McGraw Wentworth

BENEFIT Advisor

Volume Two, Issue 8 December 1999

In This Issue

This is the fourth issue in a series of the McGraw Wentworth Benefit Advisor that will be devoted to an in-depth review of the 1999 Final and Proposed Regulations. These issues will be presented in a chart format that provides the following information:

- *Each question addressed in the 1999 Final and Proposed Regulations and the corresponding section of the Internal Revenue Code (IRC) in which the question is addressed.*
- *The answers for each of the questions addressed in the Final and Proposed Regulations.*
- *Commentary on the difference between the initial 1987 Proposed Regulations (as they have been amended by previous legislation and clarified by case law) and the 1999 Final and Proposed Regulations.*

If you are interested in reviewing a copy of the 1999 Final and Proposed Regulations, you can access the text of the regulations through the McGraw Wentworth website at www.mcgrawwentworth.com. If you have any questions regarding the material outlined in this Benefit Advisor, please contact your McGraw Wentworth Account Manager.

COBRA Regulations

1999 - The Final and Proposed IRS Regulations

On February 3, 1999, the Department of Treasury released Final COBRA Regulations. In conjunction with the release of the 1999 Final Regulations, the Department of Treasury released a new set of Proposed Regulations and requested comment on certain gray issues of COBRA that have been identified through the administration of the continuation requirements over the last decade. Employers are required to comply with the Final Regulations and are encouraged to comply with the new Proposed Regulations effective the first plan year following January 1, 2000. Until that date, employers must operate in a "good faith standard" which could include following the 1999 Final and Proposed Regulations.

For the purposes of this *Benefits Advisor*, we will refer to the following three pieces of legislation:

- ***1987 Proposed Regulations***: Initial regulations released in 1987 to provide guidance on meeting continuation requirements.
- ***1999 Final Regulations:*** These regulations replace the 1987 Proposed Regulations and incorporate the changes made by legislation and case law over the course of the last 12 years.
- ***1999 Proposed Regulations:*** These regulations were issued concurrently with the Final Regulations to invite comment and clarify gray areas remaining in the 1999 Final Regulations.

The 1999 Final Regulations were issued in a question/answer format; similar to the format of the 1987 Proposed Regulations. In addition, several questions and answers are "reserved" under the 1999 Final Regulations. These "reserved" issues are addressed in the 1999 Proposed Regulations that the Department of Treasury requested comments on, prior to finalizing the regulations and may change based upon the comments received by the IRS. We have **shaded blue** the information that is addressed in the 1999 Proposed Regulations.

Section/Question	Final/Proposed Regulations	Key Differences From Previous
Section 54.4980B-7 Duration of COBRA Coverage		
Question 2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?	If a qualified beneficiary first becomes covered under another group health plan **after** the date on which COBRA coverage is elected, then the group health plan may terminate COBRA continuation on the date the qualified beneficiary first becomes covered under the other plan provided: ▪ The qualified beneficiary is covered under the other group health plan, not simply eligible for coverage. ▪ The other group health plan is not maintained by the employer or employee organization offering COBRA that maintains the plan that the COBRA coverage must otherwise be made available. ▪ The other group health plan does not contain any exclusion or limitation with respect to a pre-existing condition of the qualified beneficiary that is not offset by any provision of HIPAA.	The 1987 Proposed Regulations do not contain a question in this form, however, they do address the termination of COBRA if a qualified beneficiary becomes covered under another group health plan. This section incorporates the provisions of Geissal v. Moore Medical Corporation. COBRA continuation coverage can only be terminated if a qualified beneficiary becomes covered under another group health plan after the COBRA election date. The new group health plan cannot contain any limitations or exclusions that would result in the qualified beneficiary's loss of coverage.
Question 3: When may a plan terminate a qualified beneficiary's COBRA coverage due to the qualified beneficiary's entitlement to Medicare benefits?	If a qualified beneficiary first becomes entitled to Medicare after the date COBRA continuation is elected, then the plan may terminate COBRA coverage on the date of Medicare entitlement. If a qualified beneficiary becomes entitled to Medicare prior to the date COBRA is elected, then the plan cannot terminate COBRA coverage on the basis of Medicare entitlement.	The 1987 Proposed Regulations do not contain a question that addresses this issue directly. This section incorporates the provisions of Geissal v. Moore Medical Corporation. The regulations treat Medicare in a similar manner as other group health plans.
Question 4: When does the maximum coverage period end?	The maximum coverage period is measured from the date of the qualifying event, even if the qualifying event does not result in a loss of coverage under the plan until a later date. If the loss of coverage occurs at a later date and the plan provides for an extension of coverage for a required period, then the maximum coverage period is measured from the date coverage is lost. *(Continued next page.)*	The 1987 Proposed Regulations address this question by simply stipulating the 18 months for termination or reduction of work hours and the 36 months for loss of dependent eligibility. The 1999 Final Regulations expand this issue to address coverage periods for a qualified beneficiary that is a child born to or placed for adoption with a covered *(Continued next page.)*

