Audit Techniques and Tax Law to Examine COBRA Cases (Continuation of Employee Health Care Coverage)

NOTE: This guide is current through the publication date. Since changes may have occurred after the publication date that would affect the accuracy of this document, no guarantees are made concerning the technical accuracy after the publication date.

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Contents

Background

A task force was appointed in 1993 to address questions and concerns from field personnel on extended health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Their assignment was to provide examiners with procedural guidelines to conduct COBRA examinations and compliance checks. A second task force was convened in 2002 to revise the original guidelines to include transfer of the COBRA Program to SB/SE Office of Excise, the Health Insurance Portability and Accountability Act, the 1999 final Regulations, 2001 Proposed Regulations, and organizational changes to comply with the IRS Restructuring and Reform Act of 1998. This current revision incorporates the transition of public correspondence and telephone inquiries regarding COBRA to the Cincinnati Compliance Services Campus, Centralized Excise Operation; procedures to transfer cases to the territories; finalized 2001 interim and proposed rules; and updated audit/compliance requirements.

Proposed regulations on the COBRA continuation coverage requirements were published in June 1987 (proposed Treasury Regulations Section 1.162-26). They consisted of 48 questions and answers, most of which addressed operational requirements. As originally enacted by COBRA, the operational requirements appeared in IRC §162(k); the tax sanctions appeared in IRC §162(i)(2) and IRC §106(b).

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) replaced the original tax sanctions with the excise tax that now appears in IRC §4980B; in the process, moved the operational requirements from IRC §162(k) to IRC §4980B(f) without changing them. In the following year, the Omnibus Budget Reconciliation Act of 1989 was passed and several changes were made to the operational requirements. The 1987 proposed regulations, even though they were numbered under IRC §162, constituted the proposed regulations for IRC §4980B.

The Family & Medical Leave Act of 1993 (FMLA), as well as the Health Insurance Portability and Accountability Act of 1996, had an impact on COBRA. The new regulations took effect in February 1999, and are presented in this document in a question and answer format. Amendments to these regulations were made in January 2001 to discuss business reorganizations, employer withdrawals from multi-employer plans, and interaction of the FMLA.

Introduction

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) was enacted. Title 10 of COBRA require employers' group health plans offer qualified beneficiaries (certain employees, ex-employees, their spouse/ex-spouse and dependents) the option to continue their health care insurance despite qualifying events that would otherwise cause the loss of that coverage.

The bill was enacted because of a growing concern that many Americans lacked health care benefits. Some individuals had health insurance but lost it because of retirement, reduced work

hours, job termination, or the death/divorce from the covered employee. COBRA was designed to help people in these situations by giving them an opportunity to purchase extended health insurance coverage for a limited period.

The COBRA provisions in the Internal Revenue Code (IRC) consist of:

- Operating requirements (what an employer/plan administrator and its group health plans must do to be in compliance)
- Tax sanction (what happens in the event of noncompliance)

These provisions now appear in IRC Section 4980B (§4980B). The operating requirements are set forth in IRC §4980B(f), and described in the appendix. The tax sanction for noncompliance is set forth in the rest of IRC §4980B; it is an excise tax of $100 per day, per qualified beneficiary, for each day of the noncompliance period. Computing the Excise Tax section of this guide describes in detail various special rules that provide minimum amounts, maximum amounts, exceptions, etc.

The tax sanction is designed as a deterrent against noncompliance, rather than as a remedy for individuals who have been affected by the noncompliance. Consequently, there is no relief under IRC for individuals who have been denied (or charged an excessive premium for) COBRA continuation coverage.

A failure to comply with COBRA requirements in the IRC may also be a failure to comply with parallel requirements that COBRA added to the Employee Retirement Income Security Act of 1974 (ERISA), which is administered by the Department of Labor. ERISA provides a remedy for individuals who have been denied (or charged an excessive premium for) continuation of health care coverage.

The health plan or issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals; however, the benefits provided must be uniformly available to all similarly situated individuals. Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances).

The COBRA tax is reported on Form 8928, Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code. The purpose of the form is to report the tax due on the following failures by group health plans or employers.

- A failure to provide a level of coverage of the costs of pediatric vaccines (as defined in Section 2612 of the Public Health Service Act) that is not below the coverage provided as of May 1, 1993.
- A failure to satisfy continuation coverage requirements under Section 4980B
- A failure to meet portability, access, and renewability requirements under Section 4980D.
- A failure to make comparable Archer MSA contributions under Section 4980E
- A failure to make comparable health savings account contributions under Section 4980G.

