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Centers for Medicare & Medicaid Services

The Center for Consumer Information & Insurance Oversight

COBRA Continuation Coverage

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Background

This section provides information about COBRA continuation coverage requirements that apply to state and local government employers that maintain group health plan coverage for their employees. Group health plan coverage for state and local government employees is sometimes referred to as “public sector” COBRA to distinguish it from the requirements that apply to private employers. The landmark COBRA continuation coverage provisions became law in 1986. The law amended the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code and the Public Health Service Act (PHS Act) to provide continuation of employer-sponsored group health plan coverage that is terminated for specified reasons. CMS has jurisdiction to interpret and administer the COBRA law as it applies to state and local government (public sector) employers and their group health plans. Individuals who believe their COBRA rights are being violated have a private right of action. The COBRA law only applies to group health plans maintained by employers with 20 or more employees in the prior year. In addition, the law does not apply to plans sponsored by the governments of the District of Columbia or any territory or possession of the United States, certain church-related organizations, or the federal government. (The Federal Employees Health Benefit Program is subject to generally similar requirements to provide temporary continuation of coverage (TCC) under the Federal Employees Health Benefits Amendments Act of 1988.)

Individuals who work for a state or local government employer, and their dependents, should be aware of their rights regarding COBRA. A good starting point is reading the plan information (sometimes called a summary plan description or SPD) provided by the employer. If that information does not answer your questions, you can contact the person who manages your health benefits plan.

Premium Assistance

In General. Despite the fact that COBRA and State "mini-COBRA" laws may make continuation coverage available to employees who lose their jobs, as well as their dependents (qualified beneficiaries), many unemployed individuals and family members cannot afford the cost of the continuation coverage. These individuals may qualify for a subsidy under the American Recovery and Reinvestment Act of 2009 (ARRA), and subsequent amendments, to help pay the premium. These are discussed below.

Expedited Review: Individuals who are denied access to premium assistance by their employers or health insurance issuers can request a determination from the Department of Labor (DOL) or the Department of Health and Human Services (HHS). This expedited review must be completed within 15 business days after either Department receives the request. The DOL handles all appeals regarding plans under ERISA, while CMS, on behalf of HHS, handles all requests for review regarding public sector (state and local government with 20 or more employees) employer plans, federal government (including the Federal Employees Health Benefits Program), and State continuation coverage (mini-COBRA) laws. Each Department has developed a similar, but separate determination form.

Specific Provisions: Section 3001 of ARRA provides a subsidy to all involuntarily terminated workers and their

dependents covering 65 percent of the cost of COBRA premiums under ERISA and the PHS Act; continuation coverage for federal employees; and State continuation coverage premiums, if the state continuation coverage is comparable to COBRA. Originally, premium assistance under ARRA was available if the employee became eligible for continuation coverage as the result of an involuntary termination that occurred during the period from September 1, 2008 through December 31, 2009 and the employee or family member elected continuation coverage.

- Extension of Benefit: On December 19, 2009, the President signed into law the Department of Defense Appropriations Act of 2010 (2010 DOD Act), which extended the subsidy in several ways.
- The end of the period for involuntary terminations was extended for two months, from December 31, 2010 through February 2010
- Premium assistance was available for up to 15 months, calculated depending on the circumstances.
    - Individuals still receiving 9 months of premium assistance could receive an additional six months of premium assistance (for a total of 15 months coverage).
    - Individuals whose 9 months of premium assistance had already expired could receive up to 6 additional months if they paid the 35 percent due for unpaid premiums within a specified time period.
    - Individuals who continued their continuation coverage beyond the original 9 months by paying the full amount themselves, without a subsidy, could receive credit or a refund for payments above 35 percent of the premium cost for up to 15 months.

On March 2, 2010, President Obama signed into law the "Temporary Extension Act of 2010" (TEA) under which:

- The end of the period for involuntary terminations was again extended, to March 31, 2010.
- Eligibility for premium assistance was extended to include certain individuals who initially qualified for continuation coverage because of a reduction of hours and were later involuntarily terminated.

