

Notice of Proposed Rulemaking and Notice of Public Hearing

Continuation Coverage Requirements Applicable to Group Health Plans

REG-121865-98

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations that provide guidance under section 4980B of the Internal Revenue Code relating to the COBRA continuation coverage requirements applicable to group health plans. The proposed regulations in this document supplement final regulations being published in T.D. 8812, page 19 of this Bulletin. The regulations will generally affect sponsors of and participants in group health plans, and they provide plan sponsors and plan administrators with guidance necessary to comply with the law.

DATES: Written or electronic comments and outlines of topics to be discussed at the public hearing scheduled for June 8, 1999 at 10 a.m. must be received by May 14, 1999.

ADDRESSES: Send Submissions to: CC:DOM:CORP:R (REG-121865-98), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORP:R (REG-121865-98), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, DC. Alternatively, taxpayers may submit comments electronically via the Internet by selecting the "Tax Regs" option on the IRS Home Page, or by submitting comments directly to the IRS Internet site at http://www.irs.ustreas.gov/prod/tax_regs/comments.html. The public hearing scheduled for June 8, 1999 will be held in room 2615 of the Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Yurlinda Mathis at 202-622-4695; con-

cerning submissions of comments, the hearing, or to be placed on the building access list to attend the hearing, LaNita Van Dyke at 202-622-7190 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Internal Revenue Code (Code) to add health care continuation coverage requirements. These provisions, now set forth in section 4980B,¹ generally apply to a group health plan maintained by an employer or employee organization, with certain exceptions, and require such a plan to offer each qualified beneficiary who would otherwise lose coverage as a result of a qualifying event an opportunity to elect, within the applicable election period, COBRA continuation coverage. The COBRA continuation coverage requirements were amended on various occasions,² most recently under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Proposed regulations providing guidance under the continuation coverage requirements as originally enacted by COBRA, and as amended by the Tax Reform Act of 1986, were published as proposed Treasury Regulation §1.162-26 in the **Federal Register** of June 15, 1987

¹ The COBRA continuation coverage requirements were initially set forth in section 162(k), but were moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988 (TAMRA). TAMRA changed the sanction for failure to comply with the continuation coverage requirements of the Internal Revenue Code from disallowance of certain employer deductions under section 162 (and denial of the income exclusion under section 106(a) to certain highly compensated employees of the employer) to an excise tax under section 4980B.

² Changes affecting the COBRA continuation coverage provisions were made under the Omnibus Budget Reconciliation Act of 1986, the Tax Reform Act of 1986, the Technical and Miscellaneous Revenue Act of 1988, the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, the Small Business Job Protection Act of 1996, and the Health Insurance Portability and Accountability Act of 1996. The statutory continuation coverage requirements have also been affected by an amendment made to the definition of group health plan in section 5000(b)(1) by the Omnibus Budget Reconciliation Act of 1993; that definition is incorporated by reference in section 4980B(g)(2).

(52 F.R. 22716). Supplemental proposed regulations were published as proposed Treasury Regulation §54.4980B-1 in the **Federal Register** of January 7, 1998 (63 F.R. 708). Final regulations are being published in T.D. 8812.

The new set of proposed regulations being published in this notice of proposed rulemaking addresses how the COBRA continuation coverage requirements apply in business reorganizations. Also proposed are rules relating to the interaction of the COBRA continuation coverage requirements and the Family and Medical Leave Act of 1993, which were previously published as Notice 94-103 (1994-2 C.B. 569), and certain other issues. These provisions in the new set of proposed regulations are summarized in the explanation below. For a summary of the new proposed regulations integrated with a summary of the final regulations, see the "Explanation of Provisions" section of the preamble to the final regulations published in T.D. 8812.

Explanation of Provisions

Plans That Must Comply

The new proposed regulations would make a number of changes to the section in the final regulations that addresses which plans must comply with the COBRA continuation coverage requirements. The principal changes being proposed are to add rules simplifying the determination of whether the small-employer plan exception applies, giving employers and employee organizations broad discretion to determine the number of group health plans that they maintain, and providing an exception for certain health flexible spending accounts.

In determining whether a plan is eligible for the small-employer plan exception, part-time employees, as well as full-time employees, must be taken into account. Several commenters on the 1987 proposed regulations requested clarification of how to count part-time employees for the small-employer plan exception, and the new proposed regulations provide guidance on this issue. Under the new proposed regulations, instead of each part-time employee counting as a full employee, each part-time employee counts as a fraction of an employee, with the

fraction equal to the number of hours that the part-time employee works for the employer divided by the number of hours that an employee must work in order to be considered a full-time employee. The number of hours that must be worked to be considered a full-time employee is determined in a manner consistent with the employer's general employment practices, although for this purpose not more than eight hours a day or 40 hours a week may be used. An employer may count employees for each typical business day or may count employees for a pay period and attribute the total number of employees for that pay period to each typical business day that falls within the pay period. The employer must use the same method for all employees and for the entire year for which the small-employer plan determination is made.

The new proposed regulations provide guidance, for purposes of the COBRA continuation coverage requirements, on how to determine the number of group health plans that an employer or employee organization maintains. Under these rules, the employer or employee organization is generally permitted to establish the separate identity and number of group health plans under which it provides health care benefits to employees. Thus, if an employer or employee organization provides a variety of health care benefits to employees, it generally may aggregate the benefits into a single group health plan or disaggregate benefits into separate group health plans. The status of health care benefits as part of a single group health plan or as separate plans is determined by reference to the instruments governing those arrangements. If it is not clear from the instruments governing an arrangement or arrangements to provide health care benefits whether the benefits are provided under one plan or more than one plan, or if there are no instruments governing the arrangement or arrangements, all such health care benefits (other than those for qualified long-term care services) provided by a single entity (determined without regard to the controlled group rules) constitute a single group health plan.

Under the new proposed regulations, a multiemployer plan and a plan other than a multiemployer plan are always separate

plans. In addition, any treatment of health care benefits as constituting separate group health plans will be disregarded if a principal purpose of the treatment is to evade any requirement of law. Of course, an employer's flexibility to treat benefits as part of separate plans may be limited by the operation of other laws, such as the prohibition in section 9802 on conditioning eligibility to enroll in a group health plan on the basis of any health factor of an individual.

Many commenters on the 1987 proposed regulations requested clarification of the application of COBRA to health care benefits provided under flexible spending arrangements (health FSAs). Some commentators argued that health FSAs should not be subject to COBRA. Health FSAs satisfy the definition of group health plan in section 5000(b)(1) and, accordingly, are generally subject to the COBRA continuation coverage requirements. However, COBRA is intended to ensure that a qualified beneficiary has guaranteed access to coverage under a group health plan and that the cost of that coverage is no greater than 102 percent of the applicable premium.

The IRS and Treasury believe that the purposes of COBRA are not furthered by requiring an employer to offer COBRA for a plan year if the amount that the employer could require to be paid for the COBRA coverage for the plan year would exceed the maximum benefit that the qualified beneficiary could receive under the FSA for that plan year and if the qualified beneficiary could not avoid a break in coverage, for purposes of the HIPAA portability provisions³, by electing COBRA coverage under the FSA. Accordingly, the new proposed regulations contain a rule limiting the application of the COBRA continuation coverage requirements in the case of health FSAs.

Under this proposed rule, if the health FSA satisfies two conditions, the health FSA need not make COBRA continuation coverage available to a qualified beneficiary for any plan year after the plan year

³ Under HIPAA, a qualified beneficiary who maintains coverage after termination of employment under a group health plan that is subject to HIPAA can avoid a break in coverage and thereby avoid becoming subject to a preexisting condition exclusion upon later becoming covered by another health plan.

in which the qualifying event occurs. The first condition that the health FSA must satisfy for this exception to apply is that the health FSA is not subject to the HIPAA portability provisions in sections 9801 through 9833 because the benefits provided under the health FSA are excepted benefits. (See sections 9831 and 9832.)⁴ The second condition is that, in the plan year in which the qualifying event of a qualified beneficiary occurs, the maximum amount that the health FSA could require to be paid for a full plan year of COBRA continuation coverage equals or exceeds the maximum benefit available under the health FSA for the year. It is contemplated that this second condition will be satisfied in most cases.

