

AN EMPLOYER'S GUIDE TO GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
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Introduction



Health coverage is one of the most important benefits that employers can provide, with advantages for employees, their families, employers, and society as a whole. Employers that sponsor group health plans enable their employees and their families to take care of their essential medical needs, ensuring that they can devote their energies to productive work.

Most employer-sponsored group health plans must comply with the Employee Retirement Income Security Act (ERISA), which sets standards to protect employee benefits. One of the protections contained in ERISA is the right to COBRA continuation coverage, a temporary continuation of group health coverage that would otherwise be lost due to certain life events.

This guide summarizes COBRA continuation coverage and explains the rules that apply to group health plans. It is intended to help employers that sponsor group health plans comply with this important federal law.

What Is COBRA Continuation Coverage?

COBRA – the Consolidated Omnibus Budget Reconciliation Act -- requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain events. Those events include:

- A covered employee's death,
- A covered employee's job loss or reduction in hours for reasons other than gross misconduct,
- A covered employee's becoming entitled to Medicare,
- A covered employee's divorce or legal separation, and
- A child's loss of dependent status (and therefore coverage) under the plan.

COBRA sets rules for how and when plan sponsors must offer and provide continuation coverage, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

Employers may require individuals to pay for COBRA continuation coverage. Premiums cannot exceed the full cost of the coverage, plus a 2 percent administration charge.

Group Health Plans Subject to COBRA

COBRA generally applies to all private sector group health plans maintained by employers that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours worked divided by the hours an employee must work to be considered full time. For example, if full-time employees at Company A work 40 hours per week, a part-time employee who works 20 hours per week counts as half of a full-time employee, and a part-time worker who works 16 hours per week counts as four-tenths of a full-time employee.

COBRA also applies to plans sponsored by state and local governments.[1] The law does not apply, however, to plans sponsored by the federal government or by churches and certain church-related organizations.

[1] The Department of Health and Human Services administers the COBRA provisions of the Public Health Service Act covering state and local government plans.

What is a group health plan? It is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance, by a health maintenance organization, out of the employer's assets, or through any other means. "Medical care" includes for this purpose:

- Inpatient and outpatient hospital care;
- Physician care;
- Surgery and other major medical benefits;
- Prescription drugs; and
- Dental and vision care.

Life insurance and disability benefits are not considered "medical care." COBRA does not cover plans that provide only life insurance or disability benefits.

COBRA-covered group health plans that are sponsored by private-sector employers are generally considered welfare plans under ERISA and therefore subject to ERISA's other requirements. Under ERISA, group health plans must be administered by a plan administrator, who is usually named in the plan documents. Many group health plans are administered by the employer that sponsors the plan, but group health plans are also frequently administered, in whole or in part, by a separate individual or organization, such as a professional benefits administration firm. Carrying out the requirements of COBRA is the direct responsibility of the plan administrator.

Alternatives to COBRA Continuation Coverage

Those entitled to elect COBRA continuation coverage may have more affordable or generous alternatives for coverage. One option may be "special enrollment" in other group health coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), upon certain events, group health plans and health insurance issuers are required to provide a special enrollment period. During that period, individuals who previously declined coverage for themselves and their dependents, and who are otherwise eligible, may enroll without waiting until the next open season for enrollment. One event that triggers special enrollment is an employee or dependent losing eligibility for other health coverage. For example, an employee who loses group health coverage may be able to special enroll in a spouse's health plan. The employee or dependent must request special enrollment within **30 days** of losing other coverage.

Losing employment-based health coverage also gives the employee an opportunity to enroll in the Health Insurance Marketplace in their state of residence. The Marketplace allows individuals and small businesses to find and compare private health insurance options. Through the Marketplace, individuals may qualify for cost-sharing reductions and a tax credit that lowers monthly premiums. Being offered COBRA continuation coverage does not limit eligibility for coverage or for a tax credit through the Marketplace. The employee or dependent must select Marketplace coverage within **60 days** before or after the loss of other coverage, or will have to wait until the next open enrollment period.

