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Coordinating COBRA With Open Enrollment Now Brings New Twists

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October 12, 2010 — From a COBRA perspective, open enrollment is a time for carefully considering how to integrate COBRA's requirements with those of general health plan administration. Each year, questions arise on how best to protect the rights of qualified beneficiaries. For the upcoming 2011 plan year, however, there are several new and special considerations. Plan administrators need to be aware of these issues and consider how best to integrate them with COBRA administration.

HCTC Extension Coming to an End

As COBRA administrators well know, through the American Recovery and Reinvestment Act of 2009 (ARRA), Congress enacted a 65-percent premium subsidy for COBRA coverage where qualified beneficiaries are entitled to their COBRA coverage due to an employee's involuntary termination of employment. Another ARRA provision, though, extended and expanded the availability of the Health Coverage Tax Credit (HCTC) enacted under the Trade Act of 2002. As explained in ¶1284 of the *Guide*, an 80-percent tax credit for COBRA coverage (it was previously 65 percent) is available to qualified beneficiaries who are: (1) eligible for COBRA coverage due to a covered employee's termination or reduction of hours of employment; and (2) entitled to trade adjustment assistance (TAA) benefits. The credit is also available when a covered employee is entitled to a nonforfeitable pension benefit that is paid in whole or part by the Pension Benefit Guaranty Corporation (PBGC).

As originally enacted, these HCTC rules did not extend the duration of COBRA coverage; rather, they simply provided a tax credit to help pay for COBRA coverage. Thus, if COBRA coverage ran out (for example, the 18-month COBRA period expired), then the credit would cease to be of any use, even if a covered individual was still eligible for TAA benefits or a PBGC-paid pension benefit.

ARRA amended the maximum period of COBRA coverage for these affected individuals, as follows:

1. In the case of a qualifying event that is a termination or reduction in hours of employment for a covered employee with a nonforfeitable right to a pension benefit (any portion of which is paid by the PBGC), the maximum coverage period must not end earlier than the date of the covered employee's death (or not earlier than 24 months after the date of that covered employee's death in the case of the surviving spouse or dependent children).
2. In the case of such a qualifying event in item one, where the covered employee is TAA-eligible as of the date that the maximum coverage period would otherwise terminate, the maximum coverage period must extend during the period that he or she is a TAA-eligible individual. The ARRA provision is effective for periods of coverage that would otherwise end on or after Feb. 17, 2009, provided that the new rule does not extend any periods of coverage beyond Dec. 31, 2010.

Essentially, this change was intended to allow affected individuals to continue to use the HCTC benefit to help purchase COBRA coverage for as long as they were entitled to the TAA benefits or PBGC pensions. Nevertheless, the ARRA change included an outside end date of Dec. 31, 2010 — no COBRA coverage will have to be continued on account of the HCTC rules beyond that date.

Therefore, during open enrollment, plan administrators should review the status of any qualified beneficiaries claiming entitlement to the HCTC benefits during periods beyond the normal COBRA 18- or 29-month period on account of a termination or reduction in hours of employment. These individuals' entitlement to COBRA coverage might be ending on Dec. 31, 2010 by statute, and further COBRA coverage is not required to be offered by law.

If that coverage is otherwise going to end, plan administrators should remember to provide notice of any conversion options otherwise available under the plan. Technically, this notice is supposed to be provided within 180 days of the expiration of COBRA coverage. In many cases, the notice may be provided in updated summary plan descriptions or other material. Nevertheless, if a group of individuals will be losing coverage on Dec. 31, 2010, by virtue of the expiration of the HCTC extension period, it might be advisable to remind them of any conversion options available — especially if there is doubt about whether that notice was otherwise provided. Even if the plan does not have a conversion option, providing a notice of the termination of COBRA coverage is a good idea and can help avoid misunderstandings down the road.

Health Care Reform Issues

The starting point for COBRA administration is to remember the key COBRA rule — qualified beneficiaries are entitled to the same rights as similarly situated nonCOBRA beneficiaries. For example, in the context of open enrollment, this rule has long meant that if active employees can add or drop coverage during open enrollment, so can qualified beneficiaries. Depending on the plan design, this could include the right to: (1) change from single to family coverage (add or drop dependents); (2) change type of coverage (medical to dental, dental to vision, etc.); and (3) make any other changes in coverage otherwise allowed during open enrollment.