Moreover, if a third condition is satisfied, the health FSA need not make COBRA continuation coverage available with respect to a qualified beneficiary at all. This third condition is satisfied if, as of the date of the qualifying event, the maximum benefit available to the qualified beneficiary under the health FSA for the remainder of the plan year is not more than the maximum amount that the plan could require as payment for the remainder of that year to maintain coverage under the health FSA.

Duration of COBRA Continuation Coverage

The new proposed regulations would make two principal changes to the section in the final regulations addressing the duration of COBRA continuation coverage.

The 1987 proposed regulations reflect the statutory rules that were then in effect for the maximum period that a plan is required to make COBRA continuation coverage available. Since then the statute has been amended to add the disability extension, to permit plans to extend the notice

⁴ The IRS and Treasury together with the U.S. Department of Labor and the U.S. Department of Health and Human Services, have issued a notice (62 F.R. 67688) holding that a health FSA is exempt from HIPAA because the benefits provided under it are excepted benefits under sections 9831 and 9832 if the employer also provides another group health plan, the benefits under the other plan are not limited to excepted benefits, and the maximum reimbursement under the health FSA is not greater than two times the employee's salary reduction election (or if greater, the employee's salary reduction election plus five hundred dollars).

period if the maximum coverage period is also extended (referred to as the optional extension of the required periods), and to add a special rule in the case of Medicare entitlement preceding a qualifying event that is the termination or reduction of hours of employment. The new proposed regulations reflect these statutory changes. The maximum coverage period for a qualifying event that is the bankruptcy of the employer has also been added to the new proposed regulations.

The 1987 proposed regulations incorporate the statutory bases for terminating COBRA continuation coverage except the rule (added in 1989 and amended in 1996) that COBRA coverage can be terminated in the month that is more than 30 days after a final determination that a qualified beneficiary is no longer disabled. The new proposed regulations add this statutory basis for terminating COBRA coverage, with two clarifications. First, the new proposed regulations clarify that a determination that a qualified beneficiary is no longer disabled allows termination of COBRA continuation coverage for all qualified beneficiaries who were entitled to the disability extension by reason of the disability of the qualified beneficiary who has been determined to no longer be disabled. Second, the new proposed regulations clarify that such a determination does not allow termination of the COBRA continuation coverage of a qualified beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension.

Business Reorganizations

The 1987 proposed regulations provide little direct guidance on the allocation of responsibility for COBRA continuation coverage in the event of corporate transactions, such as a sale of stock of a subsidiary or a sale of substantial assets. Commenters on the 1987 proposed regulations requested further guidance on corporate transactions, pointing out that the existing degree of uncertainty tends to drive up the costs and risks of a transaction to both buyers and sellers. The IRS and Treasury share this view and believe also that greater certainty helps to protect the rights of qualified beneficiaries in these transactions. The IRS has been contacted by many qualified beneficiaries

whose COBRA continuation coverage has been dropped or denied in the context of a corporate transaction. In many cases, these qualified beneficiaries have been told by each of the buyer and the seller that the other party is the one responsible for providing them with COBRA continuation coverage.

The preamble to the 1998 proposed regulations requested comments on a possible approach to allocating responsibility for COBRA continuation coverage in corporate transactions. Commenters suggested that, in a stock sale, as in an asset sale, it would be consistent with standard commercial practice to provide that the seller retains liability for all existing qualified beneficiaries, including those formerly associated with the subsidiary being sold. The IRS and Treasury have studied the comments and given consideration to several alternatives with a view to establishing rules that will minimize the administrative burden and transaction costs for the parties to transactions while protecting the rights of qualified beneficiaries and maintaining consistency with the statute.

Accordingly, the new proposed regulations make clear that the parties to a transaction are free to allocate the responsibility for providing COBRA continuation coverage by contract, even if the contract imposes responsibility on a different party than would the new proposed regulations. So long as the party to whom the contract allocates responsibility performs its obligations, the other party will have no responsibility for providing COBRA continuation coverage. If, however, the party allocated responsibility under the contract defaults on its obligation, and if, under the new proposed regulations, the other party would have the obligation to provide COBRA continuation coverage in the absence of a contractual provision, then the other party would retain that obligation. This approach would avoid prejudicing the rights of qualified beneficiaries to COBRA continuation coverage based upon the provisions of a contract to which they were not a party and under which the employer with the underlying obligation under the regulations to provide COBRA continuation coverage could otherwise contract away that obligation to a party that fails to perform. Moreover, the party with the underlying responsibility under

the regulations can insist on appropriate security and, of course, could pursue contractual remedies against the defaulting party.

The new proposed regulations provide, for both sales of stock and sales of substantial assets, such as a division or plant or substantially all the assets of a trade or business, that the seller retains the obligation to make COBRA continuation coverage available to existing qualified beneficiaries. In addition, in situations in which the seller ceases to provide any group health plan to any employee in connection with the sale – whether such a cessation is in connection with the sale is determined on the basis of the facts and circumstances of each case – and thus is not responsible for providing COBRA continuation coverage, the new proposed regulations provide that the buyer is responsible for providing COBRA continuation coverage to existing qualified beneficiaries. This secondary liability for the buyer applies in all stock sales and in all sales of substantial assets in which the buyer continues the business operations associated with the assets without interruption or substantial change.

A particular type of asset sale raises issues for which the new proposed regulations do not provide any special rules. (Thus, the general rules in the new proposed regulations for business reorganizations would apply to this type of transaction.) This type of asset sale is one in which, after purchasing a business as a going concern, the buyer continues to employ the employees of that business and continues to provide those employees exactly the same health coverage that they had before the sale (either by providing coverage through the same insurance contract or by establishing a plan that mirrors the one that provided benefits before the sale). The application of the rules in the new proposed regulations to this type of asset sale would require the seller to make COBRA continuation coverage available to the employees continuing in employment with the buyer (and to other family members who are qualified beneficiaries). Ordinarily, the continuing employees (or their family members) would be very unlikely to elect COBRA continuation coverage from the seller when they can receive the same coverage (usually at much lower cost) as active employees of the buyer.

Consideration is being given to whether, under appropriate circumstances, such an asset sale would be considered not to result in a loss of coverage for those employees who continue in employment with the buyer after the sale. A countervailing concern, however, relates to those qualified beneficiaries who might have a reason to elect COBRA continuation coverage from the seller. An example of such a qualified beneficiary would be an employee who continues in employment with the buyer, whose family is likely to have medical expenses that exceed the cost of COBRA coverage, and who has significant questions about the solvency of the buyer or other concerns about how long the buyer might continue to provide the same health coverage.

Under one possible approach, a loss of coverage would be considered not to have occurred so long as the purchasing employer in an asset sale continued to maintain the same group health plan coverage that the seller maintained before the sale without charging the employees any greater percentage of the total cost of coverage than the seller had charged before the sale. For this purpose, the coverage would be considered unchanged if there was no obligation to provide a summary of material modifications within 60 days after the change due to a material reduction in covered services or benefits under the rules that apply under Title I of ERISA. If these conditions were satisfied for the maximum coverage period that would otherwise apply to the seller's termination of employment of the continuing employees (generally 18 months from the date of the sale), then those terminations of employment would never be considered qualifying events. If the conditions were not satisfied for the full maximum coverage period, then on the date when they ceased to be satisfied the seller would be obligated to make COBRA continuation coverage available for the balance of the maximum coverage period.

Comments are invited on the utility of such a rule, either in situations in which the seller retains an ownership interest in the buyer after the sale (for example, a sale of assets from a 100-percent owned subsidiary to a 75-percent owned subsidiary) or, more generally, in situations in which the seller and the buyer are unre-

lated. Suggestions are also solicited for other rules that would protect qualified beneficiaries while providing relief to employers in these situations.