Through the Marketplace, individuals also can determine whether they or their dependents qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). Eligible individuals can apply for and enroll in Medicaid and CHIP at any time. For more information about the Marketplace, including information about Medicaid or CHIP eligibility, visit **HealthCare.gov**.

If an employee or dependent chooses to elect COBRA, the employee or dependent can request special enrollment in another group health plan or the Marketplace once COBRA is exhausted. In order to exhaust COBRA coverage, the individual must receive the maximum period of COBRA coverage available without early termination. An individual must request special enrollment:

- Within 30 days of losing COBRA coverage, for coverage through another group health plan, or
- Within 60 days before or after losing COBRA coverage, for coverage through a Marketplace plan.

If an employee or dependent chooses to terminate COBRA coverage early with no special enrollment opportunity at that time, they will have to wait until the next open enrollment period to enroll in other coverage through another group health plan or the Marketplace.

Medicare is the federal health insurance program for people who are 65 or older and certain younger people with disabilities or End-Stage Renal Disease. Generally, if an employee loses employment-based health coverage after their Medicare initial enrollment period and did not enroll in Medicare Part A or B, they have an 8-month special enrollment period, beginning the earlier of:

- The month after employment ends; or
- The month after group health coverage ends.

If an employee or dependent elects COBRA coverage instead of Medicare, they may have to pay a late enrollment penalty and may have a gap in coverage if they later decide they want Part B. If they enroll in Medicare Part A or B before COBRA coverage ends, the plan may terminate their continuation coverage. However, if Medicare Part A or B is effective on or before the date an individual elects COBRA, the plan cannot discontinue COBRA coverage because of Medicare entitlement even if they enroll in the other part of Medicare after electing COBRA coverage.

Generally, if an employee or dependent is enrolled in both COBRA and Medicare, Medicare will be the primary payer and COBRA coverage will pay second. Certain plans may pay as if secondary to Medicare, even if the individual is not enrolled in Medicare. For more information visit **Medicare.gov**.

Who Is Entitled to Continuation Coverage?

A group health plan must offer COBRA continuation coverage only to **qualified beneficiaries** and only after a **qualifying event** has occurred.

Qualified Beneficiaries

A qualified beneficiary is an employee who was covered by a group health plan on the day before a qualifying event occurred or that employee's spouse, former spouse, or dependent child. The type of qualifying event determines who the qualified beneficiaries are. In certain cases involving employer bankruptcy, a retired employee and their spouse, former spouse, or dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary. An employer's agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events

"Qualifying events" are events that cause an individual to lose group health coverage. The type of qualifying event determines who the qualified beneficiaries are and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage and/or to contribute toward the cost.

The following are qualifying events for a **covered employee** if they cause the covered employee to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct," or
- Reduction in the covered employee's hours of employment.

The following are qualifying events for a **spouse** and **dependent child** of a covered employee if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct,"
- Reduction in hours worked by the covered employee,
- Covered employee becomes entitled to Medicare,
- Divorce or legal separation from the covered employee, or
- Death of the covered employee.

In addition to the above, the following is a qualifying event for a **dependent child** of a covered employee if it causes the child to lose coverage:

- Loss of "dependent child" status under the plan rules. Under the Affordable Care Act, plans that offer coverage to children on their parents' plan must make coverage available until the adult child reaches the age of 26.

COBRA Notice and Election Procedures

Under COBRA, group health plans must provide covered employees and their families with specific notices explaining their COBRA rights. Plans must also have rules for how COBRA continuation coverage is offered, how qualified beneficiaries may elect continuation coverage, and when it can be terminated.