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Question 4: When does the maximum coverage period end? *(Continued from page 2)*	In the case of a qualifying event that is the termination of employment or a reduction of work hours, the maximum coverage period is 18 months. If the qualified beneficiary is eligible for the disability extension, the coverage period is extended to 29 months. With all other qualifying events the maximum coverage period is 36 months. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a qualified beneficiary during a period of COBRA coverage is the maximum coverage period for the qualifying event that gave rise to the continuation period. For example, if a qualified beneficiary has a baby 11 months into the benefit period and adds the baby to COBRA, the baby's coverage period is 7 months (up to the end of the mother's 18-month period). In the case of a covered employee who becomes entitled to Medicare before experiencing a qualifying event that is termination of employment or reduction in work hours, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of: ▪ 36 months after the date the covered employee becomes entitled to Medicare. ▪ 18 months (or 29 months if there is a disability extension) after the date of the employee's termination or reduction of work hours. In the case of a qualifying event that is the bankruptcy of the employer, the maximum coverage period ends with the death of the retired covered employee. The maximum coverage period for the spouse, surviving spouse or dependent child of a retired covered employee ends on the earlier of: ▪ the death of the qualified beneficiary. ▪ 36 months following the death of the retired covered employee.	employee. In addition, the final regulations incorporate the clarifications made by HIPAA in regard to the maximum coverage period for Medicare entitlement.

<table>
<tr><th>Section/Question</th><th>Final/Proposed Regulations</th><th>Key Differences From Previous Proposed Regulations / Case Law</th></tr>
<tr><td>Question 5: How does a qualified beneficiary become entitled to a disability extension?</td><td>A qualified beneficiary becomes entitled to a disability extension if the following conditions are met:

▪ The qualifying event is the termination or reduction of work hours of the covered employee.
▪ A qualified beneficiary in connection with the qualifying event is determined to be social security disabled within the first 60 days of COBRA continuation coverage. If the qualified beneficiary is a child born to or placed for adoption with a covered employee, the first 60 days of COBRA continuation is measured from the date of birth or placement for adoption.

The plan administrator must be provided the determination of disability within 60 days of the date of determination and before the end of the 18-month continuation period.

The 29-month extended maximum coverage period applies to any and all qualified beneficiaries in the family, who are entitled to COBRA as a result of the qualifying event (even if the qualified beneficiary is not disabled) and the extension applies independently with respect to each qualified beneficiary.

Generally, the 60-day period during which a qualified beneficiary has to be social security disabled begins on the date of the qualifying event (even if coverage goes beyond that date). If the plan provides a non-COBRA extension of coverage and treats the COBRA period as beginning on that date the extended coverage ends, then the 60-day period begins when the extended coverage ends.</td><td>The 1987 Proposed Regulations did not contain a question that addresses the disability extension. This question includes all of the provisions implemented by HIPAA:

▪ The disability extension applies to all qualified beneficiaries, not just the disabled qualified beneficiary.
▪ The extension applies if the date of disability occurs within the first 60 days of COBRA continuation.</td></tr>
<tr><td>Question 6: Under what circumstances can the maximum coverage period be expanded?</td><td>The maximum coverage period can be extended in the situation of a disabled qualified beneficiary as outlined above. In addition, the coverage period can be extended, if, during the initial COBRA continuation period (18 months or 29 months), the qualified beneficiary experiences a second qualifying event (for ex-
(Continued from page 3)</td><td>This question is not materially different from the 1987 Proposed Regulations.