The TEA also provided the Departments of Labor (DOL) and Department of Health and Human Services (HHS) the authority to impose Civil Monetary Penalties (CMPs) on employers and insurance companies in the amount of $110 per day for failure to comply with Expedited Review determinations (discussed above) within 10 days after the date of the employer's or insurance company's receipt of the determination.

The Continuing Extension Act of 2010 (CEA), signed into law on April 15, 2010, extended the end of the period for involuntary terminations through May 31, 2010, including where that qualifying event follows a reduction of hours occurring from September 1, 2008 through May 31, 2010.

Covered Benefits

Federal COBRA requirements only apply to employment-related group health plan coverage. They do not apply to individual or association health insurance policies, and they do not apply to any non-health benefits through the employer, such as life insurance.

Qualified beneficiaries are generally entitled to continue the same coverage they had immediately before the qualifying event, under the same rules. For example, changes in the benefits that apply to active employees will apply, as well as catastrophic and other benefit limits.

Periods of Coverage

In most cases, COBRA coverage for the covered employee lasts a maximum of 18 months. However, the following exceptions apply:

29-Month Period (Disability Extension): Special rules apply for certain disabled individuals and family members. If a qualified beneficiary is determined to be entitled to disability benefits under Titles II or XVI of the Social Security Act, and is disabled at any time during the first 60 days of COBRA coverage, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA continuation coverage for up to an additional 11 months, for a total of 29 months.

However, in order to have this right, qualified beneficiaries must notify the plan administrator about the disability determination within 60 days of the date of the determination and before the expiration of the 18-month period. See "Notices Required of Qualified Beneficiaries."

18 to 36-Month Period related to Medicare eligibility (Special Rule for Dependents): If a covered employee becomes entitled to Medicare benefits (either Part A or Part B) and later has a termination of employment or a reduction of employment hours, the period of COBRA coverage for the employee's spouse and dependent children lasts until the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period that begins on the date of the covered employee's termination of employment or reduction of employment hours.

18 to 36-Month Period (Second Qualifying Event): A spouse and dependent children who already have COBRA coverage, and then experience a second qualifying event, may be entitled to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered

employee, the covered employee becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan. The following conditions must be met in order for a second event to extend a period of coverage:

1. The initial qualifying event is the covered employee's termination or reduction of hours, of employment, which calls for an 18-month period of continuation coverage;
2. The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);
3. The second event would have caused a qualified beneficiary to lose coverage under the plan in the absence of the initial qualifying event;
4. The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and
5. The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the plan administrator of a divorce or a child ceasing to be a dependent under the plan within 60 days after the event. See "Notices Required of Qualified Beneficiaries,"

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

Shortened Periods of Coverage

Continuation coverage generally begins on the date of the qualifying event and ends at the end of the maximum period. However, a period of coverage may end earlier if:

- an individual does not pay premiums on a timely basis.
- the employer ceases to maintain any group health plan.
- after the COBRA election, an individual obtains coverage with another employer group health plan.
- *after the COBRA election, a beneficiary first becomes entitled to Medicare benefits. (However, if Medicare entitlement, either Part A or Part B, is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the individual enrolls in the other part of Medicare after the date of the election of COBRA coverage. Notices Required of Employers or Plans*

Initial Notice: A group health plan (or employer) must provide an initial notice describing COBRA rights to each covered employee and spouse of the employee (if applicable) at the time coverage under the plan begins. The plan may send a single notice addressed to a covered employee and the covered employee's spouse at their joint address, provided the plan's latest information indicates that both reside at that address. Alternatively, a plan may send separate notices to an employee and the employee's spouse.

The plan must send a separate initial notice to a spouse under the following circumstances: an employee receives his or her initial notice at the workplace (in-hand delivery of the initial notice to an employee is permissible but does not constitute delivery to the spouse); the employer or plan has knowledge that the spouse resides at a different address than the employee; a spouse's coverage under the plan begins at a different time than the covered employee's coverage.