Notice Procedures

Summary Plan Description

The COBRA rights provided under the plan, like other important plan information, must be described in the plan's Summary Plan Description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works. ERISA requires group health plans to give each participant an SPD within 90 days after becoming a plan participant (or within 120 days after the plan is first subject to ERISA's reporting and disclosure provisions). In addition, if there

are material changes to the plan, the plan must give participants a Summary of Material Modifications (SMM) not later than 210 days after the end of the plan year in which the changes become effective. If the change is a material reduction in covered services or benefits, the plan administrator must furnish the Summary of Material Modifications within 60 days after the reduction is adopted. If a covered participant or beneficiary requests in writing a copy of these or any other plan documents, the plan administrator must provide them within 30 days.

COBRA General Notice

Group health plans must give each employee and spouse a general notice describing COBRA rights within the first 90 days of coverage. Group health plans can satisfy this requirement by including the general notice in the plan's SPD and giving it to the employee and spouse within this time limit.

The general notice must include:

- The name of the plan and the name, address, and telephone number of someone the employee and spouse can contact for more information on COBRA and the plan;
- A general description of the continuation coverage provided under the plan;
- An explanation of what qualified beneficiaries must do to notify the plan of qualifying events or disabilities;
- An explanation of the importance of keeping the plan administrator informed of addresses of the participants and beneficiaries; and
- A statement that the general notice does not fully describe COBRA or the plan and that more complete information is available from the plan administrator and in the SPD.

The Department of Labor has developed a **model general notice** that single-employer group health plans may use to satisfy the general notice requirement. In order to use this model general notice properly, the plan administrator must complete it by filling in the blanks with the appropriate plan information. The Department considers using the model general notice, appropriately completed, to be good faith compliance with COBRA's general notice content requirements.

COBRA Qualifying Event Notice

A group health plan must offer continuation coverage if a qualifying event occurs. The employer, employee or beneficiary must notify the group health plan of the qualifying event, and the plan is not required to act until it receives an appropriate notice. Who must give notice depends on the type of qualifying event.

The **employer** must notify the plan if the qualifying event is:

- Termination or reduction in hours of employment of the covered employee,
- Death of the covered employee,
- Covered employee becoming entitled to Medicare, or
- Employer bankruptcy.

The employer must notify the plan within 30 days after the event occurs.

The **covered employee** or one of the **qualified beneficiaries** must notify the plan if the qualifying event is:

- Divorce,
- Legal separation, or
- A child's loss of dependent status under the plan.

Group health plans must have procedures for how the covered employee or qualified beneficiaries can provide notice of these types of qualifying events. The plan can set a time limit for providing this notice, but the time limit cannot be shorter than 60 days, starting from the latest of:

- The date the qualifying event occurs,
- The date the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event, or
- The date the qualified beneficiary is informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

The procedures must describe how, and to whom, notice should be given, and what information must be included in the qualifying event notice. If one person gives notice of a qualifying event, the notice covers all qualified beneficiaries affected by that event.

If the group health plan does not have reasonable procedures for how to give notice of a qualifying event, the employee can give written or oral notice by contacting the person or unit that handles the employer's employee benefits matters. If the plan is a multiemployer plan, notice can also be given to the joint board of trustees, and, if the plan is administered by an insurance company (or the benefits are provided through insurance), notice can be given to the insurance company.

COBRA Election Notice

After receiving a notice of a qualifying event, the plan must provide the qualified beneficiaries with an election notice within 14 days. The election notice describes their rights to continuation coverage and how to make an election.

The election notice should include:

- The name of the plan and the name, address, and telephone number of the plan's COBRA administrator;
- Identification of the qualifying event;
- Identification of the qualified beneficiaries (by name or by status);
- An explanation of the qualified beneficiaries' right to elect continuation coverage;
- The date coverage will terminate (or has terminated) if continuation coverage is not elected;
- How to elect continuation coverage;
- What will happen if continuation coverage isn't elected or is waived;
- What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events;
- How continuation coverage might terminate early;
- Premium payment requirements, including due dates and grace periods;
- A statement of the importance of keeping the plan administrator informed of the addresses of qualified beneficiaries; and
- A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the plan administrator and in the SPD.

