beneficiaries and may make separate elections at the time of their initial enrollment and during open enrollment. Such children are eligible for additional continuation of coverage availability should there be a subsequent qualifying event (e.g., death of employee, divorce, or separation of employee from his or her spouse).

A qualified beneficiary cannot be charged more than 102 percent of the employer’s cost. In the case of individuals considered disabled for Social Security purposes, 150 percent of the employer’s cost may be charged for the 19th month through the balance of the COBRA period for that individual and other family members who also qualify for this continuation of coverage (see the section “Disability and COBRA,” below).

Who Pays For COBRA?

Former employees who pay for their own COBRA coverage typically experience “sticker shock.” That is because active employees (and dependents) typically pay only a portion of their entire health plan premium; employers pay for a significant portion of the premium. By contrast, COBRA beneficiaries pay for the entire premium, plus an additional 2 percent. However, there may be certain situations in which a new employer or a hospital may want to pay for the COBRA coverage, as explained below:

- If a new employer hires a COBRA beneficiary, the new health plan might find a financial advantage in paying for COBRA premiums, especially if the new plan is self-insured and the person is in poor health. The difference between a few months of COBRA premiums and actual medical costs can be substantial.
- Hospitals may also find it advantageous to pay COBRA premiums for patients eligible for COBRA. A hospital can pay the premiums and then be reimbursed for the medical care it provides. This may be cheaper and easier than trying to collect for expensive medical care from an individual without health insurance.
Disability and COBRA

An employee or his or her dependent does not qualify for COBRA solely because of disability. An employee or dependent who otherwise qualifies for COBRA because of termination of employment or reduction in hours is entitled to an extension of COBRA if he or she is disabled (as determined by the Social Security Administration (SSA)) at the time of qualifying for COBRA or at any time during the first 60 days of COBRA coverage (see next section). The actual determination by SSA must occur within the initial 18 months of continuation coverage. Qualified beneficiaries are eligible for up to 29 months of continuation coverage from the time of the initial qualifying event. The 29 months of extended coverage is available to any nondisabled family members of the disabled individual who is entitled to COBRA coverage.

COBRA and Medicare

In instances in which a COBRA-covered employee also becomes eligible for Medicare (the federal health care insurance program for the elderly and disabled), COBRA coverage for spouse or dependent child can continue for at least 18 and as long as 36 months from the date of Medicare entitlement. A maximum of 36 months of coverage is allowed for the spouse or dependent of an employee who retires less than 18 months after becoming eligible for Medicare.

For example, an active employee comes under Medicare coverage in Jan. 2001; his employer’s plan continues to cover the employee and his wife (as required by law). In this example, because there is no loss of coverage, Medicare entitlement is not a qualifying event. However, when the employee retires on Jan. 1, 2002, his 62-year-old wife will lose coverage. His wife’s COBRA coverage period is 36 months from the employee’s Medicare entitlement date (Jan. 1, 2001) until Dec. 31, 2004, or a total of 24 months of actual continuation coverage instead of the 18 months normally extended for a termination of employment but less than the usual 36 months provided for dependents.

COBRA and FMLA

COBRA does not apply to employees taking leave under the Family and Medical Leave Act (FMLA). An employee on FMLA will have a qualifying COBRA event only if the event takes place in the following situations:

- On the last day of the FMLA, if the employee does not return to work.
- When the employer learns that the employee will not return from leave, even if the employee (or other qualified beneficiary) did not have health coverage during the leave.
COBRA coverage cannot be conditioned on the employee’s repayment of health plan premiums that the employer paid during the FMLA. If the plan changes while the employee is on leave and not covered under the plan and there is a COBRA qualifying event, the employee would be entitled to the same type of coverage he or she was enrolled in immediately prior to the leave or to whatever coverage is available to employees in the COBRA beneficiary’s employment group.

**Employer Notification Requirements**

The employer must notify the employee and his or her spouse of the right to continued coverage under COBRA when they are first covered under the plan and at the time of certain qualifying COBRA events.