However, this section clarifies that a qualified beneficiary who is covered under COBRA due to a reduction of work hours and who subsequently terminates</td></tr>
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Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Question 6: Under what circumstances can the maximum coverage period be expanded? *(Continued from page 4.)*	ample, death or divorce) that gives rise to a 36-month maximum coverage period. In the case of an extension due to a second qualifing event, the original 18-month period is extended to 36 months for all applicable qualified beneficiaries. The extension only applies to qualified beneficiaries from the first qualifying event who are continuously covered under COBRA up to the date of the second qualifying event.	employment is not eligible for any extension of the maximum coverage period. The 1999 Final Regulations clarify that the termination of employment following a reduction of work hours is not considered a second qualifying event and the maximum coverage period is not extended.
Question 7: If health coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage, will such alternative coverage extend the maximum coverage period?	No, the maximum coverage period is generally measured from the date of the qualifying event except as noted in Question 1 & 6 of this section. If the alternative coverage does not satisfy all of the requirements of COBRA, then the plan must still extend COBRA coverage. If an individual rejects COBRA coverage in favor of alternative coverage, then the plan does not need to extend COBRA to the individual. However, if a covered employee rejects COBRA and covers his/her family under the alternative coverage, and then the qualified beneficiary experiences a second qualifying event (for example, death of an employee), the dependents must be given the option to extend the alternative coverage period to the 36-month maximum coverage period.	This question is not materially different from the 1987 Proposed Regulations.
Question 8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?	The plan must extend a conversion policy to qualified beneficiaries at the end of the maximum COBRA coverage period only if the health plan extends conversion coverage to all similarly situated non-COBRA beneficiaries. If applicable, notice of a conversion priviledge must be provided within the 180 days of the maximum coverage period.	This question is not materially different from the 1987 Proposed Regulations.

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Section 54.4980B-8 Paying for COBRA ContinuationCoverage		
Question 1: Can a group health plan require payment for COBRA continuation coverage?	Yes, a group health plan can require the payment of an amount that does not exceed 102 percent of the applicable premium for that period. The plan can terminate COBRA coverage the first day of any period for which timely payment is not made to the plan. ▪ For the purposes of a disability extension of COBRA period from 18 to 29 months, the plan can charge up to 150% of the applicable premium. ▪ If a qualified beneficiary experiences a second qualifying event during the initial 18 month continuation period (that would extend the maximum coverage period to 36 months), then the maximum the plan can charge is 102% of the applicable premium. The plan can not charge in excess of 102% of the premium for any COBRA continuation period the qualified beneficiary would be entitled to without the disability extension. If a qualified beneficiary experiences a second qualifying event after the initial 18-month continuation period while coverage is still in effect due to a disability extension, coverage can be extended to 36 months and the maximum premium that can be charged is 150% of the applicable premium as long as the disabled qualified beneficiary is included in coverage.	This question is similar in form and content to the initial 1987 Proposed Regulations. However, the 1999 Final Regulations contain information regarding the ability to charge 150% of the applicable premium during the 18-29 month disability extension. This section provides an example that illustrates a situation where a covered employee elects COBRA and has a spouse who also is a qualified beneficiary and does not elect COBRA. In this example, the spouse is social security disabled and meets the requirements for the disability extension. The covered employee (even though the spouse does not elect COBRA) is eligible for the disability extension and the maximum premium that can be charged the employee is 102%. The 150% increase does not apply because the disabled qualified beneficiary is not covered under the plan. ERISA defines "applicable premium" as the cost of the plan for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred.
Question 2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?	The applicable premium for each determination period must be computed and fixed by a group health plan before each determination period begins. A determination period is any 12-month period selected by the plan and it must be consistently applied from year to year. During a determination period, a plan can increase the amount it requires a qualified beneficiary to pay for COBRA coverage only as follows on the next page: *(Continued on next page)*	Again, this question is similar to the 1987 Proposed Regulations, however, the 1999 Final Regulations contain these key clarifications: ▪ The plan can increase premium if it is charging less than the maximum allowable charge. ▪ The premium can be changed due to the disability extension increase. ▪ The premium can be changed if a qualified beneficiary changes the *(Continued on next page)*