Although the new proposed regulations address how COBRA obligations are affected by a sale of stock (and a sale of substantial assets), the new proposed regulations do not address how the obligation to make COBRA continuation coverage available is affected by the transfer of an ownership interest in a noncorporate entity that causes the noncorporate entity to cease to be a member of a group of trades or businesses under common control (whether or not it becomes a member of a different group of trades or business under common control). Comments are invited on this issue.

Employer Withdrawals From Multiemployer Plans

The new proposed regulations also address COBRA obligations in connection with an employer's cessation of contributions to a multiemployer group health plan. The new proposed regulations provide that the multiemployer plan generally continues to have the obligation to make COBRA continuation coverage available to qualified beneficiaries associated with that employer. (There generally would not be any obligation to make COBRA continuation coverage available to continuing employees in this situation because a cessation of contributions is not a qualifying event.) However, once the employer provides group health coverage to a significant number of employees who were formerly covered under the multiemployer plan, or starts contributing to another multiemployer plan on their behalf, the employer's plan (or the new multiemployer plan) would have the obligation to make COBRA continuation coverage available to the existing qualified beneficiaries. This rule is contrary to the holding in *In re Appletree Markets, Inc.*, 19 F.3d 969 (5th Cir. 1994), which held that the multiemployer plan continued to have the COBRA obligations with respect to existing qualified beneficiaries after the withdrawing employer established a plan for the same class of employees previously covered under the multiemployer plan.

Interaction of FMLA and COBRA

The new proposed regulations set forth rules regarding the interaction of the COBRA continuation coverage requirements with the provisions of the Family and Medical Leave Act of 1993 (FMLA). The rules under the new proposed regulations are substantially the same as those set forth in Notice 94-103. The last two questions-and-answers in that notice have not been included in the new proposed regulations because they relate to general subject matter that is addressed elsewhere in the regulations.

Under the new proposed regulations, the taking of FMLA leave by a covered employee is not itself a qualifying event. Instead, a qualifying event occurs when an employee who is covered under a group health plan immediately prior to FMLA leave (or who becomes covered under a group health plan during FMLA leave) does not return to work with the employer at the end of FMLA leave and would, but for COBRA continuation coverage, lose coverage under the group health plan. (As under the general rules of COBRA, this would also constitute a qualifying event with respect to the spouse or any dependent child of the employee.) The qualifying event is deemed to occur on the last day of the employee's FMLA leave, and the maximum coverage period generally begins on that day. (The new proposed regulations provide a special rule for cases where coverage is not lost until a later date and the plan provides for the optional extension of the required periods.) In the case of such a qualifying event, the employer cannot condition the employee's rights to COBRA continuation coverage on the employee's reimbursement of any premiums paid by the employer to maintain the employee's group health plan coverage during the period of FMLA leave.

Any lapse of coverage under the group health plan during the period of FMLA leave and any state or local law requiring that group health plan coverage be provided for a period longer than that required by the FMLA are disregarded in determining whether the employee has a qualifying event on the last day of that leave. However, the employee's loss of coverage at the end of FMLA leave will not constitute a qualifying event if, prior to the employee's return from FMLA

leave, the employer has eliminated group health plan coverage for the class of employees to which the employee would have belonged if she or he had not taken FMLA leave.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the regulations do not impose a collection of information requirement on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Therefore, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments that are submitted timely (a signed original and eight (8) copies) to the IRS. Comments are specifically requested on the clarity of the proposed regulations and how they may be made easier to understand. All comments will be available for public inspection and copying.

A public hearing has been scheduled for June 8, 1999, beginning at 10 a.m. in room 2615 of the Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC. Due to building security procedures, visitors must enter at the 10th Street entrance, located between Constitution and Pennsylvania Avenues, NW. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 15 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the

“FOR FURTHER INFORMATION CONTACT” section of this preamble.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing must submit written comments and an outline of the topics to be discussed and the time to be devoted to each topic (signed original and eight (8) copies) by May 14, 1999. A period of 10 minutes will be allotted to each person for making comments. An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal author of these proposed regulations is Russ Weinheimer, Office of the Associate Chief Counsel (Employee Benefits and Exempt Organizations). However, other personnel from the IRS and Treasury Department participated in their development.

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Proposed Amendments to the Regulations

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended in part by adding entries in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *

Section 54.4980B-9 also issued under 26 U.S.C. 4980B.

Section 54.4980B-10 also issued under 26 U.S.C. 4980B. * * *

Par. 2. Section 54.4980B-0 is amended by:

1. Revising the introductory text.
2. Adding entries for §§54.4980B-9 and 54.4980B-10 at the end of the list of sections.
3. Revising the entries for Q-3 and Q-6 of §54.4980B-2 in the list of questions.
4. Revising the entry for Q-4 of §54.4980B-7 in the list of questions.
5. Adding an entry for the section heading for §54.4980B-9 in the list of questions.
6. Adding an entry for the section heading for §54.4980B-10 in the list of questions.

The additions and revisions read as follows:

§54.4980B-0 Table of contents.

This section contains first a list of the section headings and then a list of the questions in each section in §§54.4980B-1 through 54.4980B-10.

LIST OF SECTIONS

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§54.4980B-9 Business reorganizations and employer withdrawals from multiemployer plans.

§54.4980B-10 Interaction of FMLA and COBRA.

LIST OF QUESTIONS

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§54.4980B-2 Plans that must comply.

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Q-3: What is a multiemployer plan?

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Q-6: For purposes of COBRA, how is the number of group health plans that an employer or employee organization maintains determined?

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§54.4980B-7 Duration of COBRA continuation coverage.

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Q-4: When does the maximum coverage period end?

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§54.4980B-9 Business reorganizations and employer withdrawals from multiemployer plans.

Q-1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?

Q-2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

Q-3: In the case of an asset sale, what are the selling group and the buying group?

Q-4: Who is an M&A qualified beneficiary?

Q-5: In the case of a stock sale, is the sale a qualifying event with respect to a 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, or with respect to the spouse or dependent children of such a covered employee?

Q-6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

Q-7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

Q-8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

Q-9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

Q-10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

§54.4980B-10 Interaction of FMLA and COBRA.

Q-1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

Q-2: If a qualifying event described in Q&A-1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

Q-3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

Q-4: Is the application of the rules in Q&A-1 through Q&A-3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

Q-5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

Par. 3. Section 54.4980B-1, A-1 is amended by:

1. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the last sentence of paragraph (a).

2. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the third sentence and last sentence of paragraph (b).

3. Removing the last sentence of paragraph (c) and adding two sentences in its place to read as follows:

§54.4980B-1 COBRA in general.

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A-1: * * *

(c) * * * Section 54.4980B-9 contains special rules for how COBRA applies in connection with business reorganizations and employer withdrawals from a multiemployer plan, and §54.4980B-10 addresses how COBRA applies for individuals who take leave under the Family and Medical Leave Act of 1993. Unless the context indicates otherwise, any reference in §§54.4980B-1 through §54.4980B-10 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

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Par. 4. Section 54.4980B-2 is amended by:

1. Revising paragraph (a) in A-1.
2. Removing the language “54.4980B-8” and adding “54.4980B-10” in its place in the first sentence of paragraph (b) in A-1.
3. Revising A-2.
4. Adding Q&A-3.
5. Removing the language “54.4980B-8” and adding “54.4980B-10” in its place in the last sentence of paragraph (a) in A-4.
6. Adding a sentence immediately before the last sentence of the introductory text of paragraph (a) in A-5.
7. Removing the language “54.4980B-8” and adding “54.4980B-10” in its place in the last sentence of paragraph (c) in A-5.
8. Adding paragraphs (d), (e), and (f) in A-5.
9. Adding Q&A-6.
10. Revising A-8.
11. Revising paragraph (a) in A-10.

The additions and revisions read as follows:

§54.4980B-2 Plans that must comply.