An employer whose health plan is not self-administered must notify the third-party administrator within 30 days of an employee’s death, termination of employment, or reduction in hours, or of the employer’s bankruptcy. The employee and spouse are responsible, as explained below, for notifying the employer of other qualifying events under COBRA. The third-party administrator has 14 days from the time it is notified of a qualifying event to notify the beneficiaries of their COBRA rights.

Employers that self-administer their own group health plans have 44 days to notify beneficiaries. Multi-employer plans have longer notification periods. Notice must be made to the beneficiary’s last known address. Notice may be made by first-class mail, and does not need to be sent by certified mail in order to be in compliance.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a group health plan must provide certification of the period of creditable coverage under any applicable COBRA continuation provision and waiting period (if any) imposed on an individual. This certification must be provided when the individual ceases to be covered under the group health plan or otherwise becomes covered under a COBRA continuation provision, after any COBRA continuation coverage ceases, and on the request of an individual not later than 24 months after coverage ceased. At a COBRA qualifying event, certification of prior employer coverage may be provided along with the COBRA notification.

**Employee/Dependent Notification Requirements**

An employee or dependent must notify the plan administrator within 60 days of a divorce or legal separation or a dependent child ceasing to meet the plan’s requirements for a dependent child.
Election Period

A qualified beneficiary also has at least 60 days to elect coverage after being notified by the plan administrator of the right to COBRA coverage. Premium payments for periods preceding the election cannot be required before 45 days after the election. This allows qualified beneficiaries great flexibility in determining whether to be covered by COBRA. A qualified beneficiary may have up to 149 days to decide to accept COBRA coverage after the qualifying event. If the qualified beneficiary chooses to not pay at the time due, nothing is lost except the coverage. Therefore, the qualified beneficiary can wait and see if the coverage is in his or her best interest; there is no downside to initially electing COBRA. Unless future health coverage is certain, it would be in the best interests of the qualified beneficiaries to delay the election of COBRA, and also to delay the actual payment of premiums, as long as the law allows.

New Tax Credits and Second COBRA Election Period

In addition to the extension of health coverage available under the traditional COBRA rules, certain people who lose their jobs because of increasing import competition, and their families, may be eligible for federal tax credits covering 65 percent of their COBRA premiums as well as a new, second 60-day COBRA election period.

People qualify for the second COBRA election period if they:

- Receive federal trade adjustment assistance benefits (or would be eligible to receive such benefits except for the requirement that the person first exhaust unemployment benefits).
- Lost health coverage due to a termination of employment resulting in the person becoming eligible for trade adjustment assistance benefits.
- Did not elect COBRA coverage during the regular COBRA election period.

However, election of COBRA coverage under this second period must be made no later than six months after the date a person lost coverage as a result of separation from employment that resulted in him or her becoming eligible for benefits under the trade-adjustment legislation. (Also, coverage elected during the second COBRA election period is retroactive only to the beginning of that election period rather than to the date of the initial loss of coverage.)
Attempts to Evade Coverage

In certain cases, employers or employees may attempt to reduce or eliminate health insurance coverage in an attempt to evade COBRA. For example, if an employer eliminates health coverage in anticipation of an employee’s termination, or if an employee cancels the coverage of his or her spouse in anticipation of a divorce or legal separation, COBRA must still be offered, effective on the date of divorce or legal separation (but not for any period before the date of the divorce or legal separation). Timely notification requirements for receipt of benefits still apply (such as notifying the employer/third-party administrator within 60 days of the divorce or legal separation).

Choices of COBRA Coverage

Each qualified beneficiary can elect coverage independently at the time of each qualifying event and at open-enrollment; however, a positive election by an employee is effective for the employee’s spouse and children, and an election by a spouse (or an ex-spouse) is effective for all dependents. Thus, a spouse can elect coverage for dependent children, but the children can make their own elections if the parents decline coverage.

