



Employee Benefits Bulletin

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Time to Take Notice of Proposed COBRA Notice Regulations

Almost eighteen years after Congress enacted COBRA, the Department of Labor has finally gotten around to the task of proposing regulations on COBRA's notice requirements. This is not to say that the Department of Labor sat on its hands since COBRA's enactment: in 1985, the Department of Labor published a technical release (ERISA Technical Release 86-2), which provided initial COBRA guidance and included a model notice to be provided to each individual covered by a health care plan subject to COBRA. (Congress has amended COBRA several times since 1985, however, and the preamble to the proposed regulations indicates that continued use of the 1986 model notice now violates the statute.)

This article explores the proposed regulations on COBRA notice. The article has four sections: first, a brief history and overview of COBRA; second, a description of the proposed COBRA notice requirements; third, some predictions on when the proposed notice requirements will become final; and fourth, some thoughts on what plan sponsors should do in the interim. (The preamble to the proposed regulations indicates that some plan sponsors should take action in advance of the effective date of the final regulations.)

1. COBRA and Its History

Despite the puns about snakebite that are obligatory in every article on COBRA, the name is derived from the initials of the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA is a subtitle of ERISA, with parallel provisions in the Internal Revenue Code. Back in 1985, some commentators predicted that COBRA-related expenses would fatally poison employer-sponsored health care plans; even today, no doubt, venomous serpents are vivid in the minds of many plan administrators as they tangle warily with COBRA continuation provisions.

COBRA gives certain individuals covered under certain group health plans certain rights to continue health care coverage for limited periods of time. The rights are triggered by what the statute refers to as "qualifying events." Individuals with COBRA rights (referred to as "qualified individuals") include the employee, the employee's spouse and eligible dependents. Qualifying events include loss of health coverage due to separation from service, a reduction in hours, death, divorce or separation, and losing status as a dependent under the health care plan. Generally speaking, a qualified individual must make a COBRA election within 60 days of a qualifying event. A qualified individual who elects COBRA coverage is required to pay a premium equal to 102% of the cost paid by an active employee and the employer for coverage under the plan.

The statutory scheme depends on qualifying individuals being aware that a qualifying

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event has triggered their right to health care continuation coverage. To do this, the statute and regulations create a series of interlocking notice requirements. The notice requirements reflect two concerns: first, that the plan give qualified individuals notice of their rights at various relevant times; and second, that the employer and eligible individuals give the plan administrator notice of information it needs to provide such notices in a timely and accurate manner. For example, the statute requires a health care plan to notify an eligible individual when a qualifying event occurs. But to do this, someone has to notify the plan's administrator that a qualifying event has occurred. This latter someone might be the employer, the employee, or in some cases the employee's spouse. (In many cases, of course, the employer is the plan administrator.) In addition, qualifying individuals have to provide notice that they are electing COBRA continuation coverage.

The Department of Labor and the Department of Treasury share regulatory jurisdiction over COBRA: the Department of Treasury has primary regulatory jurisdiction over COBRA's substantive provisions—who is a qualified individual, what is a qualifying event, etc. The Department of Labor has primary regulatory jurisdiction over the COBRA notice and disclosure requirements, including when notices must be given and what information notices must include. As noted, this article is in response to the Department of Labor's proposed regulations on COBRA notices.

2. COBRA Notices Under Proposed Regulations

The proposed regulations impose notice requirements on (1) the plan administrator to provide various notices to employees and other qualified individuals (including two newly minted notice requirements); (2) the employer to notify the plan administrator of certain events; and (3) employees and other qualified individuals to notify the plan administrator of certain events and of elections to continue health care coverage.

The proposed regulations provide more specificity than previous guidance about notice content, notice timing, and notice delivery. Although the new clarity about notice will clarify some questions, the new clarity comes at a cost: somewhat more burdensome requirements, particularly for plan administrators.