There are different due dates of the form depending on which failure occurs. See the instructions to the form for the due dates.

Form 8928 is filed with Cincinnati Service Center. It is posted to Non Master File, MFT 41 with the following abstract codes:

Section 4980B – Abstract Code 126 – Part 1 of Form 8928 Line 16
Section 4980D – Abstract Code 127 – Part II of Form 8928 Line 34
Section 4980E – Abstract Code 128 – Part III of Form 8928 Line 36
Section 4980G – Abstract Code 137 – Part IV of Form 8928 Line 38

Examination Procedures

If the taxpayer (the employer) is subject to the health care continuation coverage requirements, then the next step is to determine if noncompliance has occurred. A good place to start is with the continuation coverage procedures the taxpayer has in place. To determine what procedures are in place, obtain the following information from the taxpayer:

- A copy of the health care continuation coverage procedures manual
- Copies of standard health care continuation coverage form letters sent to the qualified beneficiaries
- A copy of the taxpayer's internal audit procedures for health care continuation coverage
- Copies of all group health care plans (If necessary, reconcile the books to the amount of health care expense deduction claimed on the return to confirm that all plans are listed.)
- Details pertaining to any past or pending lawsuits filed against the taxpayer for failing to provide appropriate continuation coverage

Based on the procedures in place, the examiner should probe specific areas for noncompliance. Interview responsible parties regarding the following:

- The number of qualifying events (for example, terminations, reduced hours, etc.) occurring in the year under examination through the current date [IRC §4980B(f)(3)]
- The method by which qualified beneficiaries are notified of their rights to continuing health care coverage under COBRA [IRC §4980B(f)(6)(A)]
- The method by which the plan administrator is notified that a qualifying event has occurred [IRC §4980B(f)(6)(B)]
- The election made by qualified beneficiaries to continue health care coverage [IRC §4980B(f)(1)]
- The premium paid by qualified beneficiaries for continuing coverage under the Plan [IRC §4980B(f)(2)(C)]

The following documents can also provide useful information:

- Copies of Federal and state employment tax returns filed during the current period under examination and the preceding year (returns will show changes in the number of employees on the payroll between the two years)
- List of all individuals affected by a qualifying event (for example, termination, death, etc.) during the current year
- List of all individuals covered on 1-1-YY and 12-31-YY of the current and preceding years for each plan; this list should include all qualified beneficiaries (in other words, covered employee, spouse and dependent children)

Note: Changes in the comparative lists would show potential qualifying events not included in the second bullet above.

Review the personnel records and confirm whether or not qualified beneficiaries were properly notified of their rights to continuing health coverage. These records will also provide the beginning dates of any failure to comply, and determine when the excise tax computation should begin. Personnel records should include documents to support the following items of information; if not, ask for them specifically where applicable:

- Name and address of each beneficiary (for purposes of third party confirmation if necessary)
- Date the qualifying event took place
- Copies of the notification letters sent to qualified beneficiaries (to determine the period they were eligible to elect coverage, and in fact were offered coverage, and also to confirm they received their notice of rights under COBRA)
- Type of coverage received under COBRA (to determine if the qualified beneficiary received the proper coverage)
- Premium payments required under COBRA (review of health plan documents previously requested may indicate whether the premium charged was excessive)
- Copy of employer's letter to the insurance company/plan administrator notifying them of a qualifying event
- Reasons for termination of COBRA coverage properly elected by the beneficiary
- Reasons for employment termination

If the taxpayer is denying coverage and claims the covered employee is not eligible because they were dismissed for gross misconduct, check to see if the covered employee was denied unemployment benefits for the same reason. In a multi-employer plan, if a grievance for gross misconduct was arbitrated independently under the union agreement, the decision may help in your determination. If the employer lost in the grievance process, this may indicate a failure to comply with COBRA law requirements. In certain instances contact with former employees, including the complainant or other individuals, should be made and the provisions of IRC §7602(c) regarding third party contacts should be followed.

Computing the Excise Tax

IRC §4980B imposes an excise tax against liable persons for failure to comply with the COBRA law requirements; it is not deductible for income tax purposes. The assessed tax amount is $100 per qualified beneficiary, but not more than $200 per family, for each day of a period that the taxpayer is in violation. The period of violation is called a noncompliance period.

Noncompliance Period

The noncompliance period begins on the date the failure to comply takes place. Depending on the circumstances, this might be the first date that coverage is denied, the date that a notice is not sent out as required, or some other date.