To effectuate these rights, it is important for qualified beneficiaries to have the same open enrollment material as active employees. Does that include the right to attend employee meetings? Typically, no. However, it does mean that if brochures and explanations are provided to active employees, this same material should be sent to qualified beneficiaries so they can make intelligent decisions concerning their coverage.

In the context of health care reform, this COBRA rule also means several other specific things. As part of the health care reform law, several new requirements apply to group health plans beginning for plan years on or after Sept. 23, 2010 (Jan. 1, 2011 for calendar year plans). Thus, if a new health care reform rule applies under the plan for active employees, the new rule should be applied to qualified beneficiaries as well. For example, if a new health care reform notice must be provided to active employees or other plan participants, the notice should be provided to COBRA qualified beneficiaries as well. Following is a discussion of a few important reform issues affecting COBRA coverage and open enrollment. It is not intended as a summary of all health care reform requirements, however.

Coverage of Dependent Children to Age 26

Under one new health care reform rule, group health plans that provide coverage for dependent children must continue to provide that coverage until the child reaches age 26, without regard to any other typical conditions imposed on dependent child coverage. For example, the plan cannot impose any financial dependency requirements, residency requirements or other conditions on the availability of that coverage. One exception to this rule is that grandfathered health plans can refuse to provide coverage for a dependent child if that child has other employer-sponsored coverage available (other than coverage through a parent).

Open enrollment is the time to offer dependent children the opportunity to be re-enrolled in the group health plan under the reform law. One question that has arisen is whether this right to add dependent children must be passed through to COBRA qualified beneficiaries. The reason for this question is that the preamble to the federal agencies' interim final regulations states:

[i]f the parent is no longer eligible for coverage under the plan (for example, if the parent has ceased employment with the plan sponsor) as of the first date on which the enrollment opportunity would be required to be given, the plan would not be required to enroll the child.

Some have read this to mean, literally, that if a parent has terminated employment, the new enrollment opportunity does not have to be offered even if the parent elects COBRA coverage. This reading is not correct for the following two reasons.

1. As explained earlier, COBRA requires that group health plans provide COBRA qualified beneficiaries with the same rights to coverage as similarly situated nonCOBRA beneficiaries. So if active employees are entitled to add their dependent children back on to coverage under the group health plan, then COBRA qualified beneficiaries have the same basic right.
2. If a qualified beneficiary *does* elect COBRA coverage, he or she would then be eligible for coverage and entitled to the benefits of the health care reform rule, and the regulation on dependent children, as written, would apply.

Here's the bottom line — COBRA qualified beneficiaries should be offered the opportunity to re-enroll dependent children who were previously excluded from coverage on account of having been excluded due to age (under age 26) or other eligibility limits (such as financial dependency, marriage or student status).

Annual/Lifetime Limit Rules

Under the health care reform law, group health plans, including grandfathered group health plans, are no longer permitted to have exclusions for pre-existing conditions for children under age 19 (or for any group health plan participant effective as of the first plan year in 2014). Additionally, with limited exceptions, group health plans, other than health flexible spending arrangements, may not impose annual or lifetime limits on "essential benefits," or terminate coverage retroactively, except in the case of fraud or an intentional misrepresentation of material fact.

All these rules apply not just to active employee coverage, but to COBRA coverage for qualified beneficiaries as well.

Specifically in connection with the elimination of lifetime limits on essential benefits, individuals who reached a lifetime limit under a group health plan and are still otherwise eligible under the plan must be provided with a notice that the lifetime limit no longer applies. In addition, any such individuals who are no longer enrolled in the plan must be given the opportunity to re-enroll in the coverage. What is not at all clear is how this rule applies regarding COBRA coverage.

Example. Karen, a single qualified beneficiary, commenced COBRA coverage (due to a termination of employment) on March 1, 2010 and reached a lifetime limit for essential benefits in September 2010. That meant her COBRA coverage essentially ceased to be of value and, in all likelihood, she ceased paying for the coverage in September 2010. At that point, Karen would otherwise have been eligible for COBRA coverage until Aug. 31, 2011 (assuming an 18-month COBRA coverage period).