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Question 2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage? *(Continued from page 6)*	▪ The plan previously charged less than the maximum amount permitted by law and the increased amount required to be paid does not exceed the maximum amount permitted. ▪ The increase occurs due to a disability extension and the increased amount required to be paid does not exceed the maximum amount permitted by law. ▪ A qualified beneficiary changes the coverage being received.	plan he/she is covered by during open enrollment; this includes a situation where a qualified beneficiary becomes covered under another plan sponsored by the employer or moves out of the area for a region specific plan and becomes covered under a different plan sponsored by the employer.
Question 3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?	Yes, a group health plan must allow payment for COBRA continuation coverage to be made in monthly installments. A group health plan is permitted to also allow alternative payment intervals (such as weekly, quarterly, or semiannually) to accommodate a qualified beneficiary. However, the plan is not required to accept payment on an interval less than monthly.	This question is not materially different from the 1987 Proposed Regulations.
Question 4: Is a plan required to allow a qualified beneficiary to choose to have the first payment for COBRA continuation applied prospectively only?	No, a group health plan is permitted to apply the first payment for COBRA to the period of coverage beginning immediately after the date on which coverage is lost due to the qualifying event. The only exception is when a qualified beneficiary waives COBRA and then, after the waiver, elects COBRA within the initial election period, the first premium payment is not applicable for any period of waiver. In this situation, the first payment is applied to the period of coverage that begins on the date the waiver was revoked.	This question is not materially different from the 1987 Proposed Regulations.
Question 5: What is a timely payment for COBRA continuation coverage?	Except as noted below, timely payment for a period of COBRA continuation coverage under a group health plan means a payment that is made to the plan by a date that is 30 days after the first day of the period. A payment that is made to the plan late is still considered timely if: *(Continued on next page)*	This question is similar in form and content as presented in the 1987 Proposed Regulations. The 1999 Final Regulations do expand this section to note: ▪ The need to have the plan administrator provide details in regard to any COBRA beneficiary for whom pay- *(Continued on next page)*

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Question 5: What is a timely payment for COBRA continuation coverage? ***(Continued from page 7)***	▪ Under the terms of the plan, qualified beneficiaries are allowed until a later date to pay for their coverage for the period. ▪ Under the terms of an arrangement between the employer, an insurance company or other coverage vendor, similarly situated non-COBRA beneficiaries would be extended more time to make a payment in a similar situation. Other requirements are as follows: ▪ A plan cannot require payment for any period of COBRA continuation coverage earlier than 45 days after the date on which the election of COBRA is made. ▪ The plan must provide complete information to any provider of healthcare that contacts the plan to confirm coverage. If coverage is active but payment is not made for the most recent month, the plan needs to advise the provider that coverage is in effect but will be terminated retroactively if payment is not received. Similarly, if a plan terminates coverage but will reinstate it upon receipt of payment, then the plan administrator must provide this information. ▪ Finally, if timely payment is made to the plan, but the amount paid is not significantly less than the amount due, then that amount is deemed to satisfy the plan's requirement for the amount that must be paid unless the plan notifies the qualified beneficiary of the amount of deficit and provides reasonable time for additional payment. Thirty days is deemed to be considered a reasonable period of time. Payment is considered made the day on which it is sent to the plan.	ment has not been made. For example, if payment is due the first of the month, the plan administrator must advise a provider that inquires about coverage the specifics of the situation. ▪ In addition, the section addresses how a plan administrator should handle underpayments of COBRA premium.

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Section 54.4980 B-9 – Business Reorganizations and Employer Withdrawls From Multi-Employer Plans		
Question 1: For the purposes of this section, what are a business reorganization, a stock sale and an asset sale?	For the purposes of this section: ▪ A business reorganization is a stock sale or an asset sale. ▪ A stock sale is a transfer of stock in a corporation that causes the corporation to become a different employer or a member of a different employer. ▪ An asset sale is a sale of substantial assets, such as a plant or division or substantially all of the assets of a trade or business.	The 1987 Proposed Regulations did not include a question that outlined COBRA liability in the event of a business reorganization. This has been considered a gray area and the 1999 Proposed Regulations provide significant guidance on COBRA liability during a business reorganization.
Question 2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?	In the case of a stock sale: ▪ The selling group is the controlled group of corporations or a group of trades or businesses under common control of which a corporation ceases to be a member as a result of a stock sale. ▪ The acquired organization is the corporation that ceases to be a member of the selling group as a result of the stock sale. ▪ The buying group is the controlled group of corporations or the group of trades or businesses under common control of which the acquired organization becomes a member as a result of the stock sale. If the acquired organization does not become a member of such a group, the buying group is the acquired organization.	The 1987 Proposed Regulations did not define the terms involved in a business reorganization. Typically, COBRA liability was addressed as part of the sale agreement. If not, the acquiring corporation needed to determine if it was a "successor" employer. If so, the successor employer would generally retain any COBRA liability.
Question 3: In the case of an asset sale, what are the selling group and the buying group?	In the case of an asset sale: The selling group is the controlled group of corporations or a group of trades or businesses under common control that includes the corporation or other trade or business that is selling the assets. The buying group is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is buying the assets.	This question was not addressed in the 1987 Proposed Regulations. The 1999 Proposed Regulations provide specific guidance on COBRA liabilities in a business reorganization.