The noncompliance period ends on the date the failure to comply is corrected. However, the noncompliance period for any particular qualified beneficiary will end, even if the failure is not corrected, on the date that is six months after the last date on which continuation coverage would have been required for that beneficiary.

Liable Persons

There are three people who can be liable for an excise tax under IRC §4980B. Generally, the employer who maintains the plan is the liable person; however, if the plan is a multi-employer plan (that is, a plan of more than one employer covering union employees), then the plan is the liable person. Certain third parties (in other words, insurance companies and third party administrators), in some cases, may also be liable for the excise tax.

Maximum Annual Amount of Tax

There is an overall limitation on the excise tax for unintentional failures that are due to reasonable cause and not to willful neglect. The limits below do not apply to failures that are attributable to willful neglect. When the employer or other person liable for the tax becomes aware of the failure, and makes no effort to correct it, a failure that was originally not attributable to willful neglect then becomes attributable to willful neglect.

A) Single Employer Plans:

Under IRC §4980B(c)(4)(A), the maximum amount of tax that can be imposed for inadvertent failures during an employer's tax year is the lesser of:

- 10 percent of the amount paid or incurred by the employer, or the predecessor employer, during the preceding tax year for group health plans; or
- $500,000

B) Multi-Employer Plans:

Under IRC §4980(c)(4)(B), the maximum tax that can be imposed on a trust that is part of such a plan for inadvertent failures during the taxable year of the trust is the lesser of:

- 10 percent of the total amount paid or incurred by the trust during the tax year to provide medical care; or,
- $500,000

C) Third Party Liability

Under IRC §4980B(c)(4)(C), the maximum tax that can be imposed on a third party (for example, an insurance company) for all inadvertent failures during a taxable year is $2,000,000.

Minimum Tax Amounts

IRC §4980B(b)(3)(A) imposes a minimum tax in the following situations:

- There is a failure to comply with the continuation coverage requirements
- The failure is not corrected before the date the Service notifies the employer that an income tax examination will be initiated
- The failure occurred or continued during the period under examination

If the examiner determines that the failure is de minimis, the amount of tax per beneficiary will be the lesser of $2,500 or the amount of tax that would be imposed without regard to the inadvertent failure and the 30-day grace period exceptions discussed below.

If the failure is more than de minimis, the amount of tax will be the lesser of $15,000 or the amount of tax that would be imposed without regard to the inadvertent failure and the 30-day grace period exceptions provided for in IRC §4980B(c)(2) discussed below.

The minimum tax is allowed to override the inadvertent failure and 30-day grace period rules to ensure that employers have an incentive to monitor themselves for compliance.

The Inadvertent Failure Rule

IRC §4980B(c)(1) provides that the excise tax cannot be imposed on any failure during any period for which it is established to the satisfaction of the Service that none of the persons who would be liable for the tax knew, or would have known by exercising reasonable due diligence, that the failure existed.

The noncompliance period would begin, however, when the responsible person became aware or should have been aware of the noncompliance. Also, the exception does not apply where the failure is not corrected before the Service notifies the employer of an income tax examination, and thus triggers imposition of the minimum excise tax described above.

The 30-Day Grace Period Rule

IRC §4980B(c)(2) provides that the excise tax generally does not apply to any failure if:

- The failure is due to reasonable cause and not to willful neglect
- The failure is corrected within 30 days after it is discovered, or would have been discovered, exercising reasonable due diligence

Correction of Failure

A failure is considered corrected if:

- The rules are retroactively satisfied to the extent possible [(IRC §4980B(g)(4)(A)]; and
- The qualified beneficiary is placed in a financial position that is as good as such beneficiary would have been in had the failure not occurred [(IRC §4980B(g)(4)(B)].

Waiver by Secretary

In the case of a failure that is due to reasonable cause and not to willful neglect, the Secretary is authorized to waive part or all of the excise tax to the extent that the tax would be unreasonably burdensome [IRC §4980B(5)]. The determination of whether a tax is unreasonably burdensome is to be made based on the seriousness of the failure, and not on a particular taxpayer's ability to pay the tax.

In determining whether to exercise this waiver authority the Secretary is to take into account the efforts made by the taxpayer to comply with the health care continuation rules. In evaluating such efforts, the Secretary is to examine certain factors. One factor is the quality of the taxpayer's compliance program with respect to, for example, (1) the training of individuals responsible for operational compliance, and (2) the preparation of written instructions for such individuals.