Assume the new health care reform rule prohibiting lifetime limits on essential benefits is effective Jan. 1, 2011, for this group health plan. Does Karen now have to receive a notice that the lifetime limit no longer applies? Moreover, does she have to have the right to re-enroll in the group health plan as of Jan. 1, 2011, for the rest of the otherwise applicable COBRA coverage period? Presumably not, but this is not entirely clear. The guidance indicates that the right to re-enroll has to be extended to individuals who were hit by a lifetime limit and who are otherwise eligible for coverage. An example indicates that this rule applies where an employee remains employed and is eligible for coverage. However, it is not clear whether this right extends to COBRA qualified beneficiaries who are not otherwise connected to employment with the employer and not otherwise on COBRA coverage.

Does this answer change if the limit affected only one of several qualified beneficiaries in a single family unit?

Example. Bruce, an ex-employee, was married to Sharon and elected COBRA coverage. Sharon reached a lifetime limit before 2011. Must a notice be provided to Bruce informing him that Sharon could re-enroll in COBRA coverage? Perhaps the fact that Bruce is still "connected" to his former employer through COBRA coverage is enough to mandate the application of the rule allowing re-enrollment.

Nevertheless, even in this case, the issue is not at all clear from the available guidance. If a group health plan administrator is faced with this situation, it is advisable to contact counsel to determine how best to proceed based on the particular facts.

Health Care Reform Notices

In addition to enacting several substantive reforms for group health plans, the reform law (as interpreted by the federal agencies' guidance) mandates various types of notices. (See chart for a short list of some key notices to consider for 2011 plan years.) Some notices relate to specific mandates, such as the mandate to cover dependent children through age 26 or the requirement to eliminate lifetime limits on essential benefits. One other notice, however, is quite important for grandfathered health plans.

Grandfathered Health Plan Notice

If a group health plan wants to be treated as a grandfathered health plan (which would exempt it from having to comply with certain reform obligations), it must provide a notice to that effect in all plan materials explaining coverage. This means that the grandfathering notice needs to be provided to COBRA qualified beneficiaries covered by the group health plan as well as active employees. This may require some coordination between the group health plan's regular recordkeeper or administrator and any special COBRA administrator. A typical COBRA administrator will not necessarily know whether a group health plan is providing any types of notices related to health care reform unless the overall plan administrator (typically the employer) notifies the COBRA administrator. It is important to be sure to include the grandfather notice in communications with COBRA qualified beneficiaries because the notice is an essential part of qualifying for grandfathered status.

Coordination Is Important

These few issues show how important it is for COBRA plan administrators to coordinate their open enrollment administration with the normal plan administrative issues otherwise applying due to health care reform. Future guidance is expected to clarify many of the unanswered reform questions, particularly on how the reform rules are to be coordinated with COBRA requirements. Future issues of the newsletter will report on this guidance.

New Notices Required Under Health Care Reform			
Type of Disclosure	**Applicability**	**Content Summary**	**Timing**
Extension of dependent coverage notice (One-time notice)	All group health plans (GHPs), regardless of grandfathered status.	A statement that dependent coverage under the plan has been extended to age 26. A description of the special enrollment right (lasting at least 30 days) for a child whose coverage ended or who was denied coverage because, under the terms of the plan or coverage, the availability of dependent coverage ended before age 26.	One-time notice and enrollment opportunity that must be provided no later than the first day of the first plan year beginning on or after Sept. 23, 2010. May be included with open enrollment materials provided that statement is prominent.
Elimination of lifetime limits	All GHPs, regardless of	A statement that lifetime dollar limits under the plan have been eliminated. A	One-time notice and enrollment opportunity

notice (One-time notice)	grandfathered status.	description of the special enrollment right for an individual who is otherwise eligible for coverage under the plan whose coverage ended because s/he reached a lifetime limit under the plan before the prohibition on lifetime limits.	that must be provided no later than the first day of the first plan year beginning on or after Sept. 23, 2010. May be included with open enrollment materials provided that statement is prominent.
Grandfathering notice	All grandfathered GHPs.	A statement to the effect that the plan believes it is a grandfathered health plan. Contact information for questions or complaints regarding the plan's grandfathered status.	Include in all plan materials provided to participants and/or beneficiaries describing the benefits provided under the plan.
Enhanced claims procedure notice	All non-grandfathered GHPs.	A description, in a culturally and linguistically appropriate manner (regulations explain this in more detail), of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist with the appeals processes.	Model notices are expected to be issued. Likely that the internal and external appeals notice may be combined with other notices and/or included in a plan's SPD.

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