* * * * *

A-1: (a) For purposes of section 4980B, a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A-1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. (See paragraphs (b) through (e) in Q&A-8 of this section for rules regarding the application of the COBRA continuation coverage requirements to certain health

flexible spending arrangements.) For purposes of this Q&A-1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual’s employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A-1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A-1, and for medical savings accounts in paragraph (f) of this Q&A-1. See Q&A-6 of this section for rules to determine the number of group health plans that an employer or employee organization maintains.

* * * * *

A-2: (a) For purposes of section 4980B, employer refers to –

(1) A person for whom services are performed;

(2) Any other person that is a member of a group described in section 414(b), (c), (m), or (o) that includes a person described in paragraph (a)(1) of this Q&A-2; and

(3) Any successor of a person described in paragraph (a)(1) or (2) of this Q&A-2.

(b) An employer is a successor employer if it results from a consolidation, merger, or similar restructuring of the employer or if it is a mere continuation of the employer. See paragraph (c) in Q&A-8 of §54.4980B-9 for rules describing the circumstances in which a purchaser of substantial assets is a successor employer to the employer selling the assets.

Q-3: What is a multiemployer plan?

A-3: For purposes of §§54.4980B-1 through 54.4980B-10, a multiemployer plan is a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more col-

lective bargaining agreements between one or more employee organizations and more than one employer, and that satisfies such other requirements as the Secretary of Labor may prescribe by regulation. Whenever reference is made in §§54.4980B-1 through 54.4980B-10 to a plan of or maintained by an employer or employee organization, the reference includes a multiemployer plan.

* * * * *

A-5: (a) * * * See Q&A-6 of this section for rules to determine the number of plans that an employer or employee organization maintains. * * *

* * * * *

(d) In determining the number of the employees of an employer, each full-time employee is counted as one employee and each part-time employee is counted as a fraction of an employee, determined in accordance with paragraph (e) of this Q&A-5.

(e) An employer may determine the number of its employees on a daily basis or a pay period basis. The basis used by the employer must be used with respect to all employees of the employer and must be used for the entire year for which the number of employees is being determined. If an employer determines the number of its employees on a daily basis, it must determine the actual number of full-time employees on each typical business day and the actual number of part-time employees and the hours worked by each of those part-time employees on each typical business day. Each full-time employee counts as one employee on each typical business day and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee and the denominator equal to the number of hours that must be worked on a typical business day in order to be considered a full-time employee. If an employer determines the number of its employees on a pay period basis, it must determine the actual number of full-time employees employed during that pay period and the actual number of part-time employees employed and the hours worked by each of those part-time employees during the pay period. For each day of that pay pe-

riod, each full-time employee counts as one employee and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee during that pay period and the denominator equal to the number of hours that must be worked during that pay period in order to be considered a full-time employee. The determination of the number of hours required to be considered a full-time employee is based upon the employer's employment practices, except that in no event may the hours required to be considered a full-time employee exceed eight hours for any day or 40 hours for any week.

(f) In the case of a multiemployer plan, the determination of whether the plan is a small-employer plan on any particular date depends on which employers are contributing to the plan on that date and on the workforce of those employers during the preceding calendar year. If a plan that is otherwise subject to COBRA ceases to be a small-employer plan because of the addition during a calendar year of an employer that did not normally employ fewer than 20 employees on a typical business day during the preceding calendar year, the plan ceases to be excepted from COBRA immediately upon the addition of the new employer. In contrast, if the plan ceases to be a small-employer plan by reason of an increase during a calendar year in the workforce of an employer contributing to the plan, the plan ceases to be excepted from COBRA on the January 1 immediately following the calendar year in which the employer's workforce increased.

* * * * *

Q-6: For purposes of COBRA, how is the number of group health plans that an employer or employee organization maintains determined?

A-6: (a) The rules of this Q&A-6 apply, for purposes of COBRA, in determining the number of group health plans that an employer or employee organization maintains. Except as provided in paragraph (c) of this Q&A-6, in the case of health care benefits provided under an arrangement or arrangements of an employer or employee organization, the number of group health plans pursuant to

which those benefits are provided is determined by the instruments governing the arrangement or arrangements. However, a multiemployer plan and a nonmultiemployer plan are always separate plans. All references elsewhere in §§54.4980B-1 through 54.4980B-10 to a group health plan are references to a group health plan as determined under Q&A-1 of this section and this Q&A-6.

(b) If it is not clear from the instruments governing an arrangement or arrangements to provide health care benefits whether the benefits are provided under one plan or more than one plan, or if there are no instruments governing the arrangement or arrangements, all such health care benefits, except benefits for qualified long-term care services (as defined in section 7702B(c)), provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan.

(c) Notwithstanding paragraph (a) of this Q&A-6, if a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.

(d) The significance of treating an arrangement as two or more separate group health plans is illustrated by the following examples:

Example 1. (i) Employer X maintains a single group health plan, which provides major medical and prescription drug benefits. Employer Y maintains two group health plans; one provides major medical benefits and the other provides prescription drug benefits.

(ii) X's plan could comply with the COBRA continuation coverage requirements by giving a qualified beneficiary experiencing a qualifying event with respect to X's plan the choice of either electing both major medical and prescription drug benefits or not receiving any COBRA continuation coverage under X's plan. By contrast, for Y's plans to comply with the COBRA continuation coverage requirements, a qualified beneficiary experiencing a qualifying event with respect to each of Y's plans must be given the choice of electing COBRA continuation coverage under either the major medical plan or the prescription drug plan or both.

Example 2. If a joint board of trustees administers one multiemployer plan, that plan will fail to qualify for the small-employer plan exception if any one of the employers whose employees are covered under the plan normally employed 20 or more employees during the preceding calendar year. However, if the joint board of trustees maintains two or more multiemployer plans, then the exception would be available with respect to each of those plans in

which each of the employers whose employees are covered under the plan normally employed fewer than 20 employees during the preceding calendar year.

* * * * *

A-8: (a) The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. See paragraphs (b) through (e) of this Q&A-8 for rules limiting the obligations of certain health flexible spending arrangements. The rules of this paragraph (a) are illustrated by the following example:

Example: (i) Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a health maintenance organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indemnity arrangement are the arrangements providing health care. The instruments governing the HMO and indemnity arrangements indicate that they are separate group health plans. These group health plans are subject to COBRA. The employer does not provide any group health plan outside of the cafeteria plan. B and C are unmarried employees. B has chosen the life insurance coverage, and C has chosen the indemnity arrangement.

(ii) B does not have to be offered COBRA continuation coverage upon terminating employment, nor is a subsequent open enrollment period for active employees required to be made available to B. However, if C terminates employment and the termination constitutes a qualifying event, C must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If C makes such an election and an open enrollment period for active employees occurs while C is still receiving the COBRA continuation coverage, C must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute coverage provided under a group health plan).

(b) If a health flexible spending arrangement (health FSA), within the meaning of regulations project EE-130-86 (1989-1 C.B. 944, 986) (see §601.601(d)(2) of this chapter), satisfies the two conditions in paragraph (c) of this

Q&A-8 for a plan year, the obligation of the health FSA to make COBRA continuation coverage available to a qualified beneficiary who experiences a qualifying event in that plan year is limited in accordance with paragraphs (d) and (e) of this Q&A-8, as illustrated by an example in paragraph (f) of this Q&A-8.

(c) The conditions of this paragraph (c) are satisfied if –

(1) Benefits provided under the health FSA are excepted benefits within the meaning of sections 9831 and 9832; and

(2) The maximum amount that the health FSA can require to be paid for a year of COBRA continuation coverage under Q&A-1 of §54.4980B-8 equals or exceeds the maximum benefit available under the health FSA for the year.

(d) If the conditions in paragraph (c) of this Q&A-8 are satisfied for a plan year, then the health FSA is not obligated to make COBRA continuation coverage available for any subsequent plan year to any qualified beneficiary who experiences a qualifying event during that plan year.