Other Notices: Other notice requirements are triggered for employers and plan administrators when a qualifying event occurs. Employers must notify plan administrators of a qualifying event within 30 days after an employee's death, termination, reduced hours of employment, or entitlement to Medicare (when an employee's Medicare entitlement results in loss of plan coverage for the employee's dependents). (An employee or other qualified beneficiary must notify the plan administrator of certain other events within 60 days of the event, but the employer or plan administrator is responsible for informing them of that requirement.

Plan administrators, upon receiving notice of a qualifying event, must provide an election notice to qualified beneficiaries of their right to elect COBRA coverage. Because qualified beneficiaries have independent election rights, plan administrators should either include a separate election notice for each qualified beneficiary in a single mailing that is addressed to both the employee and spouse, or, if a single notice is sent, it should clearly identify all qualified beneficiaries covered by the notice and explain each person's separate and independent right to elect COBRA coverage.

A plan administrator must always send separate election notices to qualified beneficiaries who do not reside at the same address if the different addresses are known to the plan administrator. A notice sent to the spouse is treated as a notification to all qualified dependent children residing with the spouse at the time the spouse's notification is sent by the plan administrator. Notices must be provided in person or by first class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred.

Model Notices: The Employee Benefits Security Administration (EBSA), U.S. Department of Labor, has issued final rules implementing private sector COBRA notice requirements (69 Federal Register 30084 – 30112, May 26, 2004). The final rules include a general COBRA rights notice that is issued when coverage under the plan begins (FR page 30099), and a notice of COBRA rights that is issued following a qualifying event (FR page 30106).

Use of the model notices is not required for public sector COBRA. However, they are noted here because they may be helpful to state and local government employers and their plan administrators in developing their COBRA rights notices. State and local government employers and their plan administrators should ensure that their COBRA rights notices are provided on a timely basis and apprise individuals of all requirements for which an individual is responsible in order to elect and maintain COBRA continuation coverage for the maximum period.

Notices Required of Qualified Beneficiaries

An employee or qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce (or legal separation if that results in loss of plan coverage) or a child's ceasing to be covered as a dependent under the plan's rules. Also, a qualified beneficiary must notify the plan administrator within 60 days of those events when they occur during the initial 18 or 29-month period of coverage in order to qualify for an extension of the coverage period to 36 months.

If a second qualifying event is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a group health plan may require qualified beneficiaries to notify the plan administrator within 60 days of those events, as well. Ordinarily, the employer is responsible for notifying the plan administrator of an event that is the death of a covered employee or the covered employee becoming entitled to Medicare benefits. However, if the covered employee's employment has been terminated, the employer may not be in a position to be aware of those events. If the plan does not require qualified beneficiaries to notify the plan within 60 days of a second qualifying event that is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a qualified beneficiary should provide that notice by the later of the last day of the 18-month period or the date that is 60 days after the date of the second event.

Qualified beneficiaries who wish to take advantage of the 11-month disability extension generally must notify plan administrators of the disabled qualified beneficiary's disability determination under the Social Security Act on a date that is both within 60 days after the date of the disability determination and prior to the expiration of the initial 18-month period of COBRA coverage. However, if the date of the disability determination is before the date of the COBRA qualifying event, a qualified beneficiary can meet the 60-day requirement by notifying the plan administrator of the disability determination within an alternative 60-day period specified by the plan, such as within the 60-day COBRA election period.

The plan cannot require an individual who receives a disability determination under the Social Security Act before experiencing a COBRA qualifying event that is the covered employee's termination, or reduction of hours, of employment to notify the plan of the determination within 60 days of the determination because that requirement expressly applies to a "qualified beneficiary." An individual whose disability determination is issued before the COBRA qualifying event is not a "qualified beneficiary" at the time the disability determination is issued.

If the plan does not specify an alternative 60-day period with respect to a disability determination issued before the qualifying event, the qualified beneficiary is required to notify the plan of the disability determination only within the initial 18-month period of continuation coverage. Qualified beneficiaries also must notify the plan administrator within 30 days after the date of any final determination that a qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act.