Plan Administrator Notices

The proposed regulations require plan administrators to provide four different types of notices, two of which are familiar and two of which are new. The familiar notices are the initial notice to eligible individuals of COBRA rights (given on initial

enrollment in a plan subject to COBRA) and the election notice. The proposed regulations would also require plan administrators to provide notice when COBRA coverage terminates and when COBRA coverage becomes unavailable.

i. General COBRA Notice

COBRA requires that a covered health care plan must notify employees and their spouses of COBRA and their rights and responsibilities thereunder. The proposed regulations provide that this general, or initial, notice be given within 90 days after plan coverage begins. The notice may be included in the plan's summary plan description, which must also be delivered to plan participants within 90 days.



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The initial notice must go not only to the employee, but also the employee's spouse. The proposed regulations would permit a plan to combine the employee and spousal notices, but to do so the notice must be sent to the residence of the employee and the employee's spouse. (If the plan had information indicating that the spouse had a separate residence from the employee, notice must be sent separately to the spouse.) Note that if the notice were provided through the summary plan description, the description would have to be sent to a residence shared by the employee and the employee's spouse. For many plans, this would be a departure from the usual method of distributing summary plan descriptions at the workplace.

The proposed regulations include a model general notice, which can be incorporated into the summary plan description or a separate notice. (The notice permits incorporation of certain plan-specific details—in other words, the notice must be tailored to the particular plan.) It is possible that the final regulations may modify somewhat the language of the model notice. (As we will discuss later in the article, plans should consider using the model notice until final regulations become effective.)

An interesting aspect of the proposed regulations deals with the Trade Act of 2002, which provides a second election period for former employees who become eligible for assistance under that Act. The preamble to the proposed regulations indicates that a description of this second election period should be included in the portion of the summary plan description discussing health continuation rights.

ii. COBRA Election Notice

The plan administrator must provide each covered employee and/or qualified beneficiary of their right to elect COBRA continuation within 14 days of being notified of a qual-

ifying event (by the employer, covered employee, or qualified beneficiary), or within 44 days if the employer is the plan administrator.

The proposed regulations require that the notices include certain specific information, including information on the effects of not electing continuation coverage. Again, the proposed regulations include a model election notice.

The plan administrator may provide a single notice to members of a family if the members reside at a common address.

iii. Notice of Non-Entitlement

The proposed regulations would add a new requirement: a plan administrator who received a notice of a qualifying event concerning a person not eligible for COBRA continuation coverage would have to provide a notice of non-entitlement to the ineligible person. Although this would be a new explicit requirement, many plan administrators have already been providing such notices as a matter of course. The notice must give the reasons that the individual is not eligible for continuation coverage; the timing requirements are generally the same as for the COBRA election notice.

iv. Notice of Early Termination

The proposed regulations add a further new requirement: a plan administrator must furnish as “soon as practicable” a notice if an individual’s COBRA coverage will be terminated before the conclusion of the individual’s maximum continuation period. Such notice might be required, for example, if an employee fails to pay premiums within the required time frame or if the employer ceases to sponsor group health plans.

Employer Notices of Qualifying Events

The employer is the entity that is most likely to become aware of certain qualifying events, namely termination of employment, reduction in work hours resulting in loss of coverage, death of the employee, or the employee’s becoming enrolled in Medicare, or commencement of bankruptcy proceedings against the employer. The employer is generally given 30 days to notify the plan administrator of such qualifying events. This requirement does not, of course, have application to an employer that is also the plan administrator.

Employee and Qualified Beneficiary Notice Obligations

Covered employees and qualified beneficiaries are required to inform the plan administrator within 60 days of certain qualifying events, namely divorce or separation, or events

resulting in a dependent’s loss of coverage (for example, obtaining the age in the plan under which dependent coverage ceases or ceasing to be a full-time student if the plan requires such status of dependents over a certain age). The proposed regulations require a plan to set up a reasonable procedure for covered employees and qualified beneficiaries to give such notice. Under the regulations, a procedure would generally be considered reasonable if it is described in the plan’s summary plan description and indicates to whom notice can be given and describes the content of such notice. Employees and beneficiaries must have at least 60 days to provide such notice; moreover, the plan administrator cannot reject notices for being incomplete if they provide sufficient information for the administrator to identify the plan, the covered employee, the qualified beneficiaries, the qualifying event and the day it occurred (although the administrator may then ask for more complete information).