The Department has a **model election notice** that plans may use to satisfy their obligation to provide the election notice. In order to use this model election notice properly, the plan administrator must complete it by filling in the blanks with the appropriate plan information. The Department will consider use of the model election notice, appropriately completed, good faith compliance with the election notice content requirements of COBRA.

COBRA Notice of Unavailability of Continuation Coverage

Group health plans may sometimes deny a request for continuation coverage or for an extension of continuation coverage, when the plan determines the requester is not entitled to receive it. When a group health plan denies a request for continuation coverage or a request for an extension, the plan must give the denied individual a notice of unavailability of continuation coverage within 14 days after the request is received, and explain the reason for denying the request.

COBRA Notice of Early Termination of Continuation Coverage

Continuation coverage must generally be available for a maximum period (18, 29, or 36 months). The group health plan may terminate continuation coverage early, however, for any of a number of specific reasons. (See "Duration of Continuation Coverage" on page 8.) When a group health plan decides to terminate continuation coverage early for any of these reasons, the plan must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

Special Rules for Multiemployer Plans

Multiemployer plans are allowed to adopt some special rules for COBRA notices. First, a multiemployer plan may adopt its own uniform time limits for the qualifying event notice or the election notice. A multiemployer plan also may choose not to require employers to provide qualifying event notices, and instead to have the plan administrator determine when a qualifying event has occurred. Any special multiemployer plan rules must be set out in the plan's documents (and SPD).

Election Procedures

COBRA requires group health plans to give qualified beneficiaries an election period to decide whether to elect continuation coverage, and COBRA also gives qualified beneficiaries specific election rights.

Plans must give each qualified beneficiary at least 60 days to choose whether or not to elect COBRA coverage, beginning from the date the election notice is provided, or the date the qualified beneficiary would otherwise lose coverage under the group health plan due to the qualifying event, whichever is later.

Each qualified beneficiary has an independent right to elect continuation coverage. This means that when several individuals (such as an employee, spouse, and their dependent children) become qualified beneficiaries due to the same qualifying event, each individual can make a different choice. The plan must allow the covered employee or the covered employee's spouse, however, to elect continuation coverage on behalf of all of the other qualified beneficiaries for the same qualifying event. A parent or legal guardian of a qualified beneficiary must also be allowed to elect on behalf of a minor child.

If qualified beneficiaries waive continuation coverage during the election period, they must be permitted to later revoke the waiver of coverage and elect continuation coverage, as long as they do so before the election period ends. In such cases, the plan may make continuation coverage begin on the date the waiver was revoked.

Benefits under Continuation Coverage

COBRA also sets standards for the continuation coverage that plans must provide.

The continuation coverage must be identical to the coverage currently available under the plan to similarly situated individuals who are not receiving continuation coverage. (Generally, this is the same coverage that the qualified beneficiary had immediately before the qualifying event.) A qualified beneficiary receiving continuation coverage must receive the same benefits, choices, and services that a similarly situated participant or beneficiary currently receives under the plan, such as the right during an open enrollment season to choose among available coverage options. The qualified beneficiary is also subject to the same plan rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Any changes made to the plan's terms that apply to similarly situated active employees and their families will also apply to qualified beneficiaries receiving COBRA continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation coverage, the child is automatically considered to be a qualified beneficiary receiving continuation coverage. The plan must allow the child to be added to the continuation coverage.

Duration of Continuation Coverage

Maximum Periods

COBRA requires that continuation coverage extend from the date of the qualifying event for a limited period of 18 or 36 months. The length of time for which continuation coverage must be made available (the "maximum period" of continuation coverage) depends on the type of qualifying event. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

When the qualifying event is the covered employee's termination of employment (for reasons other than gross misconduct) or reduction in work hours, qualified beneficiaries must be eligible for **18 months** of continuation coverage.

