ROBINSON & COLE LLP
Employee Benefits & Compensation

Final COBRA Regulations Provide Guidance on Notice Obligations

The Department of Labor has issed final regulations that provide detailed guidance relating to COBRA's notice requirements. Group health plans must be administered in accordance with these regulations starting with the first plan year beginning after November, 2004. For calendar year group health plans, this will be January 1, 2005.

Initial or General Notice Requirement

Group health plans are required to provide employees and covered spouses with an initial notice that describes COBRA continuation rights. Under the final regulations, this notice must be provided to each employee and to the employee's spouse (if the spouse participates in the plan) within 90 days of the date coverage under the plan begins. Previously, this information did not have to be provided within a set time period.

A model notice is provided in the final regulations and is different from the model notice the DOL provided in the proposed regulations and from the model notice released by the DOL in 1986. If an employer elects not to use the model notice, the notice must contain the following information:

• Name of the plan and COBRA administrator and the contact information for the COBRA administrator.
• A general description of continuation coverage under the plan, including descriptions of beneficiaries, qualifying events, notice obligations, maximum coverage periods, extensions of coverage, and requirements for premium payments.
• The plan's requirements and procedures for a qualified beneficiary to provide notice of divorce, separation, loss of dependent status under the plan, or a determination of disability.
• An explanation of the importance of keeping the plan notified of any address changes.
• A statement that the notice does not fully describe continuation coverage and that more information is available from the plan administrator and in the Summary Plan Description (SPD).

The initial notice obligation may be fulfilled by including the required information in the group health plan's SPD, provided that the SPD is distributed within the 90 day period required by COBRA, and as long as the SPD is distributed to spouse participants as well as employees. A single notice addressed to the employee and the employee's spouse can be sent to their joint residence; however, in-hand delivery to the employee is not sufficient notice for a spouse. If a spouse commences coverage at a different time than the employee, a separate notice must be provided to the spouse. A separate notice is not required for dependent children living with the employee or spouse.

Employer Notice Obligation

Similar to the current rules, employers are required to provide notice to the plan administrator of an employee's death, termination of employment, reduction in hours of employment, the employee's becoming entitled to Medicare, or the commencement of a bankruptcy proceeding. Under the regulations, the employer must provide this notice within 30 days of the qualifying event, or if the plan provides that COBRA commences on the date of loss of coverage, within 30 days of the date on which the qualified beneficiary loses coverage due to the qualifying event. The Notice must identify the plan, the employee, the qualifying event, and the date of the qualifying event.

Employee and Qualified Beneficiary Notice Obligation

Covered employees and qualified beneficiaries are responsible for notifying the plan administrator of a divorce or legal separation of the employee and his or her spouse, a covered child losing dependent status under the plan, a determination of disability by the Social Security Administration, or the occurrence of a second qualifying event. The final regulations require plans to establish reasonable procedures for furnishing notices. In order to be considered to be "reasonable", a plan's notification procedures must be described in the SPD, specify who is designated to receive notices, specify the means that must be used for giving notices, and describe the required content of the notice.

A plan may require qualified beneficiaries to provide the required information on a specific form, provided that the form is readily available to qualified beneficiaries at no cost. If a plan does not maintain procedures that comply with these requirements, notice will be deemed to have been provided when a written or oral communication identifying a specific event is communicated in a manner reasonably calculated to bring the information to the attention of parties that would customarily be considered to be responsible for the plan. Since establishing and maintaining reasonable procedures is an easy task for employers, employers should be diligent in maintaining reasonable procedures.

Under COBRA, qualified beneficiaries have 60 days after the occurrence of a qualifying event or loss of coverage to provide notice of the qualifying event to the employer. In the case of a Social Security disability determination, a qualified beneficiary must provide notice of the disability within 60 days of the latest of: the date of the Social Security disability determination; the date on which the qualifying event occurs; the date on which the qualified beneficiary loses coverage; or the date on which the qualified beneficiary is told of the obligation to provide the disability notice.

Although plans may establish reasonable requirements with respect to the contents of a notice, plans must accept an incomplete notice that is provided within the 60 day time frame, if it contains information that allows the administrator to identify the applicable plan, the covered employee and qualified beneficiaries, the qualifying event, and the date on which the event occurred. In the event that a notice is timely provided, but does not provide the requisite information, the plan administrator can require qualified beneficiaries to supply the missing information.

