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COMPLIANCE WITH VERMONT'S MANDATORY GROUP HEALTH INSURANCE CONTINUATION STATUTE

Recently, both the state and the federal governments enacted laws providing for the continuation of group health insurance benefits to terminated employees. The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") was signed by President Reagan on April 7, 1986. The federal law (copy attached) only applies to employers with twenty or more employees (on a typical business day during the preceding calendar year). The scope of the Vermont law, which applies to group insurance contracts is somewhat more broad than COBRA because it impacts on virtually all employers (by virture of their insurance contracts, including self-insurers), even those employers with less than twenty employees.

Since the minimum standards for group health insurance benefits continuation set forth in COBRA are "generally" more stringent than Vermont's law, employers with twenty or more employees should be primarily concerned with COBRA. In most instances (but not all), compliance with COBRA means that the requirements set forth in the Vermont statute have also been met. Correspondingly, employers with less than twenty employees are not covered by COBRA. Thus, they need only comply with Vermont law.

The following explanation will describe the operation and the nature of Vermont's statute. The operation of COBRA will be discussed only to the extent necessary to explain compliance with Vermont law. It is worth noting, however, that COBRA is a complicated statute which amends the Internal Revenue Code, ERISA and the Public Health Service Act. Furthermore, the respective federal agencies charged with administration of the various provisions of COBRA have not yet promulgated regulations construing the statutory language. Thus, it is not possible to specify with absolute certainty how COBRA will be applied. Nonetheless, with these disclaimers in mind, the Department will touch upon the application of COBRA as it affects or relates to the Vermont law. [We have also attached, for informational purposes only, descriptive matter produced by the National Association of Insurance Commissioners outlining the major coverage provisions of COBRA. *See* Appendix A.]

The Vermont statute regulates group health insurance policies by providing covered persons (*e.g.* employees) and certain dependents with a right to continue group health insurance policies (at the "group rate") after termination of employment. 8 V.S.A. section 8090a(a). After providing this coverage, the legislature describes the situations in which the right to continued coverage does not attach. 8 V.S.A. section 8090a(b). The question has been raised whether this statutory

right can be modified by a collective bargaining agreement. The answer is no. The statute provides a benefit which exists outside the terms of an employment contract. That is not to say, however, that an employment contract can not be fashioned which provides more extensive coverage. The statute simply sets a minimum standard. The law also requires that notice of the statutory continuation privilege be included in each certificate (or other evidence) of coverage given to employees.

Assuming a person who is entitled to continue a group health insurance policy decides to exercise the option, written notice to the employer, the group agent (contractor), or insurer activates the continuation provision. 8 V.S.A. Section 4090b. If the covered employee is deceased, the employer should be notified within sixty days. The notification period is reduced to thirty days in the case of terminated employees.

An important distinction between the Vermont statute and COBRA is the length of their respective continuation periods. See 8 V.S.A. Section 4090c. Under Vermont law, there is a six (6) month continuation period, while COBRA extends group health insurance benefits for a minimum of eighteen (18) months. Thus, COBRA provides more extensive coverage in terms of length of the continuation period. A question has been asked whether Vermont's six month period tacks on or is added to the eighteen month federal continuation period. (i.e., a total of twenty-four (24) months). Again, the answer is no. The six month term is simply the minimum period prescribed by Vermont legislators. For employers subject to COBRA, the state period is satisfied at the end of the first six months under the COBRA (18 month) continuation period.

The Vermont continuation period expires after six months, however, a right or entitlement to a subsequent conversion policy is provided under 8 V.S.A. Section 4090d which the employee or dependant may exercise. Bases for termination of the continuation period before the end of six-months include: 1) failure of a covered person to make timely payment of his/her contribution; 2) the covered person is covered or is eligible for coverage under Medicare; or 3) the group policy is terminated (in this case, the covered person is entitled to coverage under any replacement policy). This last item may present some problems for the insurer processing a replacement policy since covered persons are entitled to the same level of benefits provided by the prior policy. Specifically, the law states: "the minimum level of benefits payable under the prior group policy shall be the applicable level of benefits of the prior group policy . . ." The statute does allow a reduction in the level of benefits to the extent benefits were paid or are payable under the prior policy. If a person had, for example, a million dollar lifetime policy and twenty thousand in benefits had already been paid out to this person, then the minimum conversion policy level of benefits would be $980,000. That figure