(e) If the conditions in paragraph (c) of this Q&A-8 are satisfied for a plan year, the health FSA is not obligated to make COBRA continuation coverage available for that plan year to any qualified beneficiary who experiences a qualifying event during that plan year unless, as of the date of the qualifying event, the qualified beneficiary can become entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the plan year. In determining the amount of the benefit that a qualified beneficiary can become entitled to receive during the remainder of the plan year, the health FSA may deduct from the maximum benefit available to that qualified beneficiary for the year (based on the election made under the health FSA for that qualified beneficiary before the date of the qualifying event) any reimbursable claims submitted to the health FSA for that plan year before the date of the qualifying event.

(f) The rules of paragraphs (b), (c), (d), and (e) of this Q&A-8 are illustrated by the following example:

Example: (i) An employer maintains a group health plan providing major medical benefits and a

group health plan that is a health FSA, and the plan year for each plan is the calendar year. Both the plan providing major medical benefits and the health FSA are subject to COBRA. Under the health FSA, during an open season before the beginning of each calendar year, employees can elect to reduce their compensation during the upcoming year by up to \$1200 per year and have that same amount contributed to a health flexible spending account. The employer contributes an additional amount to the account equal to the employee's salary reduction election for the year. Thus, the maximum amount available to an employee under the health FSA for a year is two times the amount of the employee's salary reduction election for the year. This amount may be paid to the employee during the year as reimbursement for health expenses not covered by the employer's major medical plan (such as deductibles, copayments, prescription drugs, or eyeglasses). The employer determined, in accordance with section 4980B(f)(4), that a reasonable estimate of the cost of providing coverage for similarly situated non-COBRA beneficiaries for 2002 under this health FSA is equal to two times their salary reduction election for 2002 and, thus, that two times the salary reduction election is the applicable premium for 2002.

(ii) Because the employer provides major medical benefits under another group health plan, and because the maximum benefit that any employee can receive under the health FSA is not greater than two times the employee's salary reduction election for the plan year, benefits under this health FSA are excepted benefits within the meaning of sections 9831 and 9832. Thus, the first condition of paragraph (c) of this Q&A-8 is satisfied for the year. The maximum amount that a plan can require to be paid for coverage (outside of coverage required to be made available due to a disability extension) under Q&A-1 of §54.4980B-8 is 102 percent of the applicable premium. Thus, the maximum amount that the health FSA can require to be paid for coverage for the 2002 plan year is 2.04 times the employee's salary reduction election for the plan year. Because the maximum benefit available under the health FSA is 2.0 times the employee's salary reduction election for the year, the maximum benefit available under the health FSA for the year is less than the maximum amount that the health FSA can require to be paid for coverage for the year. Thus, the second condition in paragraph (c) of this Q&A-8 is also satisfied for the 2002 plan year. Because both conditions in paragraph (c) of this Q&A-8 are satisfied for 2002, with respect to any qualifying event occurring in 2002, the health FSA is not obligated to make COBRA continuation coverage available for any year after 2002.

(iii) Whether the health FSA is obligated to make COBRA continuation coverage available in 2002 to a qualified beneficiary with respect to a qualifying event that occurs in 2002 depends upon the maximum benefit that would be available to the qualified beneficiary under COBRA continuation coverage for that plan year. *Case 1:* Employee *B* has elected to reduce *B*'s salary by \$1200 for 2002. Thus, the maximum benefit that *B* can become entitled to receive under the health FSA during the entire year is \$2400. *B* experiences a qualifying event that is the termination of *B*'s employment on May 31, 2002.

As of that date, *B* had submitted \$300 of reimbursable expenses under the health FSA. Thus, the maximum benefit that *B* could become entitled to receive for the remainder of 2002 is \$2100. The maximum amount that the health FSA can require to be paid for COBRA continuation coverage for the remainder of 2002 is 102 percent times 1/12 of the applicable premium for 2002 times the number of months remaining in 2002 after the date of the qualifying event. In *B*'s case, the maximum amount that the health FSA can require to be paid for COBRA continuation coverage for 2002 is 2.04 times \$1200, or \$2448. One-twelfth of \$2448 is \$204. Because seven months remain in the plan year, the maximum amount that the health FSA can require to be paid for *B*'s coverage for the remainder of the year is seven times \$204, or \$1428. Because \$1428 is less than the maximum benefit that *B* could become entitled to receive for the remainder of the year (\$2100), the health FSA is required to make COBRA continuation coverage available to *B* for the remainder of 2002 (but not for any subsequent year).

(iv) *Case 2:* The facts are the same as in *Case 1* except that *B* had submitted \$1000 of reimbursable expenses as of the date of the qualifying event. In that case, the maximum benefit available to *B* for the remainder of the year would be \$1400 instead of \$2100. Because the maximum amount that the health FSA can require to be paid for *B*'s coverage is \$1428, and because the \$1400 maximum benefit for the remainder of the year does not exceed \$1428, the health FSA is not obligated to make COBRA continuation coverage available to *B* in 2002 (or any later year). (Of course, the administrator of the health FSA is permitted to make COBRA continuation coverage available to every qualified beneficiary in the year that the qualified beneficiary's qualifying event occurs in order to avoid having to determine the maximum benefit available for each qualified beneficiary for the remainder of the plan year.)

* * * * *

A-10: (a) In general, the excise tax is imposed on the employer maintaining the plan, except that in the case of a multiemployer plan (see Q&A-3 of this section for a definition of multiemployer plan) the excise tax is imposed on the plan.

* * * * *

Par. 5. In §54.4980B-3, the language "54.4980B-8" is removed and "54.4980B-10" is added in its place in the last sentence of paragraph (a)(3) and the first sentence of paragraph (g) in A-1; in the first and second sentences of paragraph (a)(1), the first sentence of paragraph (a)(2), and the first and last sentences in paragraph (b) in A-2; and in A-3.

Par. 6. Section 54.4980B-4 is amended by:

1. Adding a sentence at the end of paragraph (a) in A-1.

2. Removing the language “Q&A-1” and adding “Q&A-4” in its place in the fifth sentence of paragraph (c) of A-1.

3. Revising the third sentence in paragraph (e) of A-1.

The addition and revision read as follows:

§54.4980B-4 *Qualifying events.*

* * * * *

A-1: (a) * * * See Q&A-1 through Q&A-3 of §54.4980B-10 for special rules in the case of leave taken under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601-2619).

* * * * *

(e) * * * For example, an absence from work due to disability, a temporary layoff, or any other reason (other than due to leave that is FMLA leave; see §54.4980B-10) is a reduction of hours of a covered employee’s employment if there is not an immediate termination of employment. * * *

* * * * *

Par. 7. In §54.4980B-5, the penultimate sentence in paragraph (a) of A-1 is amended by removing the language “54.4980B-8” and adding “54.4980B-10” in its place.

Par. 8. In §54.4980B-6, the *Example* in paragraph (c) of A-1 is revised to read as follows:

§54.4980B-6 *Electing COBRA continuation coverage.*

* * * * *

A-1: * * *

Example. (i) An unmarried employee without children who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 2001. The employee is not disabled at the time of the termination of employment nor at any time thereafter, and the plan does not provide for the extension of the required periods (as is permitted under paragraph (b) of Q&A-4 of §54.4980B-7).

(ii) *Case 1:* If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin not later than June 1, 2001, and must not end earlier than July 31, 2001. If notice of the right to elect COBRA continuation coverage is not provided to the employee until June 15, 2001, the election period must not end earlier than August 14, 2001.

(iii) *Case 2:* If the plan provides that the employer-paid coverage does not end until 6 months

after the termination of employment, the employee does not lose coverage until December 1, 2001. The election period can therefore begin as late as December 1, 2001, and must not end before January 30, 2002.

(iv) *Case 3:* If employer-paid coverage for 6 months after the termination of employment is offered only to those qualified beneficiaries who waive COBRA continuation coverage, the employee loses coverage on June 1, 2001, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage need not be provided for more than 18 months after the termination of employment (see Q&A-4 of §54.4980B-7), and in certain circumstances might be provided for a shorter period (see Q&A-1 of §54.4980B-7).

