Don’t Overlook COBRA Conversion Requirements

By Rich Glass

True or false: When COBRA’s maximum coverage period ends, so do a plan administrator’s worries about continuing health coverage for the qualified beneficiary.

This statement is false.

Sometimes overlooked are a group health plan’s duties related to conversion policies. The purpose of a conversion policy is to continue to make available to the qualified beneficiary the same coverage that was in place during the COBRA coverage period. Here are answers to some questions that exist about conversion rights.

What Types of COBRA Coverage Are Subject to Conversion Requirements?

Conversion rights apply to fully insured plans, either because of a state-law mandate or the plan terms provide for a conversion right. The attraction of conversion policies is that you qualify without having to show proof of insurability. For qualified beneficiaries who have been on COBRA coverage for a while, providing proof of insurability can be a high hurdle to clear. Most states have mandatory conversion rules when coverage terminates for reasons other than a failure to pay premiums. Some states will limit the conversion rights to a type of coverage (for example, HMOs). Check your state’s law and your insurance certificate.

A good starting point for state conversion laws is Kaiser Health Foundation’s comparison chart, available at [www.statehealthfacts.org/comparetable.jsp?ind=358&cat=7]. State conversion laws do not apply to self-insured plans (for example, health flexible spending accounts, health reimbursement arrangements), but it is possible, in theory, that a self-insured health plan could offer a conversion right.

Does a Conversion Policy Simply Continue an Individual’s COBRA Coverage?

No. A conversion policy is viewed as an individual insurance policy. Therefore, unlike COBRA coverage, conversion policies are not subject to ERISA protections. However, while the conversion policy itself is not subject to ERISA, the right to convert the group health plan — including the administrative steps of notifying the individual — is subject to ERISA. We will discuss in further detail below.

Conversion policies may be subject to additional state-law protections that might not apply to COBRA coverage. The biggest difference is the premium. For COBRA coverage, the maximum rate is 102 percent of the cost of the group coverage (150 percent during the disability extension). Conversion policies are not based on group rates but instead are subject to individual underwriting. Under the health care reform law known as the Affordable Care Act, individual insurance carriers will not be able to discriminate in their underwriting based on a health status-related factor starting in 2014. The only allowable variations will be for age, coverage category, tobacco use and rating area.

Where Does COBRA Come Into Play?

Here is a simple rule: If the group health plan is not required to offer a conversion policy, there is no COBRA obligation. As stated above, that is usually not the case for fully insured health plans.

Before the U.S. Department of Labor issued its final COBRA notice regulations in 2004, the agency required all election notices to contain information on conversion rights. The DOL dropped that requirement in the final regulations, noting that conversion rights were:

likely to be provided by the plan in some other form, either in connection with offering the individual a choice between COBRA coverage and the plan’s alternative coverage options, or at the time that COBRA continuation coverage ends.

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The DOL’s model templates do not include conversion information for either the general notice or the election notice.

COBRA and conversion rights primarily overlap in two circumstances, which we will discuss in answering the next two questions.

What Is the First Circumstance in Which COBRA and Conversion Rights Overlap?

The IRS’ final regulations indicate the COBRA conversion overlap occurs when a qualified beneficiary reaches the maximum coverage period of 18, 29 or 36 months. During the 180-day period that precedes the COBRA expiration date, the group health plan must give the qualified beneficiary the option of enrolling in a conversion plan if the option “is otherwise generally available to similarly situated nonCOBRA beneficiaries.” The regulations do not specifically require a notice, but the act of providing the option would necessitate informing the qualified beneficiary of this right.

You don’t have to provide a separate conversion notice. Including the information in other notices is sufficient. Examples would include an election notice or one or more optional notices like an expiration notice or a monthly invoice. Sometimes, conversion information is available in one or more insurance-related documents. It could even be included in the summary plan description.

The conversion notice should provide sufficient information so that the qualified beneficiary can find out more information to make an informed election. Here are some things to include:

- At a minimum, contact information, even if that information directs the qualified beneficiary to the plan administrator/employer.
- How long a person has to apply for such coverage.
- A reminder that electing a conversion policy would make that person ineligible for any HIPAA guaranteed-availability coverage.
- Contact information for the applicable state insurance department.

What Is the Second Circumstance in Which COBRA and Conversion Rights Overlap?

The IRS regulations only address when a qualified beneficiary reaches the maximum coverage period. That is not the only time you have to provide notice about conversion rights. The COBRA termination notice, which is triggered whenever COBRA coverage ends early, has three content requirements, including “[a]ny rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.”