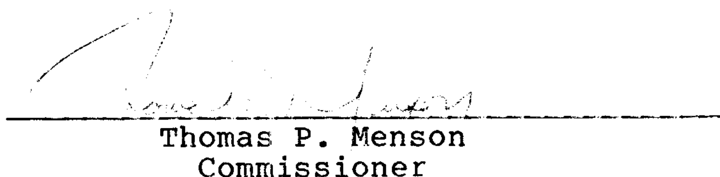
controls even if the lifetime maximum coverage under the replacement group health insurance plan is reduced, for example, to $500,000.

The Vermont law also requires that covered persons be provided with an opportunity to convert his/her group health insurance policy to an individual or a personal health insurance policy without evidence of insurability. 8 V.S.A. section 4090d. The terms and conditions for exercising this right are specified by the statute. 8 V.S.A. section 4090e. Basically, written application for conversion must be made at least 30 days before the end of the six month continuation period. The first premium payment must also be made before that date. The premium for converted policies is determined on a nongroup basis. One exception occurs when such a premium is for coverage of "qualified dependents" (widows and orphans). In that instance, the premium is limited to 102 percent of the group rate.

Employers covered by COBRA are impacted, albeit indirectly, by Vermont's conversion provisions (the word "indirectly" is used because the Vermont statute regulates insurance/self-insurance contracts, not employers). COBRA does not have any language concerning conversion. Thus, under the applicable federal statutes, the insurance coverage automatically ends when the continuation period expires. Accordingly, it is appropriate to give special attention to the Vermont law in the conversion area since it impacts on all employers.

The Vermont law allows the insurer to modify some components of converted policies. See 8 V.S.A. Section 4090e. Nevertheless, the law also requires the insurer to provide certain options to individuals exercising their conversion rights. 8 V.S.A. Section 4090g. Basically, the statute requires insurers to offer lesser levels of coverage at lower rates. The Commissioner of Banking and Insurance ("Commissioner") has discretion to adopt rules describing the lesser types of coverage which may be offered under this law. The Commissioner has not promulgated any rules concerning "lesser coverage" options and may not be doing so pending the forthcoming recommendations of the "Health Insurance Summer Study Committee of the Legislature."

While there are differences between COBRA and the Vermont statute, as stated above, in many cases compliance with COBRA will also satisfy the requirements of applicable Vermont laws. Although a conclusive analysis of COBRA is not yet possible, there does not appear to be any statutory sections which are directly or substantially inconsistent with Vermont's continuation law. As such, knowledge of and compliance with 8 V.S.A. Section 4090 is of vital importance to affected employers and insurers.



Thomas P. Menson
Commissioner

(c) Sections 504(b)(1) and 509(b) of such Act are each amended by striking out "crippled children" and inserting in lieu thereof "children with special health care needs".

SEC. 9528. ANNUAL CALCULATION OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE.

(a) ANNUAL CALCULATION.—Section 1101(a)(8)(P) of the Social Security Act is amended—

(1) by striking out "even-numbered"; and

(2) by striking out "eight quarters" and inserting in lieu thereof "four quarters".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to the Federal percentage (and Federal medical assistance percentage) for fiscal years 1987 and thereafter. Such amendments shall apply without regard to the requirement of section 1101(a)(8)(B) of the Social Security Act relating to the promulgation of the Federal percentage prior to November 30 of the year preceding the year in which the new Federal percentage becomes applicable. The Secretary of Health and Human Services shall promulgate such new percentage for fiscal year 1987 as soon as practicable after the date of the enactment of this Act.

SEC. 9529. MEDICAID COVERAGE RELATING TO ADOPTION ASSISTANCE AND FOSTER CARE.

(a) STATE OF RESIDENCE.—(1) Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by adding at the end thereof the following:

"For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of the enactment of this Act.

