



An Employer's Guide to Group Health Continuation Coverage Under COBRA

The Consolidated Omnibus
Reconciliation Act of 1986



U.S. Department of Labor
Employee Benefits Security Administration

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INTRODUCTION

Health insurance is one of the most important benefits that employers can provide for their employees. Employers that sponsor group health plans enable their employees and their families to take care of their essential medical needs, ensuring that they can devote their energies to productive work. Because of the critical importance of good health, employer-sponsored group health insurance programs benefit employees, employers, and society as a whole.

Most group health plans sponsored by employers must comply with the Employee Retirement Income Security Act of 1974 (ERISA), a Federal law that sets standards to protect employee benefits. One of the protections contained in ERISA is the right to COBRA continuation coverage, a temporary continuation of group health coverage that would otherwise be lost due to life events like termination of employment, death of an employee, and divorce.

This booklet summarizes COBRA continuation coverage and explains the rules that apply to group health plans. It is intended to assist employers that sponsor group health plans to comply with this important Federal law.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (**COBRA**)¹ health benefit provisions in 1986. The law amended the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to require most group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated.

Group Health Plans Subject to COBRA

COBRA generally applies to all private-sector group health plans maintained by employers that have at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

COBRA also applies to plans sponsored by state and local governments.² The law does not apply, however, to plans sponsored by the Federal government or by churches and certain church-related organizations.

What is a group health plan? It is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance, by a health maintenance organization, out of the employer's assets, or through any other means. "Medical care" includes for this purpose:

¹ The original health continuation provisions were contained in Title X of COBRA, which was signed into law (Pub. L. No. 99-272) on April 7, 1986.

² The COBRA provisions of the Public Health Service Act covering state and local government plans are administered by the Department of Health and Human Services under the provisions of the Public Health Service Act.

- Inpatient and outpatient hospital care;
- Physician care;
- Surgery and other major medical benefits;
- Prescription drugs;
- Dental and vision care.

Life insurance is not considered “medical care,” nor are disability benefits; and COBRA does not cover plans that provide only life insurance or disability benefits.

Group health plans covered by COBRA that are sponsored by private-sector employers are generally welfare plans under ERISA and therefore subject to ERISA’s other requirements. Under ERISA, group health plans must be administered by a plan administrator, who is usually named in the plan documents. Many group health plans are administered by the employer that sponsors the plan, but group health plans are also frequently administered, in whole or in part, by another individual or organization separate from the employer, such as a professional benefits administration firm. Carrying out the requirements of COBRA is the direct responsibility of the plan administrator.

COBRA Continuation Coverage

COBRA requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee’s employment for reasons other than gross misconduct, a covered employee’s becoming entitled to Medicare, divorce or legal separation of a covered employee and spouse, and a child’s loss of dependent status (and therefore coverage) under the plan. COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

Employers may require individuals to pay for COBRA continuation coverage. The premium that is charged cannot exceed the full cost of the coverage, plus a 2 percent administration charge.

Alternatives to COBRA Continuation Coverage

Those entitled to elect COBRA continuation coverage may have alternative options to COBRA coverage. One option may be “special enrollment” in other group health coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), upon certain events, group health plans, and health insurance issuers are required to provide a special enrollment period during which individuals who previously declined coverage for themselves and their dependents, and who are otherwise eligible, may be allowed to enroll without having to wait until the next open season for enrollment. One event that triggers special enrollment is an employee or dependent of an employee losing eligibility for other health coverage. For example, an employee who loses group health coverage may be able to special enroll in a spouse’s health plan. The employee or dependent must request special enrollment within 30 days of the loss of coverage.

If an employee or dependent chooses to elect COBRA instead of special enrollment upon a loss of group health coverage, the employee or dependent will have another opportunity to request special enrollment once COBRA has been exhausted. In order to exhaust COBRA coverage, the individual must receive the maximum period of COBRA coverage available without early termination. To special enroll after exhausting COBRA, an individual must request enrollment within 30 days of the loss of COBRA coverage.

