

COBRA Answers to Major Insurer Questions

By Constance Gilchrest



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Issues sometime arise between an insurance carrier and employer regarding COBRA. Below are eight difficult situations, along with suggestions for turning an apparent no-win situation into a win-win situation.

1. What Should I Do if the Insurer Is Denying COBRA?

First and most importantly, the employer should check to make sure the COBRA election notice was sent within the proper time frame.

The COBRA statute states that “*the employer of an employee under a plan must notify the plan administrator of a Qualifying Event within 30 days of the Qualifying Event.*” The statute further requires the plan administrator to notify any qualified beneficiary, with respect to an event, within 14 days of the date on which the employer notifies the plan administrator of the event.

If the employer is outside the proper time frame, the insurer can deny COBRA coverage, causing the employer to become self-insured for any and all claims incurred during the full 18-, 29- or 36-month COBRA coverage period. If everything was done correctly, take the following steps:

- Request that the insurer provide the specific reason for denying COBRA coverage.
- Provide documentation of your COBRA compliance along with the applicable legal guidance (most legal requirements can be found in either the notice regulations issued by the U.S. Department of Labor (DOL) in 2004, or the COBRA regulations issued by IRS in 1999 and 2001).
- Look to the COBRA language in the insurance contract and policy that obligates the insurer to comply with COBRA.

2. During the Election Period, Must Coverage Be Provided?

It depends on how the policy is written. There are two ways to handle this situation:

- 1) **No coverage until payment is received.** The qualified beneficiary can be removed from the plan during the 60-day election period (which is generally the case) and then reinstated retroactively once COBRA is elected and the first payment is made.
- 2) **Coverage until payment is not received.** The plan can provide coverage during the election period, but cancels the coverage retroactively if COBRA is not elected. The premium the employer paid during the election period could be applied to its next group billing.

To ensure that coverage will be reinstated, the employer should:

- Follow the written policy procedure.
- Notify the insurer immediately when the premium has been received.

3. What Should I Do if the Insurer Requires its Own Election Form?

Informal DOL guidance indicates that an insurer cannot deny coverage based upon not receiving a signed election form or application.

And under the Technical and Miscellaneous Revenue Act, an insurer can be enjoined as a liable party if it does not allow reinstatement of COBRA coverage when:

- 1) It provides coverage to similarly situated active employees.
- 2) A written request for COBRA coverage is submitted.

To avoid any complications, the following steps should be taken:

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- The employer should review the insurance contract and policy for the obligations regarding this issue.
- The contract should indicate who is responsible to send the election form.
- If by contract the employer is responsible, the insurer should provide the election form for the employer to send and once the signature is obtained, the employer should immediately return it to the insurer.

4. What Premium Do You Charge if Two Single Rates Are Less Than the Family Rate?

Often, insurers are not aware of IRS Revenue Ruling 96-8, which clarified that if two single premiums are less than the family rate, the qualified beneficiaries are allowed to pay two single premiums. This rule only applies for a two-tier plan; in other words, the premium structure can only be single and family.

On a side note, a DOL representative informally stated that a qualified beneficiary should be notified of all premium structures.

To ensure the insurer will accept the correct premium an employer should:

- Send Revenue Ruling 96-8.
- Follow up with a phone call or e-mail.

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paid, submitting premium changes in a timely manner and maintaining current banking information.

When individuals register for the monthly HCTC, or claim the yearly HCTC on their federal tax return, they must submit supporting documents (such as a health insurance bill, COBRA election letter or substitute letter that has the same information that a health insurance bill contains) to show they have the insurance they are claiming. HPAs typically help these individuals if they request information or documentation concerning their health coverage.

This is just a summary of the HCTC program. The full HCTC program guidelines are available online on the IRS-dedicated website. There really are not specific regulations governing the program's implementation. Therefore, employers and administrators in need of additional information should consult the online resources. Of course, new developments in this area will be reported in future issues of the newsletter. 🏠

5. Which Coverages Should Be Offered During Open Enrollment?

A qualified beneficiary has the same rights as a similarly situated active employee. Therefore, anyone on COBRA coverage should be notified of a new plan being added, such as dental or vision. Qualified beneficiaries should be notified of coverages and premiums, and be allowed the same time frame to elect as the similarly situated active employees.