SECTION/QUESTION	FINAL/PROPOSED REGULATIONS	KEY DIFFERENCES FROM PREVIOUS PROPOSED REGULATIONS / CASE LAW
Question 4: Who is a Merger & Acquisition (M&A) qualified beneficiary?	▪ In the case of an asset sale, an individual is an M&A qualified beneficiary if the individuals qualifying event occurred prior to or in connection with the sale. ▪ In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual sustained a qualifying event prior to or in connection with the sale. ▪ In the case of a qualified beneficiary who has experienced more than one qualifying event with respect to his/her current COBRA coverage, the qualifying event referenced above is the first qualifying event.	This question was not addressed in the 1987 Proposed Regulations. The 1999 Proposed Regulations provide specific guidance on COBRA liabilities in a business reorganization.
Question 5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee (and spouse and dependent child(ren) of covered employee) who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale?	No, a covered employee who continues to be employed by the acquired organization after the sale does not experience a termination of employment as a result of the sale. The sale is not a qualifying event with respect to the covered employee or any covered family members. This applies regardless of the health coverage that is extended by the buying group.	This was not addressed in the 1987 Proposed Regulations, however, it does clarify that if a corporation sells a subsidiary and the employee maintains employment with the new company that provides group health coverage, then the employee has not experienced a qualifying event as a result of the sale. The selling group is not required to extend COBRA continuation in this situation.

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Question 6: In the case of an asset sale, is the sale a qualifying event for a covered employee (and spouse and dependent child(ren) of covered employee) who was employed with the selling group prior to the sale?	Yes, unless: ▪ The buying group is the successor employer and the covered employee is employed by the buying group immediately after the sale. OR ▪ The covered employee does not lose coverage under the group health plan of the selling group after the date of sale. If neither of the above situations apply, a covered employee experiences a termination of employment with the selling group as a result of the asset sale, regardless of the whether the covered employee is employed by the buying group. Accordingly, the covered employee and any covered dependents that lose coverage under the selling group's plan in connection with the sale are considered M&A qualified beneficiaries.	Again, this situation was not addressed in the 1987 Proposed Regulations. In an asset sale situation, a qualifying event does occur as a result of the sale, if the employee loses coverage and the buying group is not considered a successor employer.
Question 7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation available to M&A qualified beneficiaries?	Yes, nothing in this section prohibits a selling group and a buying group from allocating to one or the other parties in a purchase agreement the responsibility to provide COBRA coverage. However, if and to the extent that the party assigned this responsibility fails to perform the obligation, the party outlined in question 8 of this section is responsible for providing COBRA.	Although this was not directly addressed in the 1987 Proposed Regulations, many corporations addressed COBRA liability in the sale agreement because the regulations did not contain clear guidance on who accepted COBRA liability in a business reorganization situation.
Question 8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?	In the case of a business reorganization, so long as the selling group maintains a group health plan after the sale, it has the obligation to make COBRA available to M&A qualified beneficiaries. In the case of a stock sale, if the selling group ceases to provide any group health plan to any employees in connection with the sale, the group health plan maintained by the buying group has the obligation to provide COBRA coverage to M&A qualified beneficiaries. COBRA must be provided effective the later of the date of the sale or the date the selling group ceases to provide any group health coverage. *(Continued on next page.)*	This section provides many examples of merger and acquisition situations and how the COBRA obligations should be handled. If you are in the situation of determining COBRA liability in a sale situation, you should review the examples in this section of the 1999 Proposed Regulations to determine how your specific situation should be addressed.

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Question 8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization? *(Continued from page 11)*	In the case of the asset sale, if the selling group ceases to provide a group health plan to any employees in connection with the sale and if the buying group continues business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is considered a successor employer. In this case, the buying group has the obligation to provide COBRA coverage effective the later of the date of sale or the date the selling group ceases to provide coverage.	
Question 9: Can the cessation of contributions of an employer to a multi-employer group health plan be a qualifying event?	The cessation of contributions by an employer to a multi-employer group health plan in itself is not considered a qualifying event. If the cessation of contributions coincide with a reduction of work hours (such as a strike), then the reduction of work hours is considered a qualifying event.	The 1987 Proposed Regulations did not provide guidance on the COBRA rights associated with an employer discontinuing contributions to a multi-employer group plan.
Question 10: If an employer stops contributing to a multi-employer group health plan, does the multi-employer plan have the obligation to continue COBRA coverage for qualified beneficiaries that were extended COBRA because of an affiliation with the employer who stopped making contributions?	In general, yes, the multi-employer plan should extend COBRA. However, if the employer who stopped making contributions to the plan establishes one or more group health plans that covers a significant number of the employees, the new plan has the obligation to make COBRA coverage available.	The 1987 Proposed Regulations did not provide guidance on the COBRA rights associated with an employer discontinuing contributions to a multi-employer group plan.

