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COBRA Is Not Always All or Nothing

By Constance L. Gilchrest

“All or nothing” is not always the case when it comes to offering COBRA coverage. Frequently, the question arises on whether COBRA coverage should be an all-or-nothing proposition. In other words, should it be bundled or unbundled, combined or offered on a stand-alone basis?

Note that in its earlier proposed COBRA rules, dating back to 1987, the IRS established criteria for unbundling coverage, including the use of the terms “core” and “non-core,” but the criteria were eliminated in its final rules. Instead, plan documents determine whether benefits are provided under a single or multiple group health plan. For example, if an employer sponsors a major medical plan as well as dental and vision coverage and all are maintained under separate plan documents, the coverages must be offered as an unbundled plan. In other words, an employer should offer all three benefits separately on a stand-alone basis.

The central analysis is whether coverage is “core” or “non-core.” Typically, the major medical plan is the core coverage. Most plans require medical coverage in order to receive prescription coverage. Therefore, the employer is allowed to offer the prescription bundled with the medical plan. If, however, the major medical plan is not a requirement to obtain prescription coverage, prescription coverage would be offered as an unbundled plan.

Types of non-core coverage are considered to be dental, vision, health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs), and employer assistance programs (EAPs) that are considered group health plans. To take the guesswork out, let’s review the ins and outs of how all this works.

COBRA Coverage

When a qualifying event occurs, each qualified beneficiary must be offered the opportunity to continue, under COBRA, the group health benefits they were receiving immediately before the qualifying event. The coverage offered under COBRA may not differ from the prior coverage. Eligibility for COBRA coverage may not be based on evidence of insurability.

Bundled Coverage Option

This type of plan arrangement includes all health coverage options under a single, bundled plan. Under this arrangement, active employees do not have the opportunity to select coverage options. They must take the entire plan. Likewise, the only option that must be made available to COBRA qualified beneficiaries is the bundled one. Therefore, if an active employee can only receive non-core benefits (for example, dental or vision) by electing the major medical plan, COBRA qualified beneficiaries are subject to the same rule. The coverage election combinations could be:

- | | |
|------------------|-------------------------|
| • Medical | • Medical/vision |
| • Medical/dental | • Medical/dental/vision |
| • Medical/HRA | |

Of course, in the case of bundled coverage, an employer could exceed what COBRA requires by unbundling the coverage and allowing qualified beneficiaries to elect each option separately.

Unbundled Coverage Option

This is a group health plan with both core and non-core coverage options. Active employees may separately pick and choose among the coverages available.

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Similarly, COBRA qualified beneficiaries may elect any or all of the plans they had before the qualifying event. There may be many different coverage election combinations such as:

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|----------------------|---------------------|
| • Medical only | • Dental and vision |
| • Medical and dental | • HRA |
| • Medical and vision | • Prescription |
| • Dental only | • FSA |
| • Vision only | |

Keep in mind that each qualified beneficiary has independent election rights under COBRA. Therefore, each family member (qualified beneficiary) may elect different combinations of coverage. An exception to the rule is if the group health coverage is changed or eliminated. The qualified beneficiary can change COBRA coverage if the employer has modified or eliminated their group health group coverage. In addition, if the employer changes carriers or plans, this would affect the people on COBRA as well.

If coverage is eliminated and the employer maintains other coverage for similarly situated non-COBRA beneficiaries, a qualified beneficiary must be given the right to elect the coverage from one of the plans that remains in force. If the situation is reversed (for example, offering a new plan option like an HMO), qualified beneficiaries

should be notified and given the same rights as active employees to go on the new plan. Generally, employers will allow the affected individuals to choose from all the available coverages or limit their choice to their comparable plans.


If the qualified beneficiary elects coverage under another plan, all the accumulated amounts under the prior coverage must be credited to the annual deductible or any other limits of the new plan.

At this time, the qualified beneficiary could be charged a different premium based on the type of coverage. This new premium does not fall under the “determination period” rule; therefore, even if the premium is at a higher cost, the qualified beneficiary would need to immediately pay the higher premium. If the situation were reversed where the coverage was at a lower premium, the cost would be reduced.

Employers should provide notification to inform qualified beneficiaries of their open enrollment period.

Just as a side note, an individual on COBRA can experience a reduction in premium as many times or as often as the plan is fortunate to have their premiums lowered.

A qualified beneficiary has the same rights as an active employee. Employers should provide an open enrollment notification to inform qualified beneficiaries of their open enrollment period. This notification needs to include all coverages available, monthly premium rates for each option and when the open enrollment period ends. The qualified beneficiary has the right to modify the coverage he or she is entitled to and change and/or drop family members during the open enrollment period. For example, a qualified beneficiary who did not initially elect dental or vision coverage would be able to elect such coverage during open enrollment.

COBRA clearly states if coverage is modified for any group of “similarly situated beneficiaries” it should also be modified in the same manner for qualified beneficiaries. When it comes to changing plans or insurers, one of the first things to keep in mind are people on COBRA. A qualified beneficiary needs to be properly notified of any changes and treated the same as the similarly situated active employees. Employers need to make sure their obligations are covered when making a plan or insurer change to avoid penalties and fines that come with COBRA failures. 

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