Plan Administrator Notice Obligation

Similar to current rules, within 14 days after the plan administrator is notified of a qualifying event, the administrator must provide each qualified beneficiary with a notice of COBRA rights. The final regulations clarify that when an employer is also the plan administrator, the notice must be provided within 44 days after the date of the qualifying event, or if the plan provides that COBRA coverage commences on the date of loss of coverage, the date the qualified beneficiary loses coverage under the plan.

Election Notice

The final regulations provide a new model election form (revised from the proposed regulations) that can be sent to qualified beneficiaries by group health plans sponsored by a single employer. When there is a qualifying event, an employer may elect not to use the model election form and use its own form, which must contain the following information:

- The name of the plan and the contact information for the COBRA administrator.
- An explanation of the maximum period of coverage available, if elected.
- The election procedures and election period.
- A description of the consequences of failing to elect or waiving COBRA coverage, including a description of the HIPAA portability and special enrollment rules.
- A description of the circumstances under which the COBRA coverage period may be extended and the qualified beneficiary's duty to provide notice of a second qualifying event.
- The cost of COBRA coverage and the procedures for payment of premiums.
- A statement that a full description of COBRA rights is available from the plan administrator or in the SPD.
- Identification of the qualifying event and the qualified beneficiaries who are affected by the qualifying event and the date on which coverage will terminate.
- A statement that each qualified beneficiary has an independent right to elect COBRA coverage and that a spouse or the covered employee may elect COBRA on behalf of all other qualified beneficiaries.
- Description of the COBRA coverage and when it will be made available.
- A statement that it is important to keep the plan administrator informed of the current addresses of all qualified beneficiaries.

The regulations eliminated the requirement set forth in the proposed regulations requiring information relating to alternative coverage and conversion rights to be included in the election notice.

New Notice Requirements

The final regulations establish two new notice requirements. The first requires a plan administrator that receives notice of a qualifying event from a participant or beneficiary to provide notice to the participant or beneficiary if it is determined that COBRA coverage is not available. This "Notice of Unavailability of COBRA Coverage" must explain the reason why COBRA coverage is not available. This notice must be provided within 14 days after the receipt of the notice from the individual.

The regulations also establish a new requirement for plan administrators to provide qualified

beneficiaries with notice in the event that COBRA coverage is terminated early. Such Early Termination Notice would be used in cases where the qualified beneficiary has not timely made premium payments or when an employer is discontinuing group health coverage.

A Notice of Early Termination must set forth:

• The reason for termination of coverage.
• The date coverage will be terminated.
• Any description of any rights a qualified beneficiary may have under the plan or applicable law to elect an alternative policy, such as a conversion right.

This notice obligation can be fulfilled through delivery of a single notice to multiple beneficiaries who are part of a single family. This notice must be provided as soon as practicable after the determination is made to terminate coverage.

Compliance

In order to comply, plan sponsors should update their existing notices. Additionally, employers must create an Early Termination Notice and a Notice of Unavailability of COBRA Coverage. The SPD should also be reviewed and updated, if necessary, to satisfy the requirement to maintain reasonable procedures.

United States Supreme Court Finds ERISA Preempts State Law Regarding Health Care Decisions

The United States Supreme Court has issued its much anticipated decision in the case of Aetna Aetna Health, Inc. v. Davila. In this case, two participants, an employee and a beneficiary, who participated in employer sponsored group health plans sued the HMOs under which they were covered. They claimed that they had suffered injuries as a result of their failure to obtain treatment and services recommended by their physicians after their HMOs denied coverage for the requested treatments. The participants sued the HMOs in state court under a Texas law that required the exercise of ordinary care in the handling of health care decisions. The participants argued that the HMOs violated that law by refusing to cover the prescribed treatment and services. A unanimous Court found that the state law claims of the health plan participants against the HMOs were preempted by ERISA.

