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# 'Less Is More' Does Not Always Work With COBRA

By Constance L. Gilchrest

The recently enacted economic stimulus law has put communications related to COBRA in the spotlight like never before. Specifically, the American Recovery and Reinvestment Act of 2009 (ARRA) has meant a dramatic increase in call volume as employers and COBRA administrators field a variety of questions, including those related to eligibility.

The cliché — “less is more” — may not always be best. The final COBRA regulations from the U.S. Department of Labor require that a *complete response* be given to a health care provider’s request of a qualified beneficiary’s coverage status during the initial and monthly payment grace periods. The COBRA rule dictates a different response, based on how the plan accounts for unpaid coverage that has not yet been terminated:

- A plan may cancel coverage retroactively when payment is not made by the end of the grace period. If so, your response to the inquiry should include these facts:
  - o This is COBRA coverage
  - o Payment has not been received yet
  - o The qualified beneficiary is currently considered to be covered
  - o Coverage is subject to retroactive termination if payment is not made on a timely basis
  - o Specific dates and deadlines (if requested)
- A plan may cancel coverage when payment is not made by the first day of the coverage period and reinstate coverage retroactively if payment is made on a timely basis. If so, your response to the inquiry must include these facts:
  - o This is COBRA coverage
  - o Payment has not been received yet

- o The qualified beneficiary is currently considered to not be covered
- o Coverage is subject to retroactive reinstatement if payment is made on a timely basis
- o Specific dates and deadlines (if requested)

The stakes are high. If a plan provides an incorrect or incomplete response, not only is there a COBRA violation but also potential state-law violations that may not be preempted under ERISA. State-law claims typically do not have the limitations on damages that ERISA claims have. Following is a brief overview of three recent cases that illustrate this important point.

In *Franciscan Skemp Healthcare v. Central States Joint Board Health and Welfare Trust Fund*, the health care provider (Franciscan) complained about the response received from the plan (Central). Franciscan simply called Central to confirm coverage. A Central employee did not disclose that the coverage was subject to COBRA. This meant that coverage was subject to retroactive cancellation if premiums were not paid on a timely basis.

After services were provided, Central refused to pay claims since they were incurred after COBRA coverage had been terminated. Franciscan sued for negligent misrepresentation and estoppel because it relied on Central’s statements to its detriment. The appeals court reversed a summary judgment in favor of Central and allowed the state-law claims, concluding that ERISA preemption did not apply.

In *Tenet Healthcare v. Unicare Health Plans*, the health care provider, Tenet Healthcare Ltd. brought COBRA and state-law negligent misrepresentation claims against an HMO (Unicare). More than \$240,000 in

See *Less Is More*, p. 13

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unpaid medical claims were at issue. At the time of Tenet’s eligibility inquiry to Unicare, the qualified beneficiary was in her election period. Despite this fact, Unicare preauthorized certain procedures but did not disclose that COBRA had not been elected. The qualified beneficiary never did elect COBRA.

Tenet lost on the COBRA claim, but the court ruled that the negligent misrepresentation claim based on Unicare’s preauthorization was not preempted by ERISA. Unicare was fortunate in this case because the court, in reviewing the facts, concluded that Unicare used reasonable care and competence in communicating with Tenet. If this case had been before a jury, the outcome may have been different.

Finally, in *St. John’s Mercy Health System v. Healthlink*, the hospital (St. John’s) sued the health plan (Healthlink) when it failed to communicate that COBRA had terminated. Once again, state-law claims were alleged: negligent and fraudulent misrepresentation. St. John’s provided medical services to a patient after Healthlink confirmed coverage, neglecting to disclose that COBRA had been terminated for failure to pay premiums.

As with the other cases, the court pushed aside the ERISA preemption argument offered by the plan. The state-law claims were allowed to proceed because they were not brought by a beneficiary or a beneficiary’s assignee to recover plan benefits, nor did they arise from duties imposed apart from ERISA and the plan terms.

There are some common threads in each of these cases. The plaintiffs were health care providers (that is, hospitals) that were able to continue on non-COBRA grounds. ERISA preemption was not an adequate defense. Each response to a coverage inquiry was incomplete and in some cases just inaccurate.

A response to a health care provider that a COBRA participant is simply “covered” or “not covered” during their election or payment period is inadequate. See the sidebar for a few practical pointers for communication.

To avoid disputes and potential liability, it is important that a *complete and correct response* be provided to a health care provider requesting the coverage status of a COBRA participant. It is also important that the response be consistent. Replace the adage — “less is more” — with another one: “Be careful what you say. Your words may come back to haunt you.” 🏠

## How to Communicate to Health Care Providers

Let’s say a beneficiary is removed from the plan during the 60-day election period (this is generally the case) and then reinstated once COBRA is elected and the first payment is received. If so, you should:

Inform the provider that the qualified beneficiary currently does not have coverage but will have, retroactively, once COBRA is elected and the first payment is received. (The response may need to include the specific dates of the election period and/or premium due dates.)

Conversely, the plan may provide coverage during the election period but cancel coverage retroactively if COBRA is not elected. In that case, you should:

Inform a provider that a qualified beneficiary is covered but that the coverage is subject to retroactive termination if COBRA is not elected. (The plan may need to provide a specific election date.)

The problem of what to tell a provider who calls verifying coverage for the COBRA participant applies not only during the election period but also during the retroactive premium payment period. A plan may provide coverage during the 45-day retroactive premium period but cancel coverage retroactively if the payment is not made by the end of the 45-day time frame. You should:

Inform a provider that the participant is covered but that the coverage is subject to a retroactive termination if the retroactive premium payment is not made. (The plan may need to provide the specific date for when the 45-day period would end.)

A plan may cancel coverage if the monthly COBRA premium is not paid by the first day of the coverage period but retroactively reinstate coverage if the payment is received by the end of the grace period. You should:

Inform the provider that the qualified beneficiary currently does not have coverage but will be reinstated retroactively to the first date of the period if the payment is made on time. Generally, the grace period is 30 days unless the plan allows a longer period of time. 🏠