Each qualified beneficiary could be entitled to make a separate selection among types of coverage. Presumably, this would mean that an employee, spouse, and dependents all could choose different levels of coverage or that different choices could be made in a plan that offered various health care options (e.g., medical coverage is offered separately and also offered in conjunction with dental and vision coverage).

Termination of COBRA Coverage

COBRA coverage may be terminated when one of the following events occurs:

- The employer discontinues its group health coverage entirely.
- The qualified beneficiary fails to make timely payment of premium.
- The qualified beneficiary is covered under another group health plan.
- The qualified beneficiary becomes entitled to and is covered by Medicare.

COBRA cannot be terminated because a person has other coverage and that coverage limits or excludes benefits for pre-existing conditions. Federal law now limits the circumstances under which a plan may impose a pre-existing condition waiting period on individuals. If a plan is prohibited from
imposing a waiting period on an individual, COBRA continuation coverage may be terminated.

Conversion to Individual Policy

COBRA beneficiaries who exhaust their COBRA coverage must be offered an option to convert to an individual policy, if such an insurance policy is generally available. For example, individuals covered by a fully insured health plan (such as an HMO or other insurance product that assumes the full risk for claims incurred by the plan) would typically be able to convert their group coverage to an individual policy, whereas individuals covered by a self-insured health plan (such as an employer or union that assumes the risk for claim payment and does not purchase an insurance product to assume the full risk for them) would not typically be able to convert to an individual policy. Many individuals may switch from a self-insured health plan to a fully insured plan during open enrollment for this reason.

Alternatively, federal law now requires each state insurance market to offer individual health insurance products. Accordingly, a COBRA beneficiary at the end of his or her continuation of coverage period will need to weigh the benefits of converting the current health insurance coverage offered under COBRA against the coverage that may be available in the marketplace. The conversion of a COBRA health plan does not mean that the converted health plan will provide the same coverage that was available under COBRA.

COBRA Utilization

Charles D. Spencer & Associates has conducted extensive surveys regarding COBRA for the past several years. These surveys have found that about 20 percent of eligible beneficiaries elect COBRA coverage. The length of COBRA coverage has held relatively steady for the last six years: For 18-month qualifying events, the average length of coverage is between 10 and 11 months, while 36-month qualifying events have averaged around 21–23 months. Very few individuals on COBRA convert to individual policies.

On average, COBRA claims costs are around 1.5 times the cost of active-employee claim costs. Accordingly, COBRA beneficiaries do not cover the costs of the health care services rendered, since plans are typically allowed to charge such beneficiaries only 102 percent of active employee claim costs. As one would expect in any group health plan, active employees increasingly pay the cost of adverse claims experience under COBRA (through higher insurance premiums) because former employees and their families under COBRA are not paying the true cost of the coverage they are receiving.
Enforcement

Failure to comply with COBRA generally is not prosecuted if the problem is retroactively corrected to the extent possible and the COBRA beneficiary is made whole. The Employee Retirement Income Security Act of 1974 (ERISA), the major federal law governing employee benefits, provides that employees, qualified beneficiaries, or the U.S. Department of Labor (DOL) may sue to enforce the COBRA coverage requirements. COBRA noncompliance has significant penalties associated with it. Many employers view the penalties for noncompliance as excessively large.

Additional Information

For more information about continuing health care coverage under COBRA, call the DOL Employee Benefits Security Administration's Toll-Free Employee and Employer Hotline, at (866) 444-3272.

Whether to elect COBRA coverage is an important decision for millions of Americans each year. In order to make that decision, people need to know about their rights under COBRA and a more recent law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DOL offers information about some of the factors employees and their families should consider in “IRS Notice 98-12: Deciding Whether to Elect COBRA Health Care Continuation Coverage After Enactment of HIPAA,” Questions & Answers: Recent Changes in Health Care Law, pages 49–64. The booklet can be found at www.dol.gov/ebsa/pdf/hippa.pdf