In its decision, the Court noted that the purpose of ERISA is "to provide a uniform regulatory regime over employee benefit plans [and] to this end, ERISA includes expansive preemption provisions". The Court concluded that if a state law claim duplicates or supplements a claim that could be brought under ERISA, the state law claim is preempted by ERISA. If a defendant does not have a legal obligation apart from ERISA, a claim will be preempted if it could have been brought under ERISA. The Court rejected the assertion that the duty to exercise ordinary care that is imposed under the Texas law is independent of an ERISA plan. The Court also rejected the assertion that these claims should not preempted by ERISA since they were tort claims, not contract claims, and found that the participant's claims were, in essence, claims to remedy the denial of benefits under an ERISA plan. Because a claim based on the denial of benefits may be brought under ERISA, the Court found that the Texas law provided a claim mirroring one already

available under ERISA, and was therefore preempted.

The Court also rejected the participants' argument that the HMO's coverage decisions were mixed eligibility and treatment decisions. In an earlier case, the Court had ruled that mixed decisions were not fiduciary in nature and are therefore not governed by ERISA. The Court found that the HMO's decisions in this case were pure eligibility decisions and were therefore fiduciary decisions subject to ERISA. Finally, the Court rejected the argument that the Texas law was an insurance law, and thus exempt from ERISA preemption. Certain state laws governing banking and insurance are generally exempt from preemption. However, the Court held that a state law regulating insurance may be preempted if it provides a separate avenue for ERISA plan participants to make claims for benefits outside of or in addition to those avenues set forth by ERISA.

Retaining ERISA preemption allows plan sponsors much needed protection in plan administration and plan sponsors can breathe a sigh of relief that the Court did not take this opportunity to chip away at ERISA preemption. Participants will not be able to rely on decisions of lower courts that are contrary to this ruling.

ERISA's Anti-Cutback Rule Prevent Plans from Attaching New Conditions to Accrued Benefits

ERISA's anti-cutback rule prohibits a plan sponsor from adopting any amendment to a qualified retirement plan that would result in the reduction of a participant's accrued benefit. In the case of Central Laborers' Pension Fund v. Heinz, the United States Supreme Court ruled that an amendment that expands the categories of post-retirement employment that result in a suspension of payments of accrued early retirement benefits is prohibited by the anti-cutback rule.

In this case, certain employees, including Heinz, accrued enough pension credits to satisfy the plan's requirements for an unreduced early retirement benefit and had elected to retire and begin receiving benefit payments. At the time of Mr. Heinz's retirement, the plan provided that benefit payments would be suspended if a participant worked in "disqualifying employment", which was then defined as any job as a union or nonunion construction worker. Employment in a supervisory capacity was not considered to be disqualifying employment. After his retirement, Mr. Heinz became employed as a construction supervisor. He continued to receive benefit payments from the Central Laborers' Pension Fund. Later, the retirement plan was amended to expand the definition of "disqualifying employment" to include any job in any capacity in the construction industry (either as a union or nonunion construction worker). As a result of this amendment, Mr. Heinz's benefit payments were suspended due to his employment as a construction supervisor. Mr. Heinz sued to recover the suspended benefits, alleging that the plan had violated ERISA's anti-cutback rule.

A unanimous Supreme Court found that the anti-cutback rule protects the suspension of benefit payments and agreed with Mr. Heinz that a qualified plan cannot impose a new condition on a participant's right to benefits that have already accrued. The Supreme Court stated that new conditions can be attached to benefits only if the conditions apply to benefits

that are associated with future employment.

Legislation Affecting Executive Compensation is Expected to Pass

Both the Senate and the House have passed similar legislation containing provisions relating to nonqualified deferred compensation, including a rule providing that income tax will be imposed currently on deferred compensation unless certain requirements are satisfied. Although there are some differences in the bills, these differences are expected to be resolved. The bills include changes impacting deferrals, distribution elections, funding, and investments. It is likely that this legislation will be enacted in the next few months and, at the latest, would apply to 2005 deferrals.

IRS Withdraws Cash Balance Plan Regulations

The IRS has withdrawn proposed regulations that provided guidance on how cash balance plans could be designed in order to satisfy age discrimination requirements. The IRS had previously withdrawn a portion of these proposed regulations. The IRS announced that it would not issue new guidance for cash balance plans until Congress addresses cash balance plan issues. The IRS also announced that the moratorium on determination letters for cash balance plans would continue while cash balance plan issues are under consideration by Congress.