(b) ELIGIBILITY OF CERTAIN ADOPTED CHILDREN.—(1) Section 1902(a)(10)(A)(ii) of the Social Security Act, as amended by section 9505 of this Act, is amended—

(A) by striking out "or" at the end of subclause (VI);

(B) by striking out the semicolon at the end of subclause (VII) and inserting in lieu thereof ", or"; and

(C) by adding after subclause (VII) the following new subclause:

"(VIII) who is a child described in section 1905(a)(i)—

"(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV) between the State and an adoptive parent or parents,

"(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

"(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV;".

(2) In the case of an adoption assistance agreement (other than an agreement under part E of title IV of the Social Security Act) entered into before the date of the enactment of this Act—

(A) the requirements of subdivisions (aa) and (bb) of section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act shall be deemed to be met if the State agency responsible for adoption assistance agreements determines that—

(i) at the time of adoptive placement the child had special needs for medical or rehabilitative care that made the child difficult to place; and

(ii) there is in effect with respect to such child an adoption assistance agreement between the State and an adoptive parent or parents; and

(B) the requirement of subdivision (cc) of such section shall be deemed to be met if the child was found by the State to be eligible for medical assistance prior to such agreement being entered into.

(3) This subsection, and the amendments made by this subsection, shall apply to adoption assistance agreements entered into before, on, or after the date of the enactment of this Act.

SUBTITLE C—TASK FORCE ON LONG-TERM HEALTH CARE POLICIES

SEC. 9601. RECOMMENDATIONS FOR LONG-TERM HEALTH CARE POLICIES.

(a) ESTABLISHMENT OF TASK FORCE.—(1) The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a Task Force on Long-Term Health Care Policies (hereinafter in this section referred to as the "Task Force"). The Task Force shall be established not later than 60 days after the date of the enactment of this Act and in consultation with the National Association of Insurance Commissioners.

(b) COMPOSITION OF TASK FORCE.—The Task Force shall be composed of 18 members, which shall include—

(1) two members representing the National Association of Insurance Commissioners,

(2) three members representing Federal and State agencies with responsibilities relating to health or the elderly,

(3) three members representing private insurers,

(4) three members from organizations representing consumers or the elderly, and

(5) three members from organizations representing providers of long-term health care services.

The Secretary shall designate a member of the Task Force as chair.

(c) DEVELOPMENT OF RECOMMENDATIONS.—The Task Force shall develop recommendations for long-term health care policies, including recommendations designed—

(1) to limit marketing and agent abuse for those policies,

(2) to assure the dissemination of such information to consumers as is necessary to permit informed choice in purchasing the policies and to reduce the purchase of unnecessary or duplicative coverage,

(3) to assure that benefits provided under the policies are reasonable in relationship to premiums charged, and

(4) to promote the development and availability of long-term health care policies which meet these recommendations.

(d) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Task Force shall report to the Secretary, to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate respecting—

(1) the recommendations developed under subsection (c), including an explanation of the reasons for their selection, and

(2) such recommendations for additional activities respecting long-term health care policies as the Task Force finds appropriate.

The Secretary, in cooperation with the National Association of Insurance Commissioners, shall provide for the dissemination of the report to each of the States.

(e) TERMINATION OF TASK FORCE.—The Task Force shall terminate 90 days after the date of submission of the report required under subsection (d).

(f) REPORTS OF SECRETARY.—The Secretary shall transmit to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate two reports on—

(1) actions taken by the States to implement the recommendations developed under this section and to recommend additional action; and

(2) recommendations for legislative and administrative action, if any, needed to respond to issues raised by the Task Force or to improve consumer protection with respect to long-term health care policies.

The first report shall be transmitted 18 months after the date the report is made under subsection (d), and the second report shall be transmitted 18 months later.

(g) LONG-TERM HEALTH CARE POLICY DEFINED.—In this section, the term "long-term health care policy" means an insurance policy, or similar health benefits plan, which is designed for or marketed as providing (or making payments for) health care services (such as nursing home care and home health care) or related services (which may include home and community-based services), or both, over an extended period of time.

(h) ASSURANCE OF STATES' JURISDICTION.—Nothing in this section shall be construed as recommending Federal preemption of the States in overseeing the operation and regulation of insurance carriers in their respective jurisdictions.