* * * * *

Par. 9. Section 54.4980B-7 is amended by:

1. Revising paragraph (a) of A-1.
2. Adding Q&A-4.
3. Revising the second sentence in paragraph (c) of A-5.
4. Revising paragraph (b) of Q&A-6.
5. Removing the language “Q&A-1” and adding “Q&A-4” in its place in paragraph (a) of A-7.

The addition and revisions read as follows:

§54.4980B-7 *Duration of COBRA continuation coverage.*

* * * * *

A-1: (a) Except for an interruption of coverage in connection with a waiver, as described in Q&A-4 of §54.4980B-6, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates –

- (1) The last day of the maximum coverage period (see Q&A-4 of this section);
- (2) The first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A-5 in §54.4980B-8);
- (3) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

(4) The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, as described in Q&A-2 of this section;

(5) The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits, as described in Q&A-3 of this section; and

(6) In the case of a qualified beneficiary entitled to a disability extension (see Q&A-5 of this section), the later of—

(i) Either 29 months after the date of the qualifying event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act (42 U.S.C. 401-433 or 1381-1385) that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary’s being entitled to the disability extension is no longer disabled, whichever is earlier; or

(ii) The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

* * * * *

Q-4: When does the maximum coverage period end?

A-4: (a) Except as otherwise provided in this Q&A-4, the maximum coverage period ends 36 months after the qualifying event. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the maximum coverage period for the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption. Paragraph (b) of this Q&A-4 describes the starting point from which the end of the maximum coverage period is measured. The date that the maximum coverage period ends is described in paragraph (c) of this Q&A-4 in a case where the qualifying event is a termination of employment or reduction of hours of employment, in paragraph (d) of this Q&A-4 in a case where a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) before experiencing a qualifying event that is a termination

of employment or reduction of hours of employment, and in paragraph (e) of this Q&A-4 in the case of a qualifying event that is the bankruptcy of the employer. See Q&A-8 of §54.4980B-2 for limitations that apply to certain health flexible spending arrangements. See also Q&A-6 of this section in the case of multiple qualifying events. Nothing in §§54.4980B-1 through 54.4980B-10 prohibits a group health plan from providing coverage that continues beyond the end of the maximum coverage period.

(b)(1) The end of 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, however, coverage under the plan is lost at a later date and the plan provides for the extension of the required periods, then the maximum coverage period is measured from the date when coverage is lost. A plan provides for the extension of the required periods if it provides both –

(i) That the 30-day notice period (during which the employer is required to notify the plan administrator of the occurrence of certain qualifying events such as the death of the covered employee or the termination of employment or reduction of hours of employment of the covered employee) begins on the date of the loss of coverage rather than on the date of the qualifying event; and

(ii) That the end of the maximum coverage period is measured from the date of the loss of coverage rather than from the date of the qualifying event.

(2) In the case of a plan that provides for the extension of the required periods, whenever the rules of §§54.4980B-1 through 54.4980B-10 refer to the measurement of a period from the date of the qualifying event, those rules apply in such a case by measuring the period instead from the date of the loss of coverage.

(c) In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the qualifying event if there is no disability extension, and 29 months after the qualifying event if there is a disability extension. See Q&A-5 of this section for rules to determine if there is a disability extension. If there is a disability extension and the disabled qualified benefi-

ciary is later determined to no longer be disabled, then a plan may terminate the COBRA continuation coverage of an affected qualified beneficiary before the end of the disability extension; see paragraph (a)(6) in Q&A-1 of this section.

(d)(1) If a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of –

(i) 36 months after the date the covered employee became entitled to Medicare benefits; or

(ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.

(2) See paragraph (b) of Q&A-3 of this section regarding when a covered employee becomes entitled to Medicare benefits.

(e) In the case of a qualifying event that is the bankruptcy of the employer, the maximum coverage period for a qualified beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a qualified beneficiary who is the spouse, surviving spouse, or dependent child of the retired covered employee ends on the earlier of –

(1) The date of the qualified beneficiary's death; or

(2) The date that is 36 months after the death of the retired covered employee.

* * * * *

A-5: * * *

(c) * * * For this purpose, the period of the first 60 days of COBRA continuation coverage is measured from the date of the qualifying event described in paragraph (b) of this Q&A-5 (except that if a loss of coverage would occur at a later date in the absence of an election for COBRA continuation coverage and if the plan provides for the extension of the required periods (as described in paragraph (b) of Q&A-4 of this section) then the period of the first 60 days of COBRA continuation

coverage is measured from the date on which the coverage would be lost). * * *

* * * * *

A-6: * * *

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of an employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods; see paragraph (b) in Q&A-4 of this section). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for

some other reason) will be able to receive COBRA continuation coverage through December 31, 2003. See Q&A-8(b) of §54.4980B-2 for a special rule that applies to certain health flexible spending arrangements.

* * * * *

Par. 10. Sections 54.4980B-9 and 54.4980B-10 are added to read as follows:

§54.4980B-9 Business reorganizations and employer withdrawals from multiemployer plans.

The following questions-and-answers address who has the obligation to make COBRA continuation coverage available to affected qualified beneficiaries in the context of business reorganizations and employer withdrawals from multiemployer plans:

Q-1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?

A-1: For purposes of this section:

(a) A *business reorganization* is a stock sale or an asset sale.

(b) 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. (See Q&A-2 of §54.4980B-2, which defines *employer* to include all members of a controlled group of corporations.) Thus, for example, a sale or distribution of stock in a corporation that causes the corporation to cease to be a member of one controlled group of corporations, whether or not it becomes a member of another controlled group of corporations, is a stock sale.

(c) An *asset sale* is a sale of substantial assets, such as a plant or division or substantially all the assets of a trade or business.

(d) The rules of §1.414(b)-1 of this chapter apply in determining what constitutes a controlled group of corporations, and the rules of §§1.414(c)-1 through 1.414(c)-5 of this chapter apply in determining what constitutes a group of trades or businesses under common control.

Q-2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

A-2: In the case of a stock sale –

(a) The *selling group* is the controlled group of corporations, or the group of

trades or businesses under common control, of which a corporation ceases to be a member as a result of the stock sale;

(b) The *acquired organization* is the corporation that ceases to be a member of the selling group as a result of the stock sale; and

(c) 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.

Q-3: In the case of an asset sale, what are the selling group and the buying group?

A-3: In the case of an asset sale –

(a) The *selling 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 selling the assets; and

(b) 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.

Q-4: Who is an M&A qualified beneficiary?

A-4: (a) Asset sales: In the case of an asset sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was associated with the assets being sold.

(b) Stock sales: In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.

(c) In the case of a qualified beneficiary who has experienced more than one qualifying event with respect to her or his current right to COBRA continuation coverage, the qualifying event referred to in paragraphs (a) and (b) of this Q&A-4 is the first qualifying event.

Q-5: In the case of a stock sale, is the sale a qualifying event with respect to a 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, or with respect to the spouse or dependent children of such a covered employee?

A-5: 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. Accordingly, the sale is not a qualifying event with respect to the covered employee, or with respect to the covered employee's spouse or dependent children, regardless of whether they are provided with group health coverage after the sale, and neither the covered employee, nor the covered employee's spouse or dependent children, become qualified beneficiaries as a result of the sale.

Q-6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

A-6: (a) Yes, unless –

(1) The buying group is a successor employer under paragraph (c) of Q&A-8 of this section or Q&A-2 of §54.4980B-2, and the covered employee is employed by the buying group immediately after the sale; or

(2) The covered employee (or the spouse or any dependent child of the covered employee) does not lose coverage (within the meaning of paragraph (c) in Q&A-1 of §54.4980B-4) under a group health plan of the selling group after the sale.

(b) Unless the conditions in paragraph (a)(1) or (2) of this Q&A-6 are satisfied, such a covered employee experiences a termination of employment with the selling group as a result of the asset sale, regardless of whether the covered employee is employed by the buying group or whether the covered employee's employment is associated with the purchased assets after the sale. Accordingly, the covered employee, and the spouse and dependent children of the covered em-

ployee who lose coverage under a plan of the selling group in connection with the sale, are M&A qualified beneficiaries in connection with the sale.