When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents must be available for up to **36 months** after the date the employee becomes entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date their employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for their spouse and children must be available for up to 28 months (36 months minus 8 months).

For all other qualifying events, qualified beneficiaries must receive **36 months** of continuation coverage.[2]

[2] Under COBRA, certain retirees and their family members who receive post-retirement health coverage from employers have special COBRA rights in the event that the employer is involved in bankruptcy proceedings begun on or after July 1, 1986. This booklet does not fully describe the COBRA rights of that group.

Early Termination

A group health plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis,
- The employer ceases to maintain any group health plan,
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage,
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage, or
- A qualified beneficiary engages in fraud or other conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage.

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. (See "COBRA Notice and Election Procedures" on page 4.)

Extension of an 18-month Period of Continuation Coverage

There are two circumstances under which individuals entitled to an 18-month maximum period of continuation coverage can become entitled to an extension of that maximum period. The first is when one of the qualified beneficiaries is disabled; the second is when a second qualifying event occurs.

Disability

If one of the qualified beneficiaries in a family is disabled and meets certain requirements, all of the qualified beneficiaries in that family are entitled to an 11-month extension of the maximum period of continuation coverage (for a total maximum period of **29 months** of continuation coverage). The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension.

The requirements are, first, that the Social Security Administration (SSA) determines that the qualified beneficiary is disabled before the 60th day of continuation coverage and, second, that the disability continues during the rest of the initial 18-month period of continuation coverage.

The disabled qualified beneficiary (or another person on his or her behalf) also must notify the plan of the SSA determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 days, starting from the latest of:

- The date SSA issues the disability determination,
- The date the qualifying event occurs,
- The date the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event, or
- The date the qualified beneficiary is informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

The right to the disability extension may be terminated if SSA determines that the qualified beneficiary is no longer disabled. The plan can require disabled qualified beneficiaries to provide

notice when such a determination is made. The plan must give the qualified beneficiaries at least 30 days after the SSA determination to provide such notice.

The rules for how to give a disability notice and a notice of no longer being disabled should be described in the plan's SPD (and in the election notice for any offer of an 18-month period of continuation coverage).

Second Qualifying Event

An 18-month extension may be available to qualified beneficiaries receiving an 18-month maximum period of continuation coverage (giving a total maximum period of **36 months** of continuation coverage) if the qualified beneficiaries experience a second qualifying event, for example, death of the covered employee, divorce or legal separation of the covered employee and spouse, Medicare entitlement (in certain circumstances), or loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan in the absence of the first qualifying event.

The plan must have procedures for how a qualified beneficiary should provide notice of a second qualifying event. These rules should be described in the plan's SPD (and in the election notice for any offer of an 18-month period of continuation coverage). The plan can set a time limit for providing this notice, but the time limit cannot be shorter than 60 days from the latest of:

- The date on which the qualifying event occurs,
- The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event, or
- The date on which the qualified beneficiary is informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

Summary of Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage

The following chart shows the maximum period for which continuation coverage must be offered for the specific qualifying events and the qualified beneficiaries who are entitled to elect continuation coverage when the specific event occurs. **Note that an event is a qualifying event only if it causes the qualified beneficiary to lose coverage under the plan.**

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	MAXIMUM PERIOD OF CONTINUATION COVERAGE
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 months[3]
Employee enrollment in Medicare	Spouse Dependent Child	36 months[4]
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

Paying for Continuation Coverage

Group health plans can require qualified beneficiaries to pay for COBRA continuation coverage, although plans can choose to provide continuation coverage at reduced or no cost. The maximum amount charged to qualified beneficiaries cannot exceed 102 percent of the cost to the plan for similarly situated individuals covered under the plan who have not incurred a qualifying event. In calculating premiums for continuation coverage, a plan can include the costs paid by both the employee and the employer, plus an additional 2 percent for administrative costs. For qualified beneficiaries receiving the 11-month disability extension of continuation coverage, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage.