In addition, individuals in a family may be eligible for health insurance coverage through various state programs. For more information contact your state department of insurance.

WHO IS ENTITLED TO CONTINUATION COVERAGE?

A group health plan is required to offer COBRA continuation coverage only to **qualified beneficiaries** and only after a **qualifying event** has occurred.

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred and who is **either an employee, the employee's spouse or former spouse, or the employee's dependent child.** In certain cases involving the bankruptcy of the employer, a retired employee, the retired employee's spouse (or former spouse), and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events

“Qualifying events” are events that cause an individual to lose group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage.

The following are qualifying events for a **covered employee** if they cause the covered employee to lose coverage:

- Termination of the covered employee's employment for any reason other than “gross misconduct”; or
- Reduction in the covered employee's hours of employment.

The following are **qualifying events for a spouse and dependent child** of a covered employee if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct";
- Reduction in hours worked by the covered employee;
- Covered employee becomes entitled to Medicare;
- Divorce or legal separation of the spouse from the covered employee; or
- Death of the covered employee.

In addition to the above, the following is a qualifying event for a **dependent child** of a covered employee if it causes the child to lose coverage:

- Loss of "dependent child" status under the plan rules.

COBRA NOTICE AND ELECTION PROCEDURES

Under COBRA, group health plans must provide covered employees and their families with specific notices explaining their COBRA rights. They must also have rules for how COBRA continuation coverage is offered, how qualified beneficiaries may elect continuation coverage, and when it can be terminated.

Notice Procedures

Summary Plan Description

The COBRA rights provided under the plan, like other important plan information, must be described in the plan's summary plan description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works. ERISA requires group health plans to give each participant an SPD within 90 days after he or she first becomes a participant in a plan (or within 120 days after the plan is first subject to the reporting and disclosure provisions of ERISA). In addition, if there are material changes to the plan, the plan must give participants a summary of material modifications (SMM) not later than 210 days after the end of the plan year in which the changes become effective. If the change is a material reduction in covered services or benefits, the SMM must be furnished not later than 60 days after the reduction is adopted. A participant or beneficiary covered under the plan may request a copy of the SPD and any SMMs (as well as any other plan documents), which must be provided within 30 days of a written request.

COBRA General Notice

Group health plans must give each employee and each spouse of an employee who becomes covered under the plan a general notice describing COBRA rights. The general notice must be provided within the first 90 days of coverage. Group health plans can satisfy this requirement by including the general notice in the plan's SPD and giving the SPD to the employee and to the spouse within this time limit.

The general notice must include:

- The name of the plan and the name, address, and telephone number of someone whom the employee and spouse can contact for more information on COBRA and the plan;
- A general description of the continuation coverage provided under the plan;
- An explanation of what qualified beneficiaries must do to notify the plan of qualifying events or disabilities;
- An explanation of the importance of keeping the plan administrator informed of addresses of the participants and beneficiaries; and
- A statement that the general notice does not fully describe COBRA or the plan and that more complete information is available from the plan administrator and in the SPD.

The Department of Labor has developed a model general notice that single-employer group health plans may use to satisfy the general notice requirement. It is available at the EBSA Web site at www.dol.gov/ebsa. In order to use this model general notice properly, the plan administrator must complete it by filling in the blanks with the appropriate plan information. Use of the model general notice, appropriately completed, will be considered by the Department to be good faith compliance with the general notice content requirements of COBRA.

COBRA Qualifying Event Notice

Before a group health plan must offer continuation coverage, a qualifying event must occur. The group health plan is not required to act until it receives an appropriate notice of such a qualifying event.

The employer is required to notify the plan if the qualifying event is:

- Termination or reduction in hours of employment of the covered employee;
- Death of the covered employee; or
- Covered employee's becoming entitled to Medicare.

The employer has 30 days after the event occurs to provide notice to the plan.