Another factor is the extent to which the compliance program has been designed based on competent professional advice, such as legal and actuarial counsel (where appropriate), and the extent to which such program is updated, based on such advice, to reflect changes in the law or in other circumstances. Another factor is the extent to which the operation of the compliance program is monitored to assure the independence of the auditors. (This reference was taken from the ***House Committee Report on TAMRA***.)

Continuation Coverage Requirements

A group health plan meets the continuation coverage requirements of IRC §4980B(f) if each qualified beneficiary who would lose coverage under the plan due to a qualifying event is entitled to elect, within the election period, health care continuation coverage under the plan. The group health plan should offer the beneficiary health care coverage that is provided to non-

COBRA individuals similarly situated. Normally, it would be the same coverage that the qualified beneficiary had on the day before the qualifying event happened.

The COBRA continuation coverage requirements do not generally apply to group health plans exempt from COBRA. See the Appendix section for information on excepted plans.

Election Period

IRC §4980B(f)(5) sets the period in which a qualified beneficiary can elect health care continuation coverage. The election period extends at least 60 days after the later of:

- The date health care coverage is lost due to a qualifying event; or
- The date notice is provided to the qualified beneficiary of their right to elect COBRA continuation coverage

Each qualified beneficiary may independently elect to have the COBRA health care continuation coverage; and a parent or legal guardian may elect coverage on behalf of a minor child. The beneficiary may choose to waive electing the continuation coverage during an election period; but can later revoke the waiver of coverage before the end of that election period. The plan would then need only to provide health care continuation coverage beginning on the date the waiver is revoked.

Notice Requirements

IRC § 4980B(f)(6) provides the notice requirements that must be followed to ensure that qualified beneficiaries are aware of their rights to health care continuation coverage. The notice requirements are:

- The group health plan must provide, at the time coverage under the plan commences, a written notice of the rights provided under IRC § 4980B to each covered employee and their spouse.
- The employer must notify the plan administrator within 30 days after the occurrence of any of the following qualifying events (for a multi-employer plan, the 30-day period can be extended depending upon the terms of the plan):
    - Death of the covered employee
    - Termination, other than for gross misconduct, or a reduction in the covered employee's employment hours
    - Covered employee's entitlement to Medicare
    - Bankruptcy of the employer
- The covered employee or qualified beneficiary must notify the plan administrator within 60 days after the occurrence of any of the following events under IRC §4989B(f)(6)(c):
    - Divorce or legal separation from the covered employee
    - A dependent child ceasing to be a dependent child under the requirements of the plan

    - A determination that the covered employee or a member of the covered employee's family on the health plan is disabled (under Title II or XVI of the Social Security Act) within the first 60 days of continuation coverage
      Note: The qualified beneficiary is also required to notify the plan administrator within 30 days after a final determination by Social Security that they are no longer disabled.
- Generally, within 14 days after receiving a notice of a qualifying event, the plan administrator must notify the qualified beneficiaries of their rights under the health care continuation law.

If the plan administrator is not notified of a qualifying event, the result will differ depending on who was obligated to provide the notice. If the employer was required to give the notice, the excise tax might be imposed; however, if the covered employee or qualified beneficiary was required to give the notice, then the qualified beneficiary could lose the right to health care continuation coverage.

Type of Benefit Coverage

To comply with the continuation coverage requirements of IRC §4980B(f)(2)(A), the regulations provide that the health care benefits offered to a qualified beneficiary must be the same as the coverage that they received immediately before the qualifying event occurred. However, if the coverage provided to similarly situated active employees is modified, then the coverage made available to qualified beneficiaries must be similarly modified.

If the coverage provided to similarly situated active employees is eliminated, but the employer continues to maintain one or more group health plans, the qualified beneficiary's COBRA continuation coverage cannot be terminated. The employer must give the qualified beneficiary receiving health care continuation coverage the option to be covered under any of the remaining group health plans maintained for similarly situated active employees and their family members. In other words, qualified beneficiaries generally should be entitled to the coverage they would still be receiving if the qualifying event had never occurred.

Period of Coverage

The health care continuation coverage must generally be made available for **18, 29, or 36 months**; depending on the type of qualifying event, and whether the qualified beneficiary was disabled at the time of termination or reduction in the hours of employment. In some cases the COBRA continuation coverage can be terminated sooner; such as, for nonpayment of premiums, or, for a qualified beneficiary becoming entitled to Medicare benefits.

