FREQUENTLY ASKED QUESTIONS ABOUT THE CONTINUATION COVERAGE REQUIREMENTS IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

February 2009

Introduction

On February 17, 2009, President Obama signed into law the "American Recovery and Reinvestment Act" (Pub. L. 111-5, the "Recovery Act"). The Recovery Act adopts a broad range of tax and spending incentives designed to promote economic development and provides premium subsidies to help pay for the continuation of health coverage for certain individuals who lose their jobs.[1] In addition, the legislation creates new opportunities for individuals to qualify for continuation coverage provided by a group health plan.

The following frequently asked questions ("FAQs") describe the premium subsidy and other continuation coverage requirements in the Recovery Act. ***These FAQs are not intended as a substitute for legal or compliance advice and you should consult your legal counsel for specific guidance. In addition, federal and state regulatory agencies responsible for enforcing continuation coverage requirements are expected to issue guidance regarding the implementation of Recovery Act provisions and the FAQs may be revised to reflect any applicable guidance.***

1. What is "continuation coverage?"

In general, group health plans maintained by employers with 20 or more employees are required by federal law to provide plan participants in and beneficiaries with the right to continue their health coverage after the occurrence of certain "qualifying events" such as termination of employment or the divorce from, or death of, a covered spouse. The federal continuation coverage requirements apply to group health plans subject to the Employee Retirement Income Security Act (ERISA), state and local government employee plans, and the Federal Employees Health Benefits Plan (FEHB) (*see:* 5 U.S.C. §8905a, 26 U.S.C. §4980B, 29 U.S.C. §1161 *et seq*., and 42 U.S.C. §300bb-1 *et seq*.). These requirements are referred to as "federal continuation coverage" in these FAQs.

In addition, many states require employers with fewer than 20 employees to provide continuation coverage. As discussed further below, the Recovery Act also applies to state continuation coverage that is "comparable" to federal continuation coverage. The state requirements are referred to as "state continuation coverage" in these FAQs.

[1] The continuation coverage provisions are set out in Section 3001 of the Recovery Act beginning on page 341 of H.R. 1.

2. What are the continuation coverage requirements in the Recovery Act?

The Recovery Act establishes new rights for individuals who were involuntarily terminated from employment between September 1, 2008 and December 31, 2009.

- Individuals qualify for a subsidy equal to 65% of the cost paid for state or federal continuation coverage for the individual and his or her dependents.

- Individuals who were eligible for federal continuation coverage but are not enrolled in such coverage have a one-time opportunity to enroll.

- Employers and employee organizations may, but are not required to, offer individuals currently enrolled in state or federal continuation coverage the right to change coverage to a different health coverage option offered through the group health plan.

3. Who qualifies for the premium subsidy?

In general, the subsidy is available to any individual who loses health coverage between September 1, 2008 and December 31, 2009 and meets all of the following requirements:

- The loss of health coverage is due to an involuntary termination of employment.

- The individual *is eligible* for one of the following types of state or federal continuation coverage:

  - Continuation coverage offered by a group health plan pursuant to ERISA; or
  - Continuation coverage applicable to state and local government plans; or
  - Temporary continuation coverage offered through FEHB; or
  - Continuation coverage offered under state continuation coverage requirements that are "comparable" to the federal continuation requirements.

- The individual *is not eligible* for:

  - Coverage under another group health plan (except for coverage consisting only of dental, vision, counseling and/or referral services); or
  - Medicare.

4. What is considered "involuntarily termination" from employment?

The premium subsidy is available to individuals who were involuntarily terminated from employment between September 1, 2008 and December 31, 2009. [2]

The Recovery Act does not define involuntarily termination. The Department of Labor is expected to release guidance in the near future regarding the definition of "involuntarily."

5. How much is the premium subsidy?

The subsidy is equal to 65% of the cost charged to the individual for continuation coverage. The cost of continuation coverage provided by ERISA group health plans is typically 102% of the total premium paid for the coverage (the combined employee and the employer premium plus an administrative fee). The premium subsidy would be 65% of this amount.