TITLE X—PRIVATE HEALTH INSURANCE COVERAGE

SEC. 10001. EMPLOYERS REQUIRED TO PROVIDE CERTAIN EMPLOYEES AND FAMILY MEMBERS WITH CONTINUED HEALTH INSURANCE COVERAGE AT GROUP RATES (INTERNAL REVENUE CODE AMENDMENTS).

(a) DENIAL OF DEDUCTION FOR EMPLOYER CONTRIBUTION TO PLAN.—Subsection (i) of section 162 of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

"(2) PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.—

"(A) IN GENERAL.—No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k).

"(B) EXCEPTION FOR CERTAIN SMALL EMPLOYERS, ETC.—Subparagraph (A) shall not apply to any plan described in section 106(b)(2).".

(b) DENIAL OF EXCLUSION FOR HIGHLY COMPENSATED INDIVIDUALS.—Section 106 of the Internal Revenue Code of 1954 (relating to contributions by employer to accident and health plans) is amended by inserting "(a) IN GENERAL.—" before "Gross" and by inserting at the end thereof the following new subsection:

"(b) EXCEPTION FOR HIGHLY COMPENSATED INDIVIDUALS WHERE PLAN FAILS TO PROVIDE CERTAIN CONTINUATION COVERAGE.—

"(1) IN GENERAL.—Subsection (a) shall not apply to any amount contributed by an employer on behalf of a highly compensated individual (within the meaning of section

105(h)(5)) to a group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of section 162(k).

"(2) EXCEPTION FOR CERTAIN PLANS.—Paragraph (1) shall not apply to any—

"(A) group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year,

"(B) governmental plan (within the meaning of section 414(d)), or

"(C) church plan (within the meaning of section 414(e)).

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 (relating to employers under common control) shall apply for purposes of subparagraph (A).

"(3) GROUP HEALTH PLAN.—For purposes of this subsection, the term 'group health plan' has the meaning given such term by section 162(i)(3).".

(c) CONTINUATION COVERAGE REQUIREMENTS.—Section 162 of the Internal Revenue Code of 1954 is amended by redesignating subsection (k) as subsection (l) and by inserting after subsection (j) the following new subsection:

"(k) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.—

"(1) IN GENERAL.—For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

"(2) CONTINUATION COVERAGE.—For purposes of paragraph (1), the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(B) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(i) MAXIMUM PERIOD.—In the case of—

"(I) a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(II) any qualifying event not described in subclause (I), the date which is 36 months after the date of the qualifying event.

"(ii) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

"(iii) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(iv) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

"(I) a covered employee under any other group health plan, or

"(II) entitled to benefits under title XVIII of the Social Security Act.

"(v) REMARRIAGE OF SPOUSE.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(C) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

"(i) shall not exceed 102 percent of the applicable premium for such period, and

"(ii) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(D) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(E) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under subparagraph (B)(i), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"(3) QUALIFYING EVENT.—For purposes of this subsection, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary:

"(A) The death of the covered employee.

"(B) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(C) The divorce or legal separation of the covered employee from the employee's spouse.

"(D) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"(4) APPLICABLE PREMIUM.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(B) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(i) IN GENERAL.—Except as provided in clause (ii), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

"(I) is determined on an actuarial basis, and

"(II) takes into account such factors as the Secretary may prescribe in regulations.

"(ii) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this clause apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

"(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under subparagraph (C), adjusted by

"(II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(iii) CLAUSE (ii) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have clause (ii) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under subparagraph (C).

"(C) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"(5) ELECTION.—For purposes of this subsection—

"(A) ELECTION PERIOD.—The term 'election period' means the period which—

"(i) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(ii) is of at least 60 days' duration, and

"(iii) ends not earlier than 60 days after the later of—

"(I) the date described in clause (i), or

"(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice.