The **covered employee** or one of the **qualified beneficiaries** is responsible for notifying the plan if the qualifying event is:

- Divorce;
- Legal separation; or
- A child's loss of dependent status under the plan.

Group health plans are required to have procedures for how the covered employee or one of the qualified beneficiaries can provide notice of these types of qualifying event. The procedures must give covered employees and qualified beneficiaries at least 60 days after the qualifying event occurs to give notice, and the procedures must describe how, and to whom, notice should be given, and what information must be included in the qualifying event notice. If one person gives notice of a qualifying event, the notice covers all qualified beneficiaries affected by that event.

If a group health plan does not have reasonable procedures for how to provide these notices, qualified beneficiaries are permitted to give notice (either written or oral) to the person or unit that handles the employer's employee benefits matters. If the plan is a multiemployer plan, notice can also be given to the joint board of trustees; and if the plan is administered by an insurance company (or the benefits are provided through insurance), notice can be given to the insurance company.

COBRA Election Notice

After receiving a notice of a qualifying event, the plan must provide the qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event.

The election notice must include:

- The name of the plan and the name, address, and telephone number of the plan's COBRA administrator;
- Identification of the qualifying event;
- Identification of the qualified beneficiaries (by name or by status);
- An explanation of the qualified beneficiaries' right to elect continuation coverage;
- The date coverage will terminate (or has terminated) if continuation covered is not elected;
- How to elect continuation coverage;
- What will happen if continuation coverage isn't elected or is waived;
- What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events;
- How continuation coverage might terminate early;
- Premium payment requirements, including due dates and grace periods;
- A statement of the importance of keeping the plan administrator informed of the addresses of qualified beneficiaries; and
- A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the plan administrator and in the SPD.

The Department has developed a model election notice that plans may use to satisfy their obligation to provide the election notice. The model election notice is available on the EBSA Web site at www.dol.gov/ebsa. In order to use this model election notice properly, the plan administrator must complete it by filling in the blanks with the appropriate plan information. Use of the model election notice, appropriately completed, will be considered by the Department to be good faith compliance with the election notice content requirements of COBRA.

COBRA Notice of Unavailability of Continuation Coverage

Group health plans may sometimes deny a request for continuation coverage or for an extension of continuation coverage, when the plan determines the requester is not entitled to receive it. When a group health plan makes the decision to deny a request for continuation coverage from an individual, the plan must give the individual a notice of unavailability of continuation coverage. The notice must be provided within 14 days after the request is received, and the notice must explain the reason for denying the request.

COBRA Notice of Early Termination of Continuation Coverage

Continuation coverage must generally be made available for a maximum period (18, 29, or 36 months). The group health plan may terminate continuation coverage early, however, for any of a number of specific reasons. (See *Duration of Continuation Coverage* later in this booklet.) When a group health plan decides to terminate continuation coverage early for any of these reasons, the plan must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy.

Special Rules for Multiemployer Plans

Multiemployer plans are allowed to adopt some special rules for COBRA notices. First, a multiemployer plan may adopt its own uniform time limits for the qualifying event notice or the election notice. A multiemployer plan also may choose not to require employers to provide qualifying event notices, and instead to have the plan administrator determine when a qualifying event has occurred. Any special multiemployer plan rules must be set out in the plan's documents (and SPD).

Election Procedures

COBRA requires group health plans to give qualified beneficiaries an election period during which they can decide whether to elect

continuation coverage, and COBRA also gives qualified beneficiaries specific election rights.

At a minimum, each qualified beneficiary must be given at least 60 days to choose whether or not to elect COBRA coverage, beginning from the later of the date the election notice is provided, or the date on which the qualified beneficiary would otherwise lose coverage under the group health plan due to the qualifying event.

Each qualified beneficiary must be given an independent right to elect continuation coverage. This means that when several individuals (such as an employee, his or her spouse, and their dependent children) become qualified beneficiaries due to the same qualifying event, each individual can make a different choice. The plan must allow the covered employee or the covered employee's spouse, however, to elect continuation coverage on behalf of all of the other qualified beneficiaries for the same qualifying event. A parent or legal guardian of a qualified beneficiary must also be allowed to elect on behalf of a minor child.

