§ 54.4980B–2 Plans that must comply.

The following questions-and-answers apply in determining which plans must comply with the COBRA continuation coverage requirements:

Q–1: For purposes of section 4980B, what is a group health plan?

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.

(b) For purposes of §§ 54.4980B–1 through 54.4980B–10, *health care* has the same meaning as *medical care* under section 213(d). Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer or employee organization maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides health care and so is not a group health plan. For example, if an employer maintains a spa, swimming pool, gymnasium, or other exercise/fitness program or facility that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility does not constitute a program that provides health care and thus is not a group health plan. In contrast, if an employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem, the facility or program is considered to be the provision of health care and so is considered a group health plan.

(c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132 (relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health

care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.

(d) The provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if—

(1) The health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;

(2) The health care is available only to current employees; and

(3) Employees are not charged for the use of the facility.

(e) A plan does not constitute a group health plan subject to COBRA if substantially all of the coverage provided under the plan is for qualified long-term care services (as defined in section 7702B(c)). For this purpose, a plan is permitted to use any reasonable method in determining whether substantially all of the coverage provided under the plan is for qualified long-term care services.

(f) Under section 106(b)(5), amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan subject to COBRA. Thus, a plan is not required to make COBRA continuation coverage available with respect to amounts contributed by an employer to a medical savings account. A high deductible health plan does not fail to be a group health plan subject to COBRA merely because it covers a medical savings account holder.

Q–2: For purposes of section 4980B, what is the employer?

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 collective 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.

Q–4: What group health plans are subject to COBRA?

A–4: (a) All group health plans are subject to COBRA except group health plans described in paragraph (b) of this Q&A–4. Group health plans described in paragraph (b) of this Q&A–4 are referred to in §§ 54.4980B–1 through 54.4980B–10 as excepted from COBRA.

(b) The following group health plans are excepted from COBRA—

(1) Small-employer plans (see Q&A–5 of this section);

(2) Church plans (within the meaning of section 414(e)); and

(3) Governmental plans (within the meaning of section 414(d)).

(c) The COBRA continuation coverage requirements generally do not apply to group health plans that are

excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when the plan is not a small-employer plan (see paragraph (g) of Q&A–5 of this section).

(d) Although governmental plans are not subject to the COBRA continuation coverage requirements, group health plans maintained by state or local governments are generally subject to parallel continuation coverage requirements that were added by section 10003 of COBRA to the Public Health Service Act (42 U.S.C. 300bb–1 through 300bb–8), which is administered by the U.S. Department of Health and Human Services. Federal employees and their family members covered under the Federal Employees Health Benefit Program are covered by generally similar, but not parallel, temporary continuation of coverage provisions enacted by the Federal Employees Health Benefits Amendments Act of 1988. See 5 U.S.C. 8905a.

Q–5: What is a small-employer plan?

A–5: (a) Except in the case of a multiemployer plan, a *small-employer plan* is a group health plan maintained by an employer (within the meaning of Q&A–2 of this section) that normally employed fewer than 20 employees (within the meaning of paragraph (c) of this Q&A–5) during the preceding calendar year. In the case of a multiemployer plan, a *small-employer plan* is a group health plan under which each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. See Q&A–6 of this section for rules to determine the number of plans that an employer or employee organization maintains. The rules of this paragraph (a) are illustrated in the following example:

Example. (i) Corporation *S* employs 12 employees, all of whom work and reside in the United States. *S* maintains a group health plan for its employees and their families. *S* is a wholly-owned subsidiary of *P*. In the previous calendar year, the controlled group of corporations including *P* and *S* employed more than 19 employees, although the only employees in the United States of the controlled group that includes *P* and *S* are the 12 employees of *S*.

(ii) Under §1.414(b)-1 of this chapter, foreign corporations are not excluded from membership in a controlled group of corporations. Consequently, the group health plan maintained by *S* is not a small-employer plan during the current calendar year because the controlled group including *S* normally employed at least 20 employees in the preceding calendar year.

(b) An employer is considered to have normally employed fewer than 20 employees during a particular calendar year if, and only if, it had fewer than 20 employees on at least 50 percent of its typical business days during that year.

(c) All full-time and part-time common law employees of an employer are taken into account in determining whether an employer had fewer than 20 employees; however, an individual who is not a common law employee of the employer is not taken into account. Thus, the following individuals are not counted as employees for purposes of this Q&A–5 even though they are referred to as employees for all other purposes of §§54.4980B–1 through 54.4980B–10—

(1) Self-employed individuals (within the meaning of section 401(c)(1));

(2) Independent contractors (and their employees and independent contractors); and

(3) Directors (in the case of a corporation).

(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 period, 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.