Do COBRA Conversion Requirements Only Apply To Health Coverage?

Yes. In a recent case, Proctor v. Northern Lakes Community Mental Health (see ¶1900, Case No. 848), the former employee had health and life insurance coverage. One allegation in her COBRA complaint was that the employer failed to respond to a request for more information on converting her group life policy to an individual life policy. The court held that ERISA and COBRA do not create an employer duty to give information about welfare benefits other than health insurance.

Can an Employer Eliminate a Health Plan’s Conversion Rights?

Yes, if three conditions are satisfied:

1) The plan’s coverage cannot be subject to a state-law mandate (for example, Alabama does not mandate conversion coverage). The reason could be that the coverage is self-insured (and therefore, not subject to state insurance laws) or there is no state-law mandate.

2) The plan must amend its plan in writing.

3) The plan must properly notify plan participants via a summary of material modifications.

In a case decided two decades ago, Kytle v. Stewart Title Co. (see ¶1900, Case No. 56), the court validated elimination of the conversion option as long as the SMM was provided within 210 days after the end of the plan year in which the elimination took place. This fact left the Kytle family with a lot of unpaid medical bills because their COBRA coverage already had expired after 18 months of coverage.

Arguably, the court made a mistake because eliminating the conversion right could be viewed as a material reduction of benefits, which would require a mere 60-days notice after the effective date. This was critical because the employer provided notice some five months after the effective date of the conversion coverage elimination. Thus, the employer’s notice complied with the 210-day time frame but did not comply with the 60-day notice time frame.

What Are the Consequences for Noncompliance?

In other words, what if the employer fails to notify a qualified beneficiary of conversion rights? The employer may have to deal with a two-edged sword, and the cut could be very deep.
As we review the compliance challenges human resources professionals faced over the last year, we unfortunately see an overriding theme: The complex and oftentimes conflicting federal and state laws, mounting recordkeeping and reporting requirements, redoubled enforcement efforts and emerging case law that frustrate employers now show no signs of letting up in 2013.

The good news is we’re here to help. In this special report, we discuss the issues most likely to confound Thompson customers and others. But more importantly, we provide tips to help you stay in compliance throughout the year.

Wage and Hour Compliance
Expect ongoing and, in some instances, increased enforcement of the Fair Labor Standards Act. The U.S. Department of Labor is seeking additional funding and staff to improve enforcement of minimum wage and overtime laws, FLSA classification (exempt vs. nonexempt) independent contractor rules. In addition, DOL, IRS and state agencies are increasingly sharing information about employer practices that lead to worker misclassification and independent contractor abuses.

Leave and Disability Compliance
When evaluating an individual’s request for a leave of absence for medical reasons, employers must continue to evaluate the potential impact of the Family and Medical Leave Act, the Americans with Disabilities Act and myriad other federal and state laws.

Watch for finalization of the rules, proposed in February 2012, for unpaid family and medical leave for families of service members and airline flight crew members. Most of the proposed rules were expected; one provision, however, caught many employers off guard: A plan to restore an original FMLA rule preventing employers from docking workers approved for intermittent FMLA from taking more time than they actually need.

Expect to experience continued impact of the U.S. Equal Employment Opportunity Commission’s broad interpretation of the 2008 Americans with Disabilities Amendments Act. Perhaps most notably, EEOC concluded in its 2010 rules that some conditions will almost always be considered disabilities under the ADA. As a result of this ruling — in line with the intent of the 2008 law — it is easier for an individual to establish disability and thus to be entitled to accommodation by an employer. Much to some employers’ chagrin, the EEOC is increasingly open to leave as a reasonable accommodation.

Health Care Reform
Over the last two years, the Patient Protection and Affordable Care Act has had a dramatic impact on the way employers and health-plan administrators run health plans. But with many reform provisions slated to go into effect in the next two years, expect a barrage of additional rules and guidance. The rules will require employers to change certain aspects of their coverage, update their plan documents and make various strategic planning decisions.

Domestic Partner Benefits
More employers are interested in extending their benefits coverage to domestic partners, including civil union partners and same-sex spouses in the growing number of states now recognizing same-sex marriage. The U.S. Supreme Court is expected to rule on two same-sex marriage cases in 2013, ensuring the issue will remain in the forefront of public policy. Whatever the outcome, it is likely employers will still face challenges in administering benefits for domestic partners and same-sex spouses.

More Taxes
Because the payroll tax cut has expired, employees’ required share of Social Security taxes will increase from 4.2 percent of income to 6.2 percent. (Employers’