If a qualified beneficiary waives continuation coverage during the election period, he or she must be permitted to later revoke the waiver of coverage and elect continuation coverage, as long as the revocation is done before the end of the election period. If a waiver is later revoked, however, the plan is permitted to make continuation coverage begin on the date the waiver was revoked.

BENEFITS UNDER CONTINUATION COVERAGE

COBRA also sets standards for the continuation coverage that must be provided.

The continuation coverage must be identical to the coverage that is currently available under the plan to similarly situated individuals who are covered under the plan and not receiving continuation coverage. (Generally, this is the same coverage that the qualified beneficiary had immediately before the qualifying event). A qualified beneficiary receiving continuation coverage must receive the same benefits, choices, and services that a similarly situated participant or beneficiary is currently receiving under the plan, such as the right during an open enrollment season to choose among available coverage options. The qualified beneficiary is also subject to the same plan rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Any changes made to the plan's terms that apply to similarly situated active employees and their families will also apply to qualified beneficiaries receiving COBRA continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation coverage, the child is automatically considered to be a qualified beneficiary receiving continuation coverage. The plan must allow the child to be added to the continuation coverage.

DURATION OF CONTINUATION COVERAGE

Maximum Periods

COBRA requires that continuation coverage be made available for a **limited period of time of 18 or 36 months**. The length of time for which continuation coverage must be made available (the “maximum period” of continuation coverage) depends on the type of qualifying event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

When the qualifying event is the covered employee’s termination of employment (for reasons other than gross misconduct) or reduction in hours of work, qualified beneficiaries must be provided a maximum of **18 months** of continuation coverage.

For all other qualifying events, qualified beneficiaries must be provided **36 months** of continuation coverage.³

Early Termination

A group health plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis;
- The employer ceases to maintain any group health plan;
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage (as long as that plan doesn’t impose an exclusion or limitation with respect to a preexisting condition of the qualified beneficiary);
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage;

³ Under COBRA, certain retirees and their family members who receive post-retirement health coverage from employers have special COBRA rights in the event that the employer is involved in bankruptcy proceedings begun on or after July 1, 1986. This booklet does not fully describe the COBRA rights of that group.

- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. (See *Notice and Election Procedures* earlier in this booklet.)

Extension of an 18-month Period of Continuation Coverage

There are two circumstances under which individuals entitled to an 18-month maximum period of continuation coverage can become entitled to an extension of that maximum. The first is when one of the qualified beneficiaries is **disabled**; the second is when a second qualifying event occurs.

Disability

If one of the qualified beneficiaries in a family is disabled and meets certain requirements, all of the qualified beneficiaries in that family are entitled to an 11-month extension of the maximum period of continuation coverage (**for a total maximum period of 29 months** of continuation coverage). The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension.

The requirements are, first, that the disabled qualified beneficiary must be determined by the Social Security Administration (SSA) to be disabled at some point during the first 60 days of continuation coverage, and, second, that the disability must continue during the rest of the initial 18-month period of continuation coverage.

The disabled qualified beneficiary (or another person on his or her behalf) must also notify the plan of the SSA determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 days, starting from the latest of: (1) the

date on which the SSA issues the disability determination; (2) the date on which the qualifying event occurs; or (3) the date on which the qualified beneficiary receives the COBRA general notice.

The right to a disability extension may be terminated if SSA determines that the qualified beneficiary is no longer disabled, and the plan can require disabled qualified beneficiaries to provide notice when such a determination is made. The plan must give the qualified beneficiaries at least 30 days after the SSA determination in which to provide such notice.

The rules for how to give a disability notice and a notice of no longer being disabled should be described in the plan's SPD (and in the election notice for any offer of an 18-month period of continuation coverage).