Section/Question	Final/Proposed Regulations	Key Differences From Previous Proposed Regulations / Case Law
Section 54.4980 B-10 – Interaction of FMLA and COBRA		
Question 1: In what circumstances does a qualifying event occur if an employee does not return from a leave taken under the FMLA?	Taking leave under the FMLA does not in and of itself, constitute a qualifying event. However, a qualifying event can occur: ▪ If an employee or any dependents are covered under the plan the day prior to the first day of the leave, or become covered under the group health plan during the FMLA leave, and ▪ The employee does not return to active employment at the end of the FMLA leave, and ▪ The employee and/or any covered dependents lose coverage under the group plan as a result of the employee not returning to active employment. The failure to return from an FMLA leave can be considered a qualifying event if the above conditions are met and the employer does not terminate coverage for the class of employees during the FMLA leave.	The Family and Medical Leave Act was not passed as of the effective date of the 1987 Proposed Regulations. HIPAA provided additional guidance regarding FMLA and COBRA. The 1999 Proposed Regulations do not contain any material difference to the clarifications made by HIPAA.
Question 2: If a qualifying event does occur as noted above, when does it occur and how is the maximum coverage period measured?	In the situation above, the qualifying event date is the last day of the FMLA leave. The maximum coverage period should be measured beginning that date. The only exception is that if coverage is lost at a later date because the plan provided a required extension of coverage, then the qualifying event date is the loss of coverage date and the maximum coverage period is measured from that point.	The Family and Medical Leave Act was not passed as of the effective date of the 1987 Proposed Regulations.HIPAA provided additional guidance regarding FMLA and COBRA. The 1999 Proposed Regulations do not contain any material difference to the clarifications made by HIPAA.
Question 3: If an employee fails to pay the employee portion of the premiums for coverage under the group health plan during an FMLA leave, does this affect the determination of whether or when an employee experiences a qualifying event?	No, any lapse of coverage under a group health plan is irrelevant in determining whether a set of circumstances constitutes a qualifying event as described in question #1 or when that qualifying event occurs as described in question #2.	The Family and Medical Leave Act was not passed as of the effective date of the 1987 Proposed Regulations.HIPAA provided additional guidance regarding FMLA and COBRA. The 1999 Proposed Regulations do not contain any material difference to the clarifications made by HIPAA.

SECTION/QUESTION	FINAL/PROPOSED REGULATIONS	KEY DIFFERENCES FROM PREVIOUS PROPOSED REGULATIONS / CASE LAW
Question 4: Is the application of the rules outlined in questions 1-3 of this section affected by the requirement of state or local law to provide a period of coverage longer than required by the FMLA?	No, any requirements outlined under questions 1 through 3 apply regardless of any state laws or mandates that require the FMLA period be extended beyond the mandated 12 weeks.	The Family and Medical Leave Act was not passed as of the effective date of the 1987 Proposed Regulations. HIPAA provided additional guidance regarding FMLA and COBRA. The 1999 Proposed Regulations do not contain any material difference to the clarifications made by HIPAA.
Question 5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during the FMLA leave?	In certain circumstances the Department of Labor has published rules that allow an employer to recover their portion of premiums paid during FMLA if an employee fails to return to work from the leave. However, the employer must extend COBRA rights and cannot condition the right of a qualified beneficiary to elect COBRA on the basis that the employee repay premiums the employer paid coverage during an FMLA leave.	The Family and Medical Leave Act was not passed as of the effective date of the 1987 Proposed Regulations.HIPAA provided additional guidance regarding FMLA and COBRA. The 1999 Proposed Regulations do not contain any material difference to the clarifications made by HIPAA. Please note, an employer cannot refuse to extend COBRA to a qualified beneficiary even if the covered employee owes retroactive premium payments because he/she did not return to work following an FMLA leave.

Our technical bulletins are written and produced by the McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Consult your legal counsel or tax advisor in matters that directly affect your benefit plans.

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