Important Note: With regard to the obligation of qualified beneficiaries to notify the plan administrator of certain events within a 60-day period, it is CMS's position that if a plan failed to properly inform a qualified beneficiary regarding that obligation, the plan, in determining whether an individual qualifies for COBRA coverage or an extension of COBRA coverage, must disregard the qualified beneficiary's failure to meet the 60-day notification requirement.

The law plainly places the burden of informing individuals of their COBRA rights on group health plans sponsored by state or local government employers. (Either the employer or plan administrator must provide an initial notice of COBRA rights when an individual commences coverage under the plan and again following a COBRA qualifying event.) A notice of COBRA "rights" must address all of the requirements for which an individual is responsible in order to elect and maintain COBRA continuation coverage for the maximum period. A plan cannot hold an individual responsible for COBRA-related requirements when the plan fails to meet its statutory obligation to inform an individual of those requirements.

Paying for Coverage

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. COBRA coverage may be less expensive, though, than individual health coverage. Premiums for COBRA continuation coverage cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not experienced a COBRA qualifying event. The cost to the plan is both the portion paid by employees and any portion paid by the employer before the qualifying event. The COBRA premium can equal 100 percent of that combined amount plus a 2 percent administrative fee.

For example, if the cost of providing health benefits coverage for a similarly situated employee who has not experienced a COBRA qualifying event is $400 per month, $100 of which is paid by the employee and $300 of which is paid by the employer, the plan may charge an individual a COBRA premium of up to $408 per month (102 percent times $400). The employer is not responsible for any portion of the individual's COBRA premium, but may, if it wishes, pay a portion, or all, of the qualified beneficiary's premium.

For qualified beneficiaries receiving the 11-month disability-based extension of coverage (see "Extended Periods of Coverage" for more information about the 11-month extension), the premium for those additional months may be increased from 102 percent to 150 percent of the plan's total cost of coverage as long as the disabled qualified beneficiary participates in the additional coverage. Non-disabled qualified beneficiaries may participate in the additional coverage even if the disabled qualified beneficiary does not. In that event, the plan cannot charge the non-disabled qualified beneficiaries that participate in the 11-month extension more than the 102 percent rate for the entire period of coverage, including the 19th through the 29th month of coverage.

COBRA premiums may be increased if the costs to the plan increase for similarly situated non-COBRA beneficiaries, but, for COBRA purposes, such premiums generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay premiums on a monthly basis, if you wish, but may give you the option to make payments at other intervals (for example, weekly or quarterly).

You (or someone on your behalf) must make the initial premium payment within 45 days after the date of your COBRA election; the payment generally must cover the period from the coverage loss date through the month in which the initial payment is made. However, if you only need COBRA coverage for a short period of time, such as one or two months, you can pay only for those months from the coverage loss date.

After you make the initial premium payment, subsequent premiums (usually paid on a monthly basis) are considered to be timely if made by the date due or within a grace period of 30 days after the date due (or longer period as applies to or under the plan). Payment is considered to be made on the date it is sent to the plan.

If you do not make premium payments by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage if payment is made within the grace period. Alternatively, the plan can hold any claims received during the grace period and then process them if the premium payment is made within the grace period, or deny them and terminate coverage effective the first day of the period of coverage for which payment is not made within the grace period.

If the amount of the payment you make to the plan is in error but is not significantly less than the amount due, the plan may accept the payment as satisfying the plan's requirement for the amount that must be paid. Alternatively, the plan is required to notify you 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 or payment coupons. COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to co-payments and deductibles.

Other Coverage Considerations

In deciding whether to elect COBRA continuation coverage, you should consider all your health care options.

- For instance, one option that may be available is "special enrollment" in a group health plan sponsored by a spouse's employer, if enrollment is requested within 30 days of loss of your health coverage. (If you decide to elect COBRA coverage under your plan, special enrollment also is available in a spouse's plan after COBRA continuation coverage is exhausted). The special enrollment right is provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and permits an individual who loses group health plan or health insurance coverage to enroll in a spouse's plan without having to wait for an open enrollment period. If a group health plan provided by a spouse's employer is insured by a health insurance carrier, contact your state's department of insurance for more information about special enrollment rights. Also, regarding special enrollment in a plan maintained by a state or local government employer, you can contact CMS at phig@cms.hhs.gov.