"(B) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in clause (i)(I) or (ii) of paragraph (7)(B) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"(6) NOTICE REQUIREMENTS.—In accordance with regulations prescribed by the Secretary—

"(A) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(B) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3) with respect to such employee within 30 days of the date of the qualifying event,

"(C) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3), and

"(D) the plan administrator shall notify—

"(i) in the case of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3), any qualified beneficiary with respect to such event, and

"(ii) in the case of a qualifying event described in subparagraph (C) or (E) of paragraph (3) where the covered employee notifies the plan administrator under subparagraph (C), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of subparagraph (D), any notification shall be made within 14 days of the date on which the plan administrator is notified under subparagraph (B) or (C), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"(7) DEFINITIONS.—For purposes of this subsection—

"(A) COVERED EMPLOYEE.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(B) QUALIFIED BENEFICIARY.—

"(i) IN GENERAL.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

"(I) as the spouse of the covered employee, or

"(II) as the dependent child of the employee.

"(ii) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in paragraph (3)(B), the term 'qualified beneficiary' includes the covered employee.

"(C) PLAN ADMINISTRATOR.—The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.".

(d) CONFORMING AMENDMENT.—Paragraph (1) of section 162(i) is amended by striking out "GENERAL RULE" in the heading thereof and inserting in lieu thereof "COVERAGE RELATING TO END STAGE RENAL DISEASE".

(e) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 10002. TEMPORARY EXTENSION OF COVERAGE AT GROUP RATES FOR CERTAIN EMPLOYEES AND FAMILY MEMBERS (ERISA AMENDMENTS).

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end thereof the following new part:

"PART 6—CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

"SEC. 601. PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL.—The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) EXCEPTION FOR CERTAIN PLANS.—Subsection (a) shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1954 (relating to employers under common control) shall apply for purposes of this subsection.

"SEC. 602. CONTINUATION COVERAGE.

"For purposes of section 601, the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(2) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(A) MAXIMUM PERIOD.—In the case of—

"(i) a qualifying event described in section 603(2) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(ii) any qualifying event not described in clause (i), the date which is 36 months after the date of the qualifying event.

"(B) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

"(C) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(D) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

"(i) a covered employee under any other group health plan, or

"(ii) entitled to benefits under title XVIII of the Social Security Act.

"(E) REMARRIAGE OF SPOUSE.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(3) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

"(A) shall not exceed 102 percent of the applicable premium for such period, and

"(B) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(4) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(5) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"SEC. 603. QUALIFYING EVENT.

"For purposes of this part, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

"(1) The death of the covered employee.

"(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(3) The divorce or legal separation of the covered employee from the employee's spouse.

"(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"SEC. 604. APPLICABLE PREMIUM.

"For purposes of this part—

"(1) IN GENERAL.—The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(2) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

"(i) is determined on an actuarial basis, and

"(ii) takes into account such factors as the Secretary may prescribe in regulations.

"(B) DETERMINATION ON BASIS OF PAST COST.—If an administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

"(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

"(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

"(3) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"SEC. 605. ELECTION.

"For purposes of this part—

"(1) ELECTION PERIOD.—The term 'election period' means the period which—

"(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(B) is of at least 60 days' duration, and

"(C) ends not earlier than 60 days after the later of—

"(i) the date described in subparagraph (A), or

"(ii) in the case of any qualified beneficiary who receives notice under section 606(4) the date of such notice.

"(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 607(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"SEC. 606. NOTICE REQUIREMENTS.

"In accordance with regulations prescribed by the Secretary—

"(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), or (4) of section 603 within 30 days of the date of the qualifying event,

"(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 603, and

"(4) the administrator shall notify—

"(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 603, any qualified beneficiary with respect to such event, and

"(B) in the case of a qualifying event described in paragraph (3) or (5) of section 603 where the covered employee notifies the administrator under paragraph (3), any qualified beneficiary with respect to such event, of such beneficiary's rights under this subsection.

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"SEC. 607. DEFINITIONS.

"For purposes of this part—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' means an employee welfare benefit plan that is a group health plan (within the meaning of section 162(i)(3) of the Internal Revenue Code of 1954).

"(2) COVERED EMPLOYEE.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(3) QUALIFIED BENEFICIARY.—

"(A) IN GENERAL.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

"(i) as the spouse of the covered employee, or

"(ii) as the dependent child of the employee.

"(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 603(2), the term 'qualified beneficiary' includes the covered employee.