IRC §4980b(f)(2)(B) provides that continuation coverage, elected by a qualified beneficiary, must extend for at least the period beginning on the date of the qualifying event and not ending before the earliest of the following dates:

- Last day of the maximum required coverage period (discussed below)
- Date on which the employer ceases to maintain or provide any group health plan, including successor plans, to any employee
- First day of failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary
  Note: Payment is generally considered timely if made within 30 days after the due date, or within such longer period as applicable under the terms of the plan. The plan administrator cannot require payment of the premium until after 45 days have passed that the qualified beneficiary initially elected continuation coverage.
- First day after the date of election on which the qualified beneficiary, other than a qualified beneficiary in a bankruptcy-related proceeding, becomes entitled to Medicare benefits under Title XVIII of the Social Security Act
- First day after the date of the election on which the qualified beneficiary becomes actually covered under any other group health plan that is not maintained by the employer, and which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary
- Date of termination of extended coverage for disability under Social Security

As discussed below, qualified beneficiaries can extend their coverage from **18 up to 29 months** if it is determined they were disabled at any time during the first 60 days of continuation coverage under Title II or XVI of the Social Security Act (at the time of termination or a reduction in employment hours). Under IRC §4980B(f)(2)(B)(v), the coverage obligation under the extension period ends 30 days after the date of a final determination that the qualified beneficiary is no longer disabled under Social Security.

Maximum Coverage Period

Under IRC §4980B(f)(2)(B)(i), the maximum required health care coverage period generally ends 18 months after the qualifying event if the qualifying event is termination or a reduction in the hours of employment. The maximum is 36 months after the qualifying event for all other qualifying events.

The 18-month maximum coverage period can be extended in the following situations:

- **Disabled qualified beneficiary** – In the case of a qualified beneficiary who is determined to have been disabled under Title II or XVI of the Social Security Act within the first 60 days of continuation coverage, the maximum required coverage period is extended from 18 to 29 months; provided that the beneficiary gives notice of the determination both within 60 days after the determination is made by the Social Security Administration and before the end of 18 months.
- **Multiple qualifying events** – When a second qualifying event occurs, except for bankruptcy-related events, during the 18-month period after the termination or reduction in employment hours, the original 18-month maximum required coverage period can be extended up to 36 months.

Example: If an employee covered by a group health plan that is subject to COBRA terminates employment for reasons other than gross misconduct, on Dec. 31, 2000, the termination is a qualifying event that gives rise to an 18-month maximum coverage period ending June 30, 2002.

If the employee dies on Sept. 12, 2001, and the employee's surviving spouse and dependent children had elected COBRA continuation coverage at the time of the first qualifying event, the maximum coverage period for the spouse and children will extend to Dec. 31, 2003.

A longer maximum coverage period temporarily applies for two groups of individuals from Feb. 17, 2009, until Jan. 1, 2014. They are covered employees receiving a pension benefit from the Pension Benefit Guaranty Corporation (and their family members eligible for continuation coverage) and covered employees receiving a trade readjustment allowance under the Trade Act of 1974 (and their family members eligible for continuation coverage).

Premium Requirements

IRC §4980B(f)(2)(C) allows the plan to require the qualified beneficiary to pay for any period of continuation coverage. The requirements for premium payments are:

- The required premium payment for a period of continuation coverage must not exceed 102 percent of the "applicable premium" for such period.
- In general, the applicable premium is the total cost of covering similarly situated active employees, and their families, for whom a qualifying event has not occurred. This total cost includes both the employer and employee portions of the premium.
- The premium, at the election of the payer, may be made in monthly installments.
- The plan must allow at least 45 days from the election date for the initial payment of the premium for continuation coverage.
- In cases involving a qualified beneficiary who is disabled, the required premium payment may increase from 102 percent to 150 percent of the applicable premium for any month after the 18th month of continuation coverage.

Special Rules for Employer Bankruptcy

Some of the rules discussed above are different when bankruptcy of the employer is the qualifying event. Most notable is that this type of qualifying event only pertains to retirees and their families. A qualified beneficiary's loss of coverage includes a substantial elimination of coverage within one year, before or after the date of commencement, of the bankruptcy proceeding.

The maximum period of coverage for the covered employee extends until the death of the covered employee. The maximum period of coverage for the surviving spouse and dependent children extends until **36 months** after the death of the covered employee. Finally, the qualified beneficiary's entitlement to Medicare benefits does not cut off an employer's obligation to make the health care continuation coverage available.