Second Qualifying Event

An 18-month extension may be available to qualified beneficiaries receiving an 18-month maximum period of continuation coverage (giving a total maximum period of **36 months** of continuation coverage) if the qualified **beneficiaries experience a second qualifying event that is death of the covered employee, divorce or legal separation of the covered employee and spouse, Medicare entitlement, or loss of dependent child status under the plan.** The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan in the absence of the first qualifying event. The plan should have rules for how a notice of second qualifying event should be provided, and these rules should be described in the plan's SPD (and in the election notice for any offer of an 18-month period of continuation coverage).

Conversion Options

Some group health plans contain a conversion option, which allows participants and beneficiaries whose coverage under the plan terminates to convert from group health coverage to an individual policy. If this conversion option is available under the plan to active

employees and their families, qualified beneficiaries whose maximum period of continuation coverage ends also must be given the option to convert to an individual policy. The conversion option must be offered not later than 180 days before continuation coverage ends. The option to convert, however, need not be provided if continuation coverage is terminated before the end of the maximum period for which it was made available.

SUMMARY OF QUALIFYING EVENTS, QUALIFIED BENEFICIARIES, AND MAXIMUM PERIODS OF CONTINUATION COVERAGE

The following chart shows the maximum period for which continuation coverage must be offered for the specific qualifying events and the qualified beneficiaries who are entitled to elect continuation coverage when the specific event occurs. **Note that an event is a qualifying event only if it causes the qualified beneficiary to lose coverage under the plan.**

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	MAXIMUM PERIOD OF CONTINUATION COVERAGE
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 months ⁴
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

⁴ In certain circumstances, qualified beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months) (See *Duration of Continuation Coverage* earlier in this booklet.)

PAYING FOR CONTINUATION COVERAGE

Group health plans can require qualified beneficiaries to pay for COBRA continuation coverage, although plans can choose to provide continuation coverage at reduced or no cost. The maximum amount charged to qualified beneficiaries cannot exceed 102 percent of the cost to the plan for similarly situated individuals covered under the plan who have not incurred a qualifying event. In calculating premiums for continuation coverage, a plan can include the costs paid by both the employee and the employer, plus an additional 2 percent for administrative costs. All of the necessary information about COBRA premiums, when they are due, and the consequences of payment and nonpayment should be described in the COBRA election notice. For disabled qualified beneficiaries receiving the 11-month disability extension of continuation coverage, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage.

COBRA charges to qualified beneficiaries may be increased if the cost to the plan increases but generally must be fixed in advance of each 12-month premium cycle. The plan must allow qualified beneficiaries to pay the required premiums on a monthly basis if they ask to do so, and may allow payments at other intervals (for example, weekly or quarterly).

Qualified beneficiaries cannot be required to pay a premium in connection with making the COBRA election. Plans must provide at least 45 days after the election (that is the date the qualified beneficiary mails the election form if using first-class mail), for making an initial premium payment. If a qualified beneficiary fails to make any payment before the end of the initial 45-day period, the plan can terminate the qualified beneficiary's COBRA rights. The plan should establish due dates for any premiums for subsequent periods of coverage, but must provide a minimum 30-day grace period for each payment.

Plans are permitted to terminate continuation coverage if full payment is not received before the end of a grace period. If the amount of a payment made to the plan is wrong, but is not significantly less than

the amount due, the plan must notify the qualified beneficiary of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices, but is required to provide a notice of early termination if continuation coverage is terminated early due to failure to make a timely payment.