"SEC. 608. REGULATIONS.

"The Secretary may prescribe regulations to carry out the provisions of this part.".

(b) PENALTY FOR FAILURE TO PROVIDE NOTICE.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by inserting after "Any administrator" the following: "(1) who fails to meet the requirements of paragraph (1) or (4) of section 606 with respect to a participant or beneficiary, or (2)".

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 514 the following new items:

"PART 6—CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

"Sec. 601. Plans must provide continuation coverage to certain individuals.
"Sec. 602. Continuation coverage.
"Sec. 603. Qualifying event.
"Sec. 604. Applicable premium.
"Sec. 605. Election.
"Sec. 606. Notice requirements.
"Sec. 607. Definitions.
"Sec. 608. Regulations.".

(d) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(e) NOTIFICATION TO COVERED EMPLOYEES.—At the time that the amendments made by this section apply to a group health plan (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under part 6 of subtitle B of title I of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 606(1) of such Act with respect to such individuals.

SEC. 10003. CONTINUATION OF HEALTH INSURANCE FOR STATE AND LOCAL EMPLOYEES WHO LOST EMPLOYMENT-RELATED COVERAGE (PUBLIC HEALTH SERVICE ACT AMENDMENTS).

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

"TITLE XXII—REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES

"SEC. 2201. STATE AND LOCAL GOVERNMENTAL GROUP HEALTH PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL.—In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this Act, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this title, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) EXCEPTION FOR CERTAIN PLANS.—Subsection (a) shall not apply to—

"(1) any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year, or

"(2) any group health plan maintained for employees by the government of the District of Columbia or any territory or possession of the United States or any agency or instrumentality.

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1954 (relating to employers under common control) shall apply for purposes of paragraph (1).

"SEC. 2202. CONTINUATION COVERAGE.

"For purposes of section 2201, the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(2) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(A) MAXIMUM PERIOD.—In the case of—

"(i) a qualifying event described in section 2203(2) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(ii) any qualifying event not described in clause (i), the date which is 36 months after the date of the qualifying event.

"(B) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

"(C) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(D) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

"(i) a covered employee under any other group health plan, or

"(ii) entitled to benefits under title XVIII of the Social Security Act.

"(E) REMARRIAGE OF SPOUSE.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(3) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

"(A) shall not exceed 102 percent of the applicable premium for such period, and

"(B) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(4) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(5) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph

(2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"SEC. 2203. QUALIFYING EVENT.

"For purposes of this title, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this title, would result in the loss of coverage of a qualified beneficiary:

"(1) The death of the covered employee.

"(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(3) The divorce or legal separation of the covered employee from the employee's spouse.

"(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"SEC. 2204. APPLICABLE PREMIUM.

"For purposes of this title—

"(1) IN GENERAL.—The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(2) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

"(i) is determined on an actuarial basis, and

"(ii) takes into account such factors as the Secretary may prescribe in regulations.

"(B) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

"(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

"(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

"(3) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"SEC. 2205. ELECTION.

"For purposes of this title—

"(1) ELECTION PERIOD.—The term 'election period' means the period which—

"(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(B) is of at least 60 days' duration, and

"(C) ends not earlier than 60 days after the later of—

"(i) the date described in subparagraph (A), or

"(ii) in the case of any qualified beneficiary who receives notice under section 2206(4), the date of such notice.

"(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 2208(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"SEC. 2206. NOTICE REQUIREMENTS.

"In accordance with regulations prescribed by the Secretary—

"(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(2) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in paragraph (1), (2), or (4) of section 2203 within 30 days of the date of the qualifying event,

"(3) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 2203, and

"(4) the plan administrator shall notify—

"(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 2203, any qualified beneficiary with respect to such event, and

"(B) in the case of a qualifying event described in paragraph (3) or (5) of section 2203 where the covered employee notifies the plan administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the plan administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"SEC. 2207. ENFORCEMENT.

"Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this title may bring an action for appropriate equitable relief.

"SEC. 2208. DEFINITIONS.

"For purposes of this title—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 162(i)(3) of the Internal Revenue Code of 1954.