Q-7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

A-7: Yes. Nothing in this section prohibits a selling group and a buying group from allocating to one or the other of the parties in a purchase agreement the responsibility to provide the coverage required under §§54.4980B-1 through 54.4980B-10. However, if and to the extent that the party assigned this responsibility under the terms of the contract fails to perform, the party who has the obligation under Q&A-8 of this section to make COBRA continuation coverage available to M&A qualified beneficiaries continues to have that obligation.

Q-8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

A-8: (a) In the case of a business reorganization (whether a stock sale or an asset sale), so long as the selling group maintains a group health plan after the sale, a group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that sale. This Q&A-8 prescribes rules for cases in which the selling group ceases to provide any group health plan to any employee in connection with the sale. Paragraph (b) of this Q&A-8 contains these rules for stock sales, and paragraph (c) of this Q&A-8 contains these rules for asset sales. Neither a stock sale nor an asset sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period before the sale.

(b)(1) In the case of a stock sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that stock sale. A group health plan of the buying group has this obligation beginning on the

later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in §54.4980B-7, relating to the duration of COBRA continuation coverage) –

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the stock sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the stock sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the stock sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(c)(1) In the case of an asset sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale and if the buying group continues the business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is a successor employer to the selling group in connection with that asset sale. If the buying group is a successor employer, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that asset sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in §54.4980B-7, relating to the duration of COBRA continuation coverage) –

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the asset sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the asset sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the asset sale, have an obligation to make COBRA continuation coverage available to those

qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(d) The rules of Q&A-1 through Q&A-7 of this section and this Q&A-8 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Stock Sale Examples

Example 1. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30, 2002, there are 48 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 15 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other 33 qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either *A* or *B*.)

(ii) Under these facts, *S*'s plan continues to have the obligation to make COBRA continuation coverage available to the 15 M&A qualified beneficiaries under *S*'s plan after the sale of *C* to *P*. The employees who continue in employment with *C* do not experience a qualifying event by virtue of *P*'s acquisition of *C*. If they experience a qualifying event after the sale, then the group health plan of *P* has the obligation to make COBRA continuation coverage available to them.

Example 2. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Each of *A*, *B*, and *C* maintains a group health plan for its employees (and their families). Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. As of June 30, 2002, there are 14 qualified beneficiaries receiving COBRA continuation coverage under *C*'s plan. *C* continues to employ all of its employees and continues to maintain its group health plan after being acquired by *P* on July 1, 2002.

(ii) Under these facts, *C* is an acquired organization and the 14 qualified beneficiaries under *C*'s plan are M&A qualified beneficiaries. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. *S* and *P* could negotiate to have *C*'s plan continue to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. In such a case, neither *A*'s plan nor *B*'s plan would make COBRA continuation coverage available to the 14 M&A qualified beneficiaries unless *C*'s plan failed to fulfill its contractual responsibility to make COBRA continuation coverage available to the M&A qualified beneficiaries. *C*'s employees (and their spouses and dependent children) do not experience a qualifying event

in connection with *P*'s acquisition of *C*, and consequently no plan maintained by either *P* or *S* has any obligation to make COBRA continuation coverage available to *C*'s employees (or their spouses or dependent children) in connection with the transfer of stock in *C* from *S* to *P*.

Example 3. (i) The facts are the same as in *Example 2*, except that *C* ceases to employ two employees on June 30, 2002, and those two employees never become covered under *P*'s plan.

(ii) Under these facts, the two employees experience a qualifying event on June 30, 2002 because their termination of employment causes a loss of group health coverage. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the two employees (and to any spouse or dependent child of the two employees who loses coverage under *C*'s plan in connection with the termination of employment of the two employees) because they are M&A qualified beneficiaries with respect to the sale of *C*.

Example 4. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30, 2002, there are 25 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 20 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other five qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either *A* or *B*.) *S* terminates its group health plan effective June 30, 2002 and begins to liquidate the assets of *A* and *B* and to lay off the employees of *A* and *B*.

(ii) Under these facts, *S* ceases to provide a group health plan to any employee in connection with the sale of *C* to *P*. Thus, beginning July 1, 2002 *P*'s plan has the obligation to make COBRA continuation coverage available to the 20 M&A qualified beneficiaries, but *P* is not obligated to make COBRA continuation coverage available to the other 5 qualified beneficiaries with respect to *S*'s plan as of June 30, 2002 or to any of the employees of *A* or *B* whose employment is terminated by *S* (or to any of those employees' spouses or dependent children).

Asset Sale Examples

Example 5. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells the assets of one of its divisions to Buying Group *P*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan. Immediately before the sale, there are two qualified beneficiaries receiving COBRA continuation coverage under a group health

plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These two qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, a group health plan of *S* retains the obligation to make COBRA continuation coverage available to these two M&A qualified beneficiaries. In addition, the one employee *P* does not hire as well as all of the employees *P* hires (and the spouses and dependent children of these employees) who were covered under a group health plan of *S* on the day before the sale are M&A qualified beneficiaries with respect to the sale. A group health plan of *S* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

Example 6. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*, and *S* ceases to provide any group health plan to any employee on the date of the sale. *P* hires all but one of *S*'s employees on the date of the asset sale by *S*, gives those employees the same positions that they had with *S* before the sale, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. Immediately before the sale, there are 10 qualified beneficiaries receiving COBRA continuation coverage under a group health plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These 10 qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, *P* is a successor employer described in paragraph (c) of this Q&A-8. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to these 10 M&A qualified beneficiaries.

(iii) The one employee that *P* does not hire and the family members of that employee are also M&A qualified beneficiaries with respect to the sale. A group health plan of *P* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

(iv) The employees who continue in employment in connection with the asset sale (and their family members) and who were covered under a group health plan of *S* on the day before the sale are not M&A qualified beneficiaries because *P* is a successor employer to *S* in connection with the asset sale. Thus, no group health plan of *P* has any obligation to make COBRA continuation coverage available to these continuing employees with respect to the qualifying event that resulted from their losing coverage under *S*'s plan in connection with the asset sale.

Example 7. (i) Selling Group *S* provides group health plan coverage to employees at each of its two operating divisions. *S* sells the assets of one of its divisions to Buying Group *P1*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P1* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan.

(ii) Under these facts, a group health plan of *S* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale to *P1*. (If an M&A qualified beneficiary first became covered under *P1*'s plan after electing COBRA continuation coverage under *S*'s plan, then *S*'s plan could terminate the COBRA continuation coverage once the M&A qualified beneficiary became covered under *P1*'s plan, provided that the remaining conditions of Q&A-2 of §54.4980B-7 were satisfied.)

(iii) Several months after the sale to *P1*, *S* sells the assets of its remaining division to Buying Group *P2*, and *S* ceases to provide any group health plan to any employee on the date of that sale. Thus, under Q&A-1 of §54.4980B-7, *S* ceases to have an obligation to make COBRA continuation coverage available to any qualified beneficiary on the date of the sale to *P2*. *P1* and *P2* are unrelated organizations.

(iv) Even if it was foreseeable that *S* would sell its remaining division to an unrelated third party after the sale to *P1*, under these facts the cessation of *S* to provide any group health plan to any employee on the date of the sale to *P2* is not in connection with the asset sale to *P1*. Thus, even after the date *S* ceases to provide any group health plan to any employee, no group health plan of *P1* has any obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. If *P2* is a successor employer under the rules of paragraph (c) of this Q&A-8 and maintains one or more group health plans after the sale, then a group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P2* by *S* (but in such a case employees of *S* before the sale who continued working for *P2* after the sale would not be M&A qualified beneficiaries). However, even in such a case, no group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. Thus, under these facts, after *S* has ceased to provide any group health plan to any employee, no plan has an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1*.