Plans may increase COBRA premiums for qualified beneficiaries if the cost to the plan increases, but generally plans must fix premiums before each 12-month premium cycle. The plan must allow qualified beneficiaries to pay the required premiums on a monthly basis if they ask to do so, and may allow payments at other intervals (for example, weekly or quarterly). The COBRA election notice should describe all of the necessary information about COBRA premiums, when they are due, and the consequences of payment and nonpayment.

Plans cannot require qualified beneficiaries to pay a premium when they make the COBRA election. Plans must provide at least 45 days after the election (that is, the date the qualified beneficiary mails the election form if using first-class mail) for making an initial premium payment. If a qualified beneficiary fails to make any payment before the end of the initial 45-day period, the plan can terminate the qualified beneficiary's COBRA rights. The plan should establish due dates for any premiums for subsequent periods of coverage, but it must provide a minimum 30-day grace period for each payment.

[3] In certain circumstances, qualified beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months). (See "Duration of Continuation Coverage" on page 8.)

[4] The actual period of continuation coverage may vary depending on factors such as whether the Medicare entitlement occurred prior to or after the end of the covered employee's employment or reduction in hours. For more information, see "Duration of Continuation Coverage" on page 8 or contact the Department of Labor's **Employee Benefits Security Administration** or call toll-free at 1-866-444-3272.

Plans can terminate continuation coverage if full payment is not received before the end of a grace period. If the amount of a payment made to the plan is incorrect, but is not significantly less than the amount due, the plan must notify the qualified beneficiary of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices, but must provide a notice of early termination if it terminates continuation coverage early due to failure to make a timely payment.

Health Coverage Tax Credit

Certain individuals may be eligible for a Federal income tax credit that can help with qualified monthly premium payments. The Health Coverage Tax Credit, while available, is a refundable tax credit to pay for specified types of health insurance coverage (including COBRA continuation coverage).

Those potentially eligible for the Health Coverage Tax Credit include workers who lose their jobs due to the negative effects of global trade and who are eligible to receive certain benefits under the Trade Adjustment Assistance (TAA) Program, as well as certain individuals who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). The Health Coverage Tax Credit pays 72.5 percent of qualified health insurance premiums, with individuals paying 27.5 percent. For more information on TAA, visit the **Employment and Training Administration's website**.

Individuals who are eligible for the Health Coverage Tax Credit may claim the tax credit on their income tax returns at the end of the year. Qualified family members of eligible TAA recipients or PBGC payees who enroll in Medicare, die, or finalize a divorce, are eligible to receive the Health Coverage Tax Credit for up to 24 months from the month of the event.

If an individual was receiving the Health Coverage Tax Credit in 2020, they may have been removed from the program pending its expiration at the end of the year and advised to seek alternative insurance options. With the Health Coverage Tax Credit's extension through 2021, the individual may be able to work with their health coverage provider to be placed back on coverage that would qualify for the credit. Then they can either re-enroll in the program or claim the credit on their federal income tax form next year. At the time of this printing, the Health Coverage Tax Credit is set to expire on December 31, 2021.

For questions about the Health Coverage Tax Credit and how to re-enroll, visit the **IRS's website**.

Coordination with Other Federal Benefit Laws

The Family and Medical Leave Act (FMLA) requires employers to maintain coverage under any "group health plan" for employees on Family and Medical Leave Act leave under the same conditions coverage would have been provided if the employee had continued working. Group health coverage that is provided under the Family and Medical Leave Act during a family or medical leave is **not** COBRA continuation coverage, and taking leave under the Act is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under the Family and Medical Leave Act ceases, such as when an employee taking Family and Medical Leave Act leave decides not to return to work and notifies an employer of his or her intent.

The Affordable Care Act provides additional protections for coverage under an employment-based group health plan, including COBRA continuation coverage. These protections include:

- Extending dependent child coverage to age 26,
- Prohibiting limits or exclusions from coverage for preexisting conditions,
- Banning lifetime or annual dollar limits on coverage for essential health benefits, and
- Requiring group health plans and insurers to provide an easy-to-understand summary of a health plan's benefits and coverage.