"(2) COVERED EMPLOYEE.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(3) QUALIFIED BENEFICIARY.—

"(A) IN GENERAL.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

"(i) as the spouse of the covered employee, or

"(ii) as the dependent child of the employee.

"(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 2203(2), the term 'qualified beneficiary' includes the covered employee.

"(4) PLAN ADMINISTRATOR.—The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.".

(b) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(c) NOTIFICATION TO COVERED EMPLOYEES.—At the time that the amendments made by this section apply to a group health plan (covered under section 2201 of the Public Health Service Act), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under title XXII of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 2206(1) of such Act with respect to such individuals.

TITLE XI—SINGLE-EMPLOYER PLAN TERMINATION INSURANCE SYSTEM AMENDMENTS

SEC. 11001. SHORT TITLE AND TABLE OF CONTENTS.

This title may be cited as "Single-Employer Pension Plan Amendments Act of 1986".

TABLE OF CONTENTS

Sec. 11001. Short title and table of contents.
Sec. 11002. Findings and declaration of policy.
Sec. 11003. Amendment of the Employee Retirement Income Security Act of 1974.
Sec. 11004. Definitions.
Sec. 11005. Single-employer plan termination insurance premiums.
Sec. 11006. Notice of significant reduction in benefit accruals.
Sec. 11007. General requirements relating to termination of single-employer plans by plan administrators.
Sec. 11008. Standard termination of single-employer plans.

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National
Association
of Insurance
Commissioners

June 27, 1986

TO: All NAIC Members
ATTENTION: Department Personnel Interested in COBRA Amendments

FROM: Sandra L. Gilfillan, CLU
General Counsel

RE: Requirements for Continuing Health Insurance Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

We have received numerous questions in this office regarding the recent amendments to COBRA dealing with continuation of group health coverages. This memorandum describes provisions of COBRA and problems that have been identified by regulatory or industry sources relating to the amendments. Definitive answers to many of these questions are not available and may require further administrative interpretation or legislative amendment, but this summary may be helpful in illustrating concerns. This writer does not warrant that the industry "interpretive problems" are necessarily of merit but only that the questions have been raised.

1. Covered Individuals

COBRA applies to private employers of 20 or more, state and local government and governmental subdivisions subject to the Fair Labor Standards Act and with 20 or more employees, and employee welfare benefit plans of 20 or more employees.

Comments

State law will continue to apply to employers with less than 20 employees. Additional questions have been raised about METs and associations of employers to whom a group policy is issued -- does the 20 or more requirement apply to each employer member or to the entire MET or association?

Previous employers are required to provide continuation but previous is not defined in the act. The industry has suggested the following situation could occur: The employee and spouse are divorced but no notice is given by the spouse (beneficiary) to the plan administrator and therefore no notice of the spouses right to continue is given. The employee subsequently terminiates and the administrator notifies the employee of his/her continuation rights and the employee continues for eighteen months. Years later the spouse notifies the plan administrator of the divorce, and the administrator must now notify ex-spouse/beneficiary of rights to continue for thirty-six months.

Duration of Continuation Coverage

The period of mandated continuation coverage is thirty-six months for (1) surviving spouses and children of the deceased employees, (2) separated, divorced or medicare ineligible spouses and children of current employees, and (3) children of current employees who would lose coverage because of their age.

The period of mandated continuation of coverages is eighteen months per worker and their dependents in case of loss of coverage through (1) reduction in work hours, (2) voluntary quit, (3) lay-off for economic reasons and (4) discharge for misconduct other than gross misconduct.

Comments

The industry perceives problems with stacking of benefits under this COBRA provision. For example, the employee continues after a lay-off under the plan but dies in the seventeenth month. The spouse then continues under the surviving spouse provision and during that thirty-six month period a dependent child reaches limiting age and is therefore continued for another thirty-six months period in his or her own right.

Termination of Coverage

The employer may terminate coverage prior to the expiration of a thirty-six month or eighteen month period only upon (1) abolition of all health plans provided to any employee, (2) the beneficiary's failure to pay premium, or (3) beneficiary eligibility for another health plan upon reemployment, remarriage or attainment of medicare eligibility.