The proposed regulations add a further new requirement: a plan administrator must furnish as “soon as practicable” a notice if an individual’s COBRA coverage will be terminated before the conclusion of the individual’s maximum continuation period.

The proposed regulations also prescribe procedures for qualified beneficiaries to provide notices of a Social Security disability determination, which can extend the COBRA continuation period.

3. Predicted Effective Date

The DOL initially indicated that the proposed regulations would become final as of the first day of the first plan year occurring on or after January 1, 2004. Subsequent to the publication of the proposed regulations, the Department of Labor indicated that it would delay the effective date until six months after the final regulations are published in the Federal Register. We think it probable that the regulations will be published early next year.

4. What to do in the Interim.

Sponsors of health care plans should consider making changes in response to the regulation, even though the final regulations are still months away from being issued.

First, as we have noted, the preamble to the proposed regulations indicates that the summary plan description for a group health plan should include information about the effects of the Trade Act of 2002 on COBRA continuation rights. Second, the preamble

indicates that the notice provided in ERISA Technical Release 86-2 no longer shows good faith compliance with the statutory requirements. Thus, plans that have continued to use this notice should begin using the new model notices. Moreover, since using the new model notices—both the initial notice and the participant election notice—will show good-faith compliance with the statute, it generally will be prudent for plan sponsors to use the new model notices and to begin the process of adapting plan procedures to reflect the provisions of the proposed regulations.

A Spoonful of Regulatory Sugar to Help the Medicine Go Down: Rev. Rul. 2003-102 Permits Health Care Plans to Reimburse Costs of Non-Prescription Drugs

The IRS reversed long-standing (although unwritten) policy in a September revenue ruling (Revenue Ruling 2003-102), which held that employer health care plans may now reimburse an employee's expenditure for over-the-counter drugs to alleviate or treat personal injuries or sickness.

The facts on which the ruling is based are these: an employee who had a health flexible spending account ("FSA") purchased over-the-counter allergy and cold medicine, pain relievers and antacids. The ruling held that the FSA could reimburse the employee for these expenses because they were purchased to alleviate or treat personal injuries or sickness.

The ruling, however, also held that the FSA could not reimburse the employee (on a before-tax basis) the cost of an over-the-counter nutritional supplement that the employee purchased to maintain her general health (and not to treat or alleviate a particular illness or injury). (But under the reasoning of the revenue ruling, a nutritional supplement might be reimbursable in some cases: for example, when a pregnant woman purchases a folic acid supplement on her doctor's recommendation).

Although the ruling's facts involved an FSA, the ruling's holding is based on an interpretation of Internal Revenue Code § 105(b), which applies to employer-sponsored health care plans generally. Thus, the ruling applies not only to FSAs, but also to other health care plans.

The ruling is an unusual statement for the IRS: it is an aggressive, result-oriented, albeit pro-taxpayer, interpretation of section 105(b) and section 213 of the Internal Revenue Code. Section 105(b) excludes from employee income health-care reimbursements for expenditures for health care that fit the description of a medical expense under section 213.

Section 213 (although broadly authorizing deductions for medical expenses that alleviate or treat personal injury or sickness) imposes a bright-line condition for deduction of the cost of medicine: only prescription drug expenses are deductible. In the revenue ruling, however, the IRS says that this limitation on deductibility does not apply to reimbursements of over-the-counter medicines by employer-sponsored health care plans (it applies only to an individual's deduction of expenses paid by the individual and not reimbursed by an employer-sponsored health care plan).