If any portion of the premium charged to the individual is paid by the individual's former employer, that amount is not taken into account in determining the premium subsidy. For example, if the monthly premium is $1,000 and the employer pays $500 of this amount pursuant to a severance agreement, the subsidy would be 65% of $500 or $325.

6. Does an individual qualify for the subsidy if he or she is eligible for other health coverage?

No. An individual who is eligible for coverage under another group health plan (except coverage consisting of only dental, vision, counseling, and/or referral services) or under Medicare, *regardless of whether he or she is enrolled in such coverage*, does not qualify for the subsidy. Individuals are required to notify the group health plan when they become eligible for other coverage.

7. Do family members qualify for the subsidy?

Yes. Continuation coverage provided to a qualified individual and any dependents (e.g., family members) qualifies for the subsidy. The dependent must, however, qualify for the continuation coverage as specified by federal or state continuation coverage requirements.

In some cases, the subsidy will continue if the qualified individual is no longer receiving continuation coverage. For example, if the continuation coverage is provided pursuant to ERISA and the qualified individual dies, the surviving spouse and any children will continue to qualify for continuation coverage and for the subsidy.

[2] The federal continuation coverage requirements disqualify individuals for continuation coverage if they were terminated from employment for reasons of "gross misconduct" (e.g., fraud) (*see:* 5 U.S.C. §8905a, 29 U.S. C. §1163, and 42 U.S.C. §300bb-3).

8. May individuals who were involuntarily terminated after September 1, 2008 and did not take continuation coverage still qualify for the subsidy?

Individuals who were involuntarily terminated after September 1, 2008 and were eligible for federal continuation coverage after September 1, 2008 may still qualify for the subsidy even if they did not enroll in coverage when it was first available or if they enrolled and subsequently discontinued coverage.

Group health plans have 60 days to notify individuals of this special enrollment right. The individual then has 60 days after the notice is provided to exercise his or her right to enroll in the continuation coverage.

Regardless of when the election is made, the continuation coverage enrollment (and any premium subsidy) will be retroactive to March 1, 2009.

9. Are there income limits on eligibility to receive a subsidy?

Yes. An individual is not eligible for the subsidy if his or her modified adjusted gross income ("AGI") exceeds $145,000 for an individual income tax filer and $290,000 for a joint income tax filer. The subsidy is phased out if the individual's modified AGI is between $125,000 and $145,000 for individual filers and $250,000 and $290,000 for joint filers.[3]

It is up to individual taxpayers to report the amount of any subsidy on their federal income tax returns and repay any subsidy amounts that exceed the income limitations.

10. Is the amount of the subsidy considered income for purposes of determining an individual's eligibility for a public assistance program?

No. The amount of the premium subsidy *is not taken into consideration* for purposes of determining the individual's eligibility for any public benefit provided under Federal law or the law of any state or political subdivision.

11. Can you use the premium subsidy for dental and vision continuation coverage?

Yes. Any health coverage offered by a group health plan subject to federal or state continuation coverage requirements (except for a health Flexible Spending Arrangement), including dental or vision benefits, qualifies for the premium subsidy.

[3] "Modified" adjusted income is defined as the individual's adjusted gross income as established under section 162 of the Internal Revenue Code (IRC) increased by amounts otherwise excludable as income or housing expenses for residents of Puerto Rico, U. S. Territories, and foreign countries (*see:* IRC sections 911, 931, and 933).

12. Do all state continuation coverage options qualify for the subsidy?

In order to qualify for the subsidy, the state continuation coverage must be "comparable" to the federal continuation coverage requirements. Although "comparable" coverage is not defined in the Recovery Act, the Conference Report for the legislation includes additional clarification regarding the type of state coverage that would qualify for a subsidy:

> Comparable continuation coverage under State law does not include every State law right to continue health coverage, such as a right to continue coverage with no rules that limit the maximum premium that can be charged with respect to such coverage. To be comparable, the right generally must be to continue substantially similar coverage as was provided under the group health plan (or substantially similar coverage as is provided to similarly situated beneficiaries) at a monthly cost that is based on a specified percentage of the group health plan's cost of providing such coverage.