Certain individuals may be eligible for a Federal income tax credit that can alleviate the financial burden of monthly COBRA premium payments. The Trade Adjustment Assistance Reform Act of 2002 (Trade Act of 2002) created the Health Coverage Tax Credit (HCTC), an advanceable, refundable tax credit for up to 65 percent of the premiums paid for specified types of health insurance coverage (including COBRA continuation coverage). The HCTC is available to certain workers who lose their jobs due to the effects of international trade and who qualify for trade adjustment assistance (TAA), as well as certain individuals who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Individuals who are eligible for the HCTC may choose to have the amount of the credit paid on a monthly basis to their health coverage provider as it becomes due, or may claim the tax credit on their income tax returns at the end of the year. For more information about the Health Coverage Tax Credit, call the HCTC Customer Contact Center at 1-866-628-HCTC (4282) (TDD/TYY: 1-866-626-HCTC (4282)). You may also visit the HCTC Web site at www.irs.gov by entering the keyword: "HCTC."

COORDINATION WITH OTHER FEDERAL BENEFIT LAWS

The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any “group health plan” for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Group health coverage that is provided under the FMLA during a family or medical leave is **NOT** COBRA continuation coverage, and taking FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer’s obligation to maintain health benefits under FMLA ceases, such as when an employee taking FMLA leave decides not to return to work and notifies an employer of his or her intent not to return to work.

HIPAA requires that a group health plan or health insurance issuer provide a certificate of health coverage automatically to individuals entitled to elect COBRA continuation coverage, at a time no later than when a notice is required to be provided for a qualifying event under COBRA, and to individuals who elected COBRA coverage, either within a reasonable time after learning that the COBRA coverage has ceased, or within a reasonable time after the end of the grace period for payment of COBRA premiums.

Under HIPAA, upon certain events, group health plans and health insurance issuers are required to provide a special enrollment period during which an individual who previously declined coverage for themselves and/or their dependents may be allowed to enroll without having to wait until the next open season for enrollment, regardless of whether the plan has an open season or when the next open season begins. When an employee or dependent of an employee loses eligibility for other health coverage, a special enrollment right may be triggered. If the other health coverage was COBRA, special enrollment can be requested only after COBRA is exhausted.

Finally, under HIPAA any preexisting condition exclusion period that would apply under a group health plan or group health insurance coverage generally is reduced by an individual’s number of days of creditable coverage that occurred without a break in coverage of 63 days or more. For this purpose, most health coverage, including COBRA coverage, is creditable coverage.

The Trade Act of 2002 also amended COBRA to provide certain workers who lose their jobs due to the effects of international trade and who qualify for trade adjustment assistance (TAA) with a *second* opportunity to elect COBRA continuation coverage. For more information about the operation and scope of the second COBRA election opportunity created by the Trade Act, call the HCTC Customer Contact Center at 1-866-628-HCTC (4282) (TDD/TTY: 1-866-626-HCTC (4282)). You may also visit the HCTC Web site on-line at www.irs.gov by entering the keyword: "HCTC."

ROLE OF THE FEDERAL GOVERNMENT

COBRA continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private-sector group health plans. The Department of Health and Human Services administers the continuation coverage law as it affects State and local government health plans.

The Labor Department's interpretive responsibility for COBRA is limited to the disclosure and notification requirements of COBRA. The Labor Department has issued regulations on the COBRA notice provisions. The Treasury Department has interpretive responsibility to define the required continuation coverage. The Internal Revenue Service, Department of the Treasury, has issued regulations on COBRA provisions relating to eligibility, coverage, and payment. The Departments of Labor and the Treasury share jurisdiction for enforcement of these provisions.

RESOURCES

If you need further information about COBRA, ERISA, or HIPAA, call (toll free) 1-866-444-EBSA (3272) to reach the Employee Benefits Security Administration regional office nearest you, or visit the agency's Web site at www.dol.gov/ebsa.

For information about the interaction of COBRA and HIPAA, visit the EBSA Web site and click on *Publications/Reports*, then the publication *Compliance Assistance Guide, Recent Changes in Health Care Law*.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

For questions about eligibility for the TAA tax credit for qualified health insurance coverage, call the HCTC Customer Contact Center (toll free) at 1-866-628-HCTC (4282) (TDD/TTY: 1-866-626-HCTC (4282)). You may also visit the HCTC Web site at www.irs.gov by entering the keyword "HCTC."