Example 8. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*. *P* hires most of *S*'s employees on the date of the purchase of *S*'s assets, retains those employees in the same positions that they had with *S* before the purchase, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. *S* continues to employ a few employees for the principal purpose of winding up the affairs of *S* in preparation for liquidation. *S* continues to provide coverage under a group health plan to these few remaining employees for several weeks after the date of the sale and then ceases to provide any group health plan to any employee.

(ii) Under these facts, the cessation by *S* to provide any group health plan to any employee is in connection with the asset sale to *P*. Because of this, and because *P* continued the business operations as-

sociated with those assets without substantial change or interruption, *P* is a successor employer to *S* with respect to the asset sale. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale beginning on the date that *S* ceases to provide any group health plan to any employee. (A group health plan of *S* retains this obligation for the several weeks after the date of the sale until *S* ceases to provide any group health plan to any employee.)

Q-9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

A-9: The cessation of contributions by an employer to a multiemployer group health plan is not itself a qualifying event, even though the cessation of contributions may cause current employees (and their spouses and dependent children) to lose coverage under the multiemployer plan. An event coinciding with the employer's cessation of contributions (such as a reduction of hours of employment in the case of striking employees) will constitute a qualifying event if it otherwise satisfies the requirements of Q&A-1 of §54.4980B-4.

Q-10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

A-10: (a) In general, yes. (See Q&A-3 of §54.4980B-2 for a definition of *multiemployer* plan.) If, however, the employer that stops contributing to the multiemployer plan establishes one or more group health plans (or starts contributing to another multiemployer plan that is a group health plan) covering a significant number of the employer's employees formerly covered under the multiemployer plan, the plan established by the employer (or the other multiemployer plan) has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee

whose last employment prior to the qualifying event was with the employer.

(b) The rules of Q&A-9 of this section and this Q&A-10 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Example 1. (i) Employer *Z* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Z* has been making contributions to *M*. *Z* experiences financial difficulties and stops making contributions to *M* but continues to employ all of the employees covered by the collective bargaining agreement. *Z*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Z* does not establish any group health plan covering any of the employees covered by the collective bargaining agreement.

(ii) After *Z* stops contributing to *M*, *M* continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Z*. The loss of coverage under *M* for those employees of *Z* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 2. (i) Employer *Y* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Y* has been making contributions to *M*. *Y* experiences financial difficulties and is forced into bankruptcy by its creditors. *Y* continues to employ all of the employees covered by the collective bargaining agreement. *Y* also continues to make contributions to *M* until the current collective bargaining agreement expires, on June 30, 2001, and then *Y* stops making contributions to *M*. *Y*'s employees (and their spouses and dependent children) lose coverage under *M* effective July 1, 2001. *Y* does not enter into another collective bargaining agreement covering the class of employees covered by the expired collective bargaining agreement. Effective September 1, 2001, *Y* establishes a group health plan covering the class of employees formerly covered by the collective bargaining agreement. The group health plan also covers their spouses and dependent children.

(ii) Under these facts, *M* has the obligation to make COBRA continuation coverage available from July 1, 2001 until August 31, 2001, and the group health plan established by *Y* has the obligation to make COBRA continuation coverage available from September 1, 2001 until the obligation ends (see Q&A-1 of §54.4980B-7) to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Y*. The loss of coverage under *M* for those employees of *Y* who continue in em-

ployment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 3. (i) Employer *X* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *X* has been making contributions to *M*. The employees covered by the collective bargaining agreement vote to decertify their current employee representative effective January 1, 2002 and vote to certify a new employee representative effective the same date. As a consequence, on January 1, 2002 they cease to be covered under *M* and commence to be covered under multiemployer group health plan *N*.

(ii) Effective January 1, 2002, *N* has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *X*. The loss of coverage under *M* for those employees of *X* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

§54.4980B-10 Interaction of FMLA and COBRA.

The following questions-and-answers address how the taking of leave under the Family and Medical Leave Act of 1993 (FMLA) (29 U.S.C. 2601-2619) affects the COBRA continuation coverage requirements:

Q-1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

A-1: (a) The taking of leave under FMLA does not constitute a qualifying event. A qualifying event under Q&A-1 of §54.4980B-4 occurs, however, if -

(1) An employee (or the spouse or a dependent child of the employee) is covered on the day before the first day of FMLA leave (or becomes covered during the FMLA leave) under a group health plan of the employee's employer;

(2) The employee does not return to employment with the employer at the end of the FMLA leave; and

(3) The employee (or the spouse or a dependent child of the employee) would, in the absence of COBRA continuation coverage, lose coverage under the group health plan before the end of the maximum coverage period.

(b) However, the satisfaction of the three conditions in paragraph (a) of this Q&A-1 does not constitute a qualifying

event if the employer eliminates, on or before the last day of the employee's FMLA leave, coverage under a group health plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken FMLA leave.

Q-2: If a qualifying event described in Q&A-1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

A-2: A qualifying event described in Q&A-1 of this section occurs on the last day of FMLA leave. The maximum coverage period (see Q&A-4 of §54.4980B-7) is measured from the date of the qualifying event (that is, the last day of FMLA leave). If, however, coverage under the group health plan is lost at a later date and the plan provides for the extension of the required periods (see paragraph (b) of Q&A-4 of §54.4980B-7), then the maximum coverage period is measured from the date when coverage is lost. The rules of this Q&A-2 are illustrated by the following examples:

Example 1. (i) Employee *B* is covered under the group health plan of Employer *X* on January 31, 2001. *B* takes FMLA leave beginning February 1, 2001. *B*'s last day of FMLA leave is 12 weeks later, on April 25, 2001, and *B* does not return to work with *X* at the end of the FMLA leave. If *B* does not elect COBRA continuation coverage, *B* will not be covered under the group health plan of *X* as of April 26, 2001.

(ii) *B* experiences a qualifying event on April 25, 2001, and the maximum coverage period is measured from that date. (This is the case even if, for part or all of the FMLA leave, *B* fails to pay the employee portion of premiums for coverage under the group health plan of *X* and is not covered under *X*'s plan. See Q&A-3 of this section.)

Example 2. (i) Employee *C* and *C*'s spouse are covered under the group health plan of Employer *Y* on August 15, 2001. *C* takes FMLA leave beginning August 16, 2001. *C* informs *Y* less than 12 weeks later, on September 28, 2001, that *C* will not be returning to work. Under the FMLA regulations, 29 CFR Part 825 (§§825.100-825.800), *C*'s last day of FMLA leave is September 28, 2001. *C* does not return to work with *Y* at the end of the FMLA leave. If *C* and *C*'s spouse do not elect COBRA continuation coverage, they will not be covered under the group health plan of *Y* as of September 29, 2001.

(ii) *C* and *C*'s spouse experience a qualifying event on September 28, 2001, and the maximum coverage period (generally 18 months) is measured from that date. (This is the case even if, for part or all of the FMLA leave, *C* fails to pay the employee portion of premiums for coverage under the group health plan of *Y* and *C* or *C*'s spouse is not covered under *Y*'s plan. See Q&A-3 of this section.)

Q-3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

A-3: No. Any lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a set of circumstances constitutes a qualifying event under Q&A-1 of this section or when such a qualifying event occurs under Q&A-2 of this section.

Q-4: Is the application of the rules in Q&A-1 through Q&A-3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

A-4: No. Any state or local law that requires coverage under a group health plan to be maintained during a leave of absence for a period longer than that required under FMLA (for example, for 16 weeks of leave rather than for the 12 weeks required under FMLA) is disregarded for purposes of determining when a qualifying event occurs under Q&A-1 through Q&A-3 of this section.

Q-5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

A-5: No. The U.S. Department of Labor has published rules describing the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, under a group health plan during FMLA leave from an employee who fails to return from leave. See 29 CFR 825.213. Even if recovery of premiums is permitted under 29 CFR 825.213, the right to COBRA continuation coverage cannot be conditioned upon the employee's reimbursement of the employer for premiums the employer paid to maintain coverage under a group health plan during FMLA leave.

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Deputy Commissioner of
Internal Revenue.

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