H. Rept. 111-16, 111th Cong., 1st Sess., (Feb. 12, 2009) at p. 716.

13. When does the subsidy begin?

The subsidy starts with the period of coverage beginning on or after the date of the enactment (February 17, 2009). As a result, for most individuals currently receiving continuation coverage, the premium subsidy will begin with coverage periods on or after March 1, 2009.

The subsidy *does not* apply to coverage periods prior to the date of enactment.

14. How long does the subsidy last?

The subsidy continues until *the earliest* of the following events:

- The individual is no longer *enrolled in* state or federal continuation coverage.
- The individual is *eligible for* coverage under a group health plan (except for coverage only for dental, vision, counseling or referral services) or Medicare.
- Nine months after the date the individual begins receiving the subsidy.

15. Does the subsidy continue after December 31, 2009?

Yes, in some cases. The subsidy continues for up to nine months for any individual who is eligible for state or federal continuation coverage and is involuntarily terminated from employment between September 1, 2008 and December 31, 2009. For example, if an individual eligible for federal continuation coverage is involuntarily terminated from

employment and begins coverage September 1, 2009, the subsidy continues until May 31, 2010 (unless the individual is no longer enrolled or becomes eligible for other specified coverage).

16. Who is responsible for the subsidy?

Responsibility for the premium subsidy depends on the type of continuation coverage:

- The group health plan, in the case of a multiemployer group health plan.
- The employer, in the case of a group health plan subject to the federal continuation coverage requirements.
- The insurance carrier, in the case of continuation coverage offered pursuant to state continuation coverage requirements.

17. How does the entity that is responsible for the subsidy recover the amount?

The entity that is responsible for the 65% subsidy (the multiemployer group health plan, employer or insurance carrier) is permitted to offset the amount of any subsidy payments against their payroll tax payments to the federal government. The subsidy may be offset from employee income tax withholding, employee FICA tax withholding or employer FICA tax obligations.

The Internal Revenue Service (IRS) has released a revised Form 941 and Instructions for reporting the amount of the premium subsidy that is taken as a payroll tax set-off.

18. What happens if the qualified individual has already paid continuation coverage premiums, but qualifies for the subsidy?

There is a 60 day "grace period" for the premium subsidy to begin in the case of individuals who have already paid for state or federal continuation coverage. For example, if the individual pays 100% of the continuation coverage premium due for March and April, 2009, the entity that is responsible for the subsidy may either: (a) refund the subsidy amounts to the individual; or (b) reduce subsequent premium amounts as a credit for the subsidy.

19. May individuals who are enrolled in continuation coverage change their coverage options?

Employers that offer multiple continuation coverage options (e.g., coverage through a health maintenance organization, point-of-service plan, and high deductible health plan), may (but are not required to) allow individuals a one-time opportunity to change to a different continuation coverage option prior to the annual open enrollment period if each of the following conditions is met:

- The individual qualifies for the subsidy (i.e., were involuntarily terminated from employment after September 1, 2008).

- The premium for the new coverage does not exceed the premium for coverage in which the individual was enrolled.

- The different coverage is also offered to the active employees of the employer.

- The different coverage is not:

    - Coverage that provides only dental, vision, counseling, and/or referral services.
    - Coverage under a health Flexible Spending Arrangement.
    - Coverage for services or treatments furnished in an on-site medical facility maintained by the employer consisting primarily of first-aid services, prevention and wellness care, and/or similar care.

As discussed below, individuals must be given a notice of their right to choose a different conversion option, and individuals have 90 days to make a choice.