Comments

Under some state laws, coverage may not be terminated during the first six months solely because the employee obtains other group coverage; each state should research carefully its own continuation provisions.

Additionally, the industry has raised questions about the failure to include a notification requirement from the beneficiary to the employer as to when the event terminating the continuation occurs. Additionally, there is some concern that continuation as to some beneficiaries occurs when the individual becomes "covered" under another plan and some believe "eligibility" is an easier trigger for administration.

Charge to Beneficiary

The employer may charge a premium for continuation coverage, which the beneficiary may pay in monthly installments. To maintain continuity of coverage, the plan may require that a premium be paid for the period of coverage preceding the election to stay in the plan; this premium must be paid within forty-five days after the election. The amount of the premium may not exceed 102% of "the cost of the plan to similarly situated beneficiaries". The portion of plan cost paid the employer with respect to workers and their dependents may be included in computation of the premium for continuation coverage. The premium must be calculated in advance for twelve month periods.

Special rules apply to self-funded plans, which may base the premium on a "reasonable estimate of the cost of providing (continuation) coverage for similarly situated beneficiaries" and is determined on an actuarial basis.

Comments

In some states, the premium for the first six months period may be limited to 100% of the regular premium and therefore would be a more restrictive requirement than the federal law.

Questions that have been asked include does 102% of the premium mean a charge to a beneficiary of up to 102% of the insurer premium charge to the employer? Another question is what if the family unit premium rate was used in a group policy and a dependent child continues - can the dependent be charged 102% of such family unit premium? Additionally, there are no provisions as to whom the continuation premium is to be paid and some health insurers believe the "continuee" should be required to pay the employer or the plan administrator.

Effective Date of Law

The amendments are effective for plan years beginning on or after July 1, 1986. Plans which are collectively bargained are not affected until January 1, 1987 or until expiration of the collective bargaining agreement, whichever is later.

Problems of Federal/State Law Interpretation

Title X did not explicitly override state laws regarding continuation of coverage; therefore there is confusion regarding employers and insurers obligations with state and federal laws. Some industry sources are assuming that COBRA and state continuation and other related state laws apply to insured employer plans. With respect to the duplicity of COBRA and state continuation laws, some interpret the law to read that COBRA rights are triggered initially and then state continuation laws would apply. This example has been citied: A surviving spouse continues under a plan for thirty-six months (COBRA requirement) at which point the "plan terminates". Under some interpretations state law might be triggered which would allow the additional state continuation period to run. I have reviewed the comments which have been circulated by the trade associations, insurers and law firms regarding this act, and have found no definitive answer to this question.

Some observers are convinced that the federal law preempts state law where the state continuation provisions are less strigent than COBRA and they are convinced it was not the intent of Congress nor would it be the intent of the states to add the state continuation coverage provisions to the COBRA mandated provisions. However, other observers are as strongly convinced that there is a possibility of stacking of federal and state provisions which would result in great confusion in their opinion in the application of COBRA's substative and mechanical provisions with respect to periods of eligibility, notice, etc., as the employer/insurers would be required to switch to the state requirements at the completion of COBRA's mandated continuation.

Another problem envisioned is that some state laws impose extensions of coverage requirements on group policies in discontinuance and replacement situations. Since these state requirements apply at the time the group policy would otherwise terminate, and COBRA applies to the qualifying "event", there is a possible conflict between the laws. COBRA continuation obligations cease with the termination of the "plan" but not the "policy". Further in such replacement situations, the "plan" would not be terminated.

With respect to the dependent coverage, state law requires termination of group coverage as to dependent children on attainment of limiting age whereas COBRA requires coverage in such cases to continue. The question is posed if this is a conflict that must be addressed. Additionally, the children of a husband and wife each of whom are covered as employees would be eligible as beneficiaries under both plans -- which COBRA plan would continue or is duplicate continuation coverage required?

The industry hopes to schedule a meeting with the Department of Treasury shortly to request a question and answer interpretive ruling of the COBRA amendments. Additionally, the industry has discussed the possibility of technical amendments to clarify certain of the provisions. If interpretive materials are received from the Department of Treasury, those will be provided to you as soon as possible.