Note: The term **qualified beneficiary** includes a covered employee who retired on or before the substantial elimination of coverage. A spouse, dependent child, or surviving spouse of a covered employee who was a beneficiary under the plan on the day before the qualifying event occurred, is also considered a qualified beneficiary.

Definitions

Group Health Plan

IRC Section 5000(b) defines a group health plan as any plan of, or contributed to by, an employer (including self-insured plans) to provide health care to the employer's employees, former employees, or the families of such employees or former employees. Under the COBRA regulations, a group health plan is maintained by an employer to provide medical care regardless of whether the medical care is provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as noted in the following paragraph), or through a cafeteria plan (as defined in IRC Section 125), or other flexible-benefit arrangement.

Under Regulation 54.4980B-2(d), the provision for medical care at a facility located on the premises of an employer does not constitute a group health plan if:

- The medical care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours
- The medical care is available only to the employer's current employees
- Employees are not charged for the use of the facility

Medical Care

Medical care [as defined under IRC 213(d)] includes the diagnosis, cure, mitigation, treatment, or prevention of a disease; as well as any other undertaking for the purpose of affecting any structure or function of the body. It also includes the costs of transportation incurred primarily for, and essential to, medical care.

Example: An employer maintains a health fitness club that offers a spa, swimming pool, and an exercise or fitness program to all of its employees. If the club is normally accessible to and used by the employees for reasons other than for relief of health or medical problems, such a facility would not constitute medical care and would not be a group health plan. [54.4980B-1 Q & A 1(d)]

In contrast, if the employer maintains a drug or alcohol treatment program, a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem (whether chronic or acute), the facility or program is considered to be the provision of medical care and hence, would qualify as a group health plan. [54.4980B-2]

Covered Employee

A covered employee is an individual who is, or was, provided coverage under a group health plan by virtue of their performance of services for one or more persons maintaining the plan. Thus, a common-law employee receiving coverage under a group health plan maintained by the employee's employer would be a covered employee. Under IRC Section 4980B(f)(7) the following individuals could be considered covered employees if they are, or were, actually covered under a group health plan by virtue of their performance of services for an employer maintaining the plan:

- Self-employed individuals
- Agents and independent contractors
- Corporate directors
- Partners in a partnership

Note: An individual (whether a present or former employee) who is merely eligible for coverage under a group health plan is not a covered employee if the individual is not, and has not been, actually covered under the plan.

Qualified Beneficiary

A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under a group health plan maintained by the employer of a covered employee by virtue of being any of the following individuals:

- Covered employee
- Spouse of the covered employee
- Dependent child of the covered employee
- A child who is born to, or placed for adoption with, a covered employee during a period of continuation coverage

Note: A covered employee can be a qualified beneficiary only if the qualifying event is the termination of (for reasons other than gross misconduct on the part of the employee) or reduction in hours for employment.

Qualifying Event

In order for a qualified beneficiary to be eligible to elect health care continuation coverage, a qualifying event must occur. A qualifying event is one of the following events which, except for the continuation coverage required under IRC Section 4980B(f)(3), would cause the qualified beneficiary to lose coverage under the plan:

- Death of the covered employee
- Termination (for reasons other than gross misconduct on the part of the employee) or reduction in employment hours for a covered employee

- Divorce or legal separation of a covered employee from their spouse
- The covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act
- Loss of dependent child status under the generally applicable requirements of the plan
- A bankruptcy proceeding under Title 11, U.S. Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time (some continuation coverage rules are different when bankruptcy is the qualify event, see the section above titled Special Rules for Employer Bankruptcy).

Loss of Coverage

Under Treasury Regulation §54.4980B-4 Q & A (6)(c), "to lose coverage" means to cease to be covered under a group health plan with the same terms and conditions as in effect immediately before the qualifying event. A loss of coverage does not have to occur immediately after the event, so long as the loss of coverage will occur before the end of the maximum coverage period. In addition, if coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

Appendix

Internal Revenue Code 4980B

Integrated COBRA Regulations

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§54.4980b-1	COBRA in general
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Additional COBRA Guidance

- Revenue Ruling 96-8 (PDF)
- Revenue Ruling 2002-88 (PDF)
- Revenue Ruling 2003-70 (PDF)
- Revenue Ruling 2004-22 (PDF)
- Federal Register 2009, Pages 45994-46000, Employer Comparable Contributions to Health Savings Accounts Under Section 4980G
- Form 8928, Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code (PDF)