20. What happens if someone requests premium assistance or the right to elect continuation coverage from a group health plan and the request is denied?

Individuals who request treatment as an eligible individual may appeal if their request is denied by the group health plan. The appeal will be handled by the Department of Labor (in consultation with the Department of the Treasury) in the case of federal continuation coverage provided by a group health plan pursuant to ERISA. The Department of Health and Human Services (in consultation with the Department of the Treasury) will handle the appeals in the case of all other group health plans that are subject to state or federal continuation coverage requirements.

The federal agencies must make a determination regarding the individual's eligibility within 15 business days after the application for review is submitted, and the agency's decision regarding eligibility may be appealed to a reviewing court.

21. When are notices required to be sent and who gets the notice?

All individuals who became qualified for state or federal continuation coverage after September 1, 2008 must be informed of their applicable rights to: (a) the premium subsidy; (b) enrollment in federal continuation coverage (if not already enrolled); and (c) enrollment in a different plan option (if the employer makes such option available). *In general, these notices must be provided to anyone who becomes eligible for state or federal continuation coverage regardless of whether the person qualifies for the premium subsidy.*

Amendments to Standard Eligibility Notices

Notices that are provided pursuant state or federal requirements when an individual becomes eligible for continuation coverage must be amended to include the following information:

- The availability of and requirements for the premium subsidy (must be "prominently displayed").
- The option to enroll in different continuation coverage (if the employer makes such option available).
- A description of the individual's right to "special enrollment" in federal conversion coverage (e.g., the individual was involuntarily terminated after September 1, 2008 and did not enroll at that time).
- The forms necessary for establishing eligibility for the premium subsidy.
- The name, address, and telephone number to contact the plan administrator (or other person) with relevant information about the subsidy.
- A description of the individual's obligation to notify the plan if the individual is eligible for Medicare or for other group health plan coverage.

Special Eligibility Notices

Group health plan administrators must provide a notice to all individuals who become eligible for state or federal continuation coverage after September 1, 2008, but who have not received the amended standard eligibility notice. The notice must include the same information as described above. The notice must be provided within 60 days after enactment (February 17, 2009).

Model Notices and Notice Rules

The Department of Labor (in consultation with the Departments of Health and Human Services and the Treasury) is required to publish model notice language, within 30 days after enactment (February 17th), for group health plans providing state and federal continuation coverage.[4] In addition, the Department of Labor will provide rules for the provision of notices to individuals subject to state continuation coverage requirements.

Who Sends the Notice

In general, group health plan administrators are responsible for providing continuation coverage notices. However, state or federal law or plan administration agreements may provide that another entity – such as the employer or an insurance carrier – is responsible for sending the notice.

[4] Model language for notices provided to individuals eligible for FEHB continuation coverage will be developed by the Office of Personnel Management.

22. What reports are required to be provided?

Entities that are responsible for the premium subsidy and claim the subsidy amount on the entity's payroll taxes are required to report the following information to the Department of the Treasury:

- An attestation of the involuntary termination of employment of each individual who receives the subsidy.
- The amount of payroll taxes that are offset for a reporting period and an estimate of the amounts will be offset for the next reporting period.
- The tax identification numbers (social security numbers) for all individuals who qualify for the subsidy.
- The amount of the subsidy paid for each person.
- Whether the subsidy is for more than one person.

The IRS has released a revised Form 941 and Instructions for reporting the payroll tax set-off.

23. Where can I get more information?

The Department of Labor, Employee Benefits Security Administration (EBSA) and the Department of the Treasury, Internal Revenue Service (IRS) have created web pages to post information on the continuation coverage requirements:

EBSA Website:

http://www.dol.gov/ebsa/COBRA.html

IRS Website:

http://www.irs.gov/newsroom/article/0,,id=204505,00.html

America's Health Insurance Plans
601 Pennsylvania Ave., NW
South Building, Suite 500
Washington, DC 20004

202.778.3200
www.ahip.org