If the group health plan provided by a spouse's employer is a self-funded, private sector (not a state or local government) plan, contact the Employee Benefits Security Administration, Department of Labor (telephone # 1-866-444-3272 (toll free) or 202-219-8776).

- Also, individuals in a family may be eligible for health insurance coverage through various state programs, such as Medicaid or the Children's Health Insurance Program. For more information about state programs, contact your state's department of insurance or Medical Assistance (Medicaid) office.

- Additionally, you and your family may qualify for individual health insurance coverage as "HIPAA-eligible individuals" when COBRA coverage is exhausted. (COBRA coverage is exhausted when it ends for any reason other than either failure of the individual to pay premiums on a timely basis or for cause, such as making a fraudulent claim.)

HIPAA eligible individuals are eligible to purchase individual health coverage on a guaranteed available basis with no exclusion period for preexisting medical conditions. Certain criteria must be met. For more information about obtaining individual health coverage as a "HIPAA-eligible individual," contact your state's department of insurance, preferably before your COBRA coverage ends. Also, you can contact CMS at 1-877-267-2323, option 6, extension 61565. See the Important Note below about the interaction of HIPAA eligibility and conversion options.

If you elect COBRA continuation coverage, some options that were available to you before electing COBRA coverage may still be available after COBRA coverage is exhausted.

- Although COBRA specifies certain minimum periods of time that continued health coverage must be offered to

qualified beneficiaries, COBRA does not prohibit plans from providing continuation coverage beyond the periods required by COBRA.

- Also, some plans provide an opportunity for participants and beneficiaries to “convert” to an individual health insurance policy instead of electing COBRA continuation of group coverage. If this option is available from the plan, and if you choose COBRA rather than the conversion option, the COBRA law gives you the right to exercise that option when you reach the end of your COBRA continuation coverage. The plan must offer a qualified beneficiary the option of enrollment in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the COBRA premium, and the conversion policy may provide a lower level of coverage. The federal law requirement regarding the conversion option is not available if the qualified beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.

Important Note: One of the conditions that must be met to obtain individual health coverage as a HIPAA-eligible individual is that the individual's most recent period of coverage must be employer-sponsored group health plan coverage. COBRA coverage meets that requirement. A “conversion policy” does not. A conversion policy is individual market coverage, so choosing a conversion policy forfeits the right to later switch to other individual health coverage on a guaranteed available basis as a HIPAA-eligible individual.

Contact Information

If you are unable to find the COBRA-related information you are looking for on this Website, you may e-mail us at phig@cms.hhs.gov. Below are other sources of information about continuation coverage benefits, and subsidies and other rights under ARRA.

1. **Centers for Medicare & Medicaid Services (CMS).** For assistance with questions regarding premium assistance for continuation coverage please contact CMS via email at phig@cms.hhs.gov or call toll free at 1-877-267-2323, option #6, extension 61565.
2. **State Departments of Insurance (DOIs).** Your State DOI can advise you whether it requires State continuation coverage (or mini-COBRA plans) and, if so, whether it considers that coverage "comparable" such that you might qualify for ARRA premium assistance.
3. **Department of Labor (DOL).** DOL’s Employee Benefits Security Administration (EBSA) shares jurisdiction with IRS over private sector COBRA. EBSA has lead authority with respect to reporting and disclosure provisions, which includes requirements that plans notify individuals of their right to elect COBRA continuation coverage. DOL is also responsible for reviewing denials of premium assistance as discussed above. You can reach EBSA at 1-866-444-3272 or through its website.
4. **The Department of the Treasury (Treasury) and the Internal Revenue Service (IRS).** Treasury through the IRS oversees tax issues for all individuals and group health plans affected by the ARRA premium assistance. The IRS website contains detailed information.