Some plan sponsors may have chosen to make only routine changes and generally keep the coverage under their health plan the same as it was on March 23, 2010. These grandfathered health plans are required to comply with some of the Affordable Care Act protections (including those noted above), but not all. Additional protections that may apply to non-grandfathered health plans include coverage for:

- Certain preventive services (such as blood pressure, diabetes and cholesterol tests, regular well-baby and well-child visits, routine vaccinations and many cancer screenings) without cost sharing; and
- Emergency services in an emergency department of a hospital outside your plan's network without prior approval from your health plan.

For more information regarding whether your plan is a grandfathered health plan and the requirements under the Affordable Care Act, visit **DOL's Affordable Care Act web page**.

Certain TAA Program participants have a second opportunity to elect COBRA continuation coverage. Individuals who are eligible and receive Trade Readjustment Allowances, individuals who would be eligible to receive Trade Readjustment Allowances but have not yet exhausted their unemployment insurance benefits, and individuals receiving benefits under Alternative Trade Adjustment Assistance or Reemployment Trade Adjustment Assistance who did not elect COBRA during the general election period, may get a second election period. This additional, second election period is measured 60 days from the first day of the month in which an individual is determined eligible for the TAA benefits listed above and receives such benefit. For example, if an individual's general election period runs out and he or she is determined eligible for Trade Readjustment Allowances (or would be eligible for Allowances but have not exhausted unemployment insurance benefits) or begin to receive Alternative Trade Adjustment Assistance or Reemployment Trade Adjustment Assistance benefits 61 days after separating from employment, at the beginning of the month, he or she would have approximately 60 more days to elect COBRA. However, if this same individual does not meet the eligibility criteria until the end of the month, the 60 days are still measured from the first of the month, in effect giving the individual about 30 days. Additionally, a COBRA election must be made no later than 6 months after the date of the TAA-related loss of coverage. COBRA coverage chosen during the second election period typically begins on the first day of that period. More information about the Trade Act is available at the **Employment and Training Administration's website**.

Role of the Federal Government

COBRA continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private-sector group health plans. The Department of Health and Human Services administers the continuation coverage law as it applies to state and local government health plans.

The Labor Department's interpretive responsibility for COBRA is limited to the disclosure and notification requirements of COBRA. The Labor Department has issued regulations on the COBRA notice provisions. The Treasury Department has interpretive responsibility to define the required continuation coverage. The Internal Revenue Service, Department of the Treasury, has issued regulations on COBRA provisions relating to eligibility, coverage, and payment. The Departments of Labor and the Treasury share jurisdiction for enforcement of these provisions.

Resources

If you need further information about COBRA, the Affordable Care Act, HIPAA, or ERISA, visit the **Employee Benefits Security Administration's (EBSA) website**. Or contact EBSA **electronically** or call toll free 1-866-444-3272.

For more information on COVID-19 protections, visit the Employee Benefits Security Administration's **COVID-19 Response page**.

The Centers for Medicare and Medicaid Services offer information about COBRA provisions for public-sector employees. To find out more, visit their **website** or contact the agency via **email** or by calling toll free at 1-877-267-2323, ext. 6-1565.

Federal employees are covered by a federal law similar to COBRA. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

For more information on the Affordable Care Act, visit **HealthCare.gov**.

Further information on the Family and Medical Leave Act is available at the **Wage and Hour Division's website** or by calling toll free 1-866-487-9243.

For more information on Medicare, visit their **website** or call 1-800-MEDICARE.

For information on the Trade Adjustment Assistance (TAA) Program, visit the **Employment and Training Administration's website**. For information about the Health Coverage Tax Credit, visit the **IRS's website**.



EMPLOYEE BENEFITS SECURITY ADMINISTRATION
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