The relevant provisions of Sections 105(b) and 213 have been in place for 50 years and until the revenue ruling no one supposed that the prescription drug requirement did not apply equally to both sections. So the question is, why did the IRS change the rules now? An IRS press release explained that the ruling is a "sensible expansion" of the law to the reality that "many prescription drugs have moved to the over-the-counter market."

The revenue ruling expands employer flexibility in designing plans, but does not require plans to cover over-the-counter medicines. So the big question is whether plan sponsors should amend their plans to provide for coverage of non-prescription medications? What are the considerations?



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Employees would certainly appreciate such an expansion of coverage, especially employees who have seen the FDA recently shift certain popular medicines from prescription-only to over-the-counter status. The other side of the story is that for plans (other than FSAs) coverage of over-the-counter drugs will generally increase their total health-care expenditures. Moreover, all plans—including FSAs—would have to establish administrative procedures to ensure that over-the-counter drugs are in fact being used to treat an illness or injury (for example, a doctor's recommendation that an employee take an over-the-counter medication)—if the purpose of the drug's purchase is simply to maintain general health, the costs of the drug could not be excluded from the employee's income.

The question of how much over-the-counter drug coverage would actually cost a particular plan should be answered only after study of current utilization by employees of the plan's prescription drug coverage. It is possible that in some cases physicians may be prescribing drugs when less expensive over-the-counter medications are also available to save their patients the expense of purchasing an over-the-counter drug. Moreover, the cost of many if not most non-prescription drugs may be less than a plan's deductible, which means that coverage of over-the-counter drugs might not be an unusually expensive addition for some plans. But a dollar of health care expense always costs the plan a dollar and in this time of rapidly escalating health care costs, even small increases in coverage need to be carefully considered.

Temporary Shelter Against a GUSTY Wind: Revenue Procedure 2003-72 Extends Deadline for GUST Amendments for Certain Plans

The IRS has issued Revenue Procedure 2003-72, which extends the GUST amendment period for “pre-approved plans, i.e., master and prototype and volume submitter plans, until January 31, 2004 (with the payment of a \$250 fee). In addition, the sponsor of a non-standardized prototype plan that is amended by the plan’s GUST amendment remedial period (for most such plans, by September 30, 2003) can delay filings a determination letter application for the plan until January 31, 2004, without payment of an extra fee. Finally, the revenue procedure provides that the deadline for defined contribution plans to comply with the required-minimum distribution regulations is extended to the later of the GUST amendment period or the end of the 2003 plan year.

(Note: an earlier revenue procedure postponed indefinitely the period that pre-approved defined benefit plans have to comply with the RMD regulations and extended the period for other defined benefit plans until the end of the EGTRRA remedial amendment period.)

IRA Beneficiaries Have Until December 31st to Change From Five-Year to Life Expectancy Period for Distributions

The final regulations on the required-minimum-distribution rules (under IRC § 401(a)(9)) allow certain beneficiaries of deceased IRA owners to move from a five-year maximum distribution period (the inherited IRA must distribute all of its assets by the end of the five year period ending on December 31 of the

year following the year of the death of the original IRA owner) to a life expectancy distribution period. A change to a life-expectancy distribution period will generally result in a longer distribution period, which can have significant tax benefits. For a beneficiary to make this election, three conditions must be met: 1) the IRAs agreement must be amended to allow the election; 2) the IRA must make up the difference between actual distributions already made over the five year period and the distributions that would have been required had a life-expectancy period been used from the time of death; and 3) there must not be instructions from the original IRA owner that prevents the beneficiary from altering the distribution election.

The election must be made by December 31, 2003; moreover, all make-up distributions must be made by this date.

Let Us Relish the Catch-Up Contribution Final Regulations

The IRS adopted final regulations on catch-up contributions to 401(k) plans and other plans permitting elective contributions. The regulations become effective January 1, 2004, with a good-faith compliance standard applicable for earlier years.

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We will try to address your question or topic in a future newsletter.

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