To avoid any issues, an employer should:

- Look at the COBRA language in the insurance contract.
- If the plan is self-insured, follow the same procedure with the stop-loss insurer.
- Provide the IRS' 1999 final regulations.

6. What Is the Procedure if a Severance Package Is Being Offered?

Unfortunately, this is dealt with after the fact and generally has not been handled in the appropriate manner. At the time of the layoff or termination of employment, employers are offering the affected employee a longer period of coverage. Employees are left on the group health plan for three or more months, then when the severance has ended, they are removed from the plan and are offered COBRA coverage. The best way to handle the severance package is to offer COBRA coverage per the group health plan terms.

To avoid having to "self-insure" coverage because the insurer, uninformed about the severance agreement, declines to provide the "extra" coverage, employers should:

- Make prior arrangements (preferably in writing) with the insurer before a severance agreement is put into place to see what will be allowed.

7. What Should I Do if the Premium Is Received Past the Proper Grace Period?

Anyone can pay the COBRA premiums, and the COBRA law gives the qualified beneficiary at least a 30-day grace period to pay the premium, or longer if the plan so allows. Sometimes the premium is received a day or two past the grace period. One should be careful and not terminate coverage immediately.

The COBRA law makes it clear that the payment is considered made on the date it is *sent* to the plan. The best proof of when the premium was sent is the postmark date on the envelope. This would be the best procedure to

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handle this situation, which would hold up in the court of law or if DOL were contacted.

There are always exceptions to the rules and this situation has one. Rule 77(c) addresses legal holidays. If the grace period falls on the following days, the employer should extend the grace date to the next business day:

Saturday, Sunday, Birthday of Martin Luther King, Jr., Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day, and any other day appointed as a holiday by the President or the Congress of the United States, or by the state in which the district court is held.

An insurer *must* allow the coverage to remain in force or reinstate if the premium is *sent* within the proper grace period. If the insurer is denying reinstatement of coverage, the employer should:

- Request the insurer provide the specific reason for denying the reinstatement.
- Provide the insurer a copy of the envelope showing the postmark date.
- Provide a copy of the IRS' 1999 final regulations.

8. What Should I Do if the Insurer Is Denying An Extension of Coverage?

One important and first thing to do is make sure the qualified beneficiary was properly notified of their 60-day responsibility to notify the plan of a secondary event. The notice must include who and in what manner to notify. Until a qualified beneficiary has been told of this 60-day responsibility the clock does not start ticking.

To ensure the extension will be allowed, the employer needs to:

- Request the insurer provide the specific reason for denying the extension.
- Provide the insurer all documentation showing the proper time frames were met.
- Provide all documentation received from the qualified beneficiary.
- Provide the DOL's 2004 final regulations.

Timing is everything when it comes to COBRA. It is essential that employers and insurers work together to guarantee all the rules and regulations are met to ensure coverage is provided in the correct manner to avoid the employer becoming self-insured. 🏠

IRS Seeking Comments on COBRA Rules

The IRS has opened up a public comment period until July 11 regarding its COBRA regulations. No, there's not been a change; rather, it's part of the agency's administrative duty regarding "proposed and/or continuing information collections," like the COBRA rules.

Under the Paperwork Reduction Act of 1995, the Treasury Department is charged with allowing the general public and other federal agencies to comment on proposed and/or continuing information collections, as part of its "continuing effort to reduce paperwork and respondent burden." So periodically, it issues a request for comments.

In the May 12, 2011, *Federal Register* notice (see 76 Fed. Reg. 27750), the IRS generally listed the rule's provisions on election notices, elections by qualified beneficiaries, "short" premium payments and responses to health care provider inquiries during the election period. The agency is inviting comments on: (1) whether the collection of information is necessary for the proper performance of the agency's functions,

including whether the information shall have practical utility; (2) the accuracy of the agency's estimate of the information collection burden; (3) ways to enhance the quality, utility and clarity of the information; (4) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology; and (5) estimates of capital or start-up costs and costs of operation, maintenance and purchase of services to provide information.

Written comments should be received on or before July 11, 2011 and sent to Yvette B. Lawrence, Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, D.C. 20224. In your comments, refer to Continuation Coverage Requirements Application to Group Health Plans, OMB Number: 1545-1581, Regulation Project Number: REG-209485-86 (TD8812).

For more information, contact Joel Goldberger at the IRS, (202) 927-9368, or Joel.P.Goldberger@irs.gov. 🏠

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