(g) A small-employer plan is generally excepted from COBRA. If, however, a plan that has been subject to COBRA (that is, was not a small-employer plan) becomes a small-employer plan, the plan remains subject to COBRA for qualifying events that occurred during the period when the plan was subject to COBRA. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. An employer maintains a group health plan. The employer employed 20 employees on more than 50 percent of its working days during 2001, and consequently the plan is not excepted from COBRA during 2002. Employee *E* resigns and does not work for the employer after January 31, 2002. Under the terms of the plan, *E* is no longer eligible for coverage upon the effective date of the resignation, that is, February 1, 2002. The employer does not hire a replacement for *E*. *E* timely elects and pays for COBRA continuation coverage. The employer employs 19 employees for the remainder of 2002, and consequently the plan is not subject to COBRA in 2003. The plan must nevertheless continue to make COBRA continuation coverage available to *E* during 2003 until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until August 1, 2003, the date that is 18 months after the date of *E*'s qualifying event, or longer if *E* is eligible for a disability extension.

Example 2. The facts are the same as in *Example 1*. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005. Spouse *S* is covered under the plan because *S* is married to one of the employer's employees. On April 1, 2002, *S* is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because *X* normally employed 20 employees during 2001. *S* timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to *S* during those years until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of *S*'s qualifying event.

Example 3. The facts are the same as in *Example 2*. *C* is a dependent child of one of the employer's employees and is covered under the plan. A dependent child is no longer eligible for coverage under the plan upon the attainment of age 23. *C* attains age 23 on November 16, 2005. The plan is excepted from COBRA with respect to *C* during 2005 because the employer normally employed fewer than 20 employees during 2004. Consequently, the plan is not obligated to make COBRA continuation coverage available to *C* (and would not be obligated to make COBRA continuation coverage available to *C* even if the plan later became subject to COBRA again).

Q–6: 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 in determining the number of group health plans that an employer or employee organization maintains. 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. Except as provided in paragraph (b) or (c) of this Q&A–6, all health care benefits, other than 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, unless—

(1) It is clear from the instruments governing an arrangement or arrangements to provide health care benefits that the benefits are being provided under separate plans; and

(2) The arrangement or arrangements are operated pursuant to such instruments as separate plans.

(b) A multiemployer plan and a nonmultiemployer plan are always separate plans.

(c) 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.

Q–7: What is the plan year?

A–7: (a) The *plan year* is the year that is designated as the plan year in the plan documents.

(b) If the plan documents do not designate a plan year (or if there are no plan documents), then the plan year is determined in accordance with this paragraph (b).

(1) The plan year is the deductible/limit year used under the plan.

(2) If the plan does not impose deductibles or limits on an annual basis, then the plan year is the policy year.

(3) If the plan does not impose deductibles or limits on an annual basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year.

(4) In any other case, the plan year is the calendar year.

Q–8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

A–8: (a)(1) 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.

(2) 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 section 106(c)(2), 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. To the extent that a health FSA is obligated to make COBRA continuation coverage available to a qualified beneficiary, the health FSA must comply with all the applicable rules of §§ 54.4980B–1 through 54.4980B–10, including the rules of Q&A–3 in § 54.4980B–5 (relating to limits).

(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 nonCOBRA 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.)

Q–9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

A–9: Under section 4980B(a), if a group health plan subject to COBRA fails to comply with section 4980B(f), an excise tax is imposed. Moreover, non-tax remedies may be available if the plan fails to comply with the parallel requirements in ERISA, which are administered by the Department of Labor.

Q–10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

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.

(b) In certain circumstances, the excise tax is also imposed on a person involved with the provision of benefits under the plan (other than in the capacity of an employee), such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan. In general, such a person will be liable for the excise tax if the person assumes, under a legally enforceable written agreement, the responsibility for performing the act to which the failure to comply with the COBRA continuation coverage requirements relates. Such a person will be liable for the excise tax notwithstanding the absence of a written agreement assuming responsibility for complying with COBRA if the person provides coverage under the plan to a similarly situated nonCOBRA beneficiary (see Q&A–3 of § 54.4980B–3 for a definition of similarly situated nonCOBRA beneficiaries) and the employer or plan administrator submits a written request to the person to provide to a qualified beneficiary the same coverage that the person provides to the similarly situated nonCOBRA beneficiary. If the person providing coverage under the plan to a similarly situated nonCOBRA beneficiary is the plan administrator and the qualifying event is a divorce or legal separation or a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the plan administrator will also be liable for the excise tax if the qualified beneficiary submits a written request for coverage.

Q–11: If a person is liable for the excise tax under section 4980B, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–11: (a) *In general. See* §§ 54.6011–2 and 54.6151–1.

(b) *Due date for filing of return by employers or other persons responsible for benefits under a group health plan. See* § 54.6071–1(a)(1).

(c) *Due date for filing of return by multiemployer plans. See* § 54.6071–1(a)(2).

(d) *Effective/applicability date.* In the case of an employer or other person mentioned in paragraph (b) of this Q & A–11, the rules in this Q & A–11 are effective for taxable years beginning on or after January 1, 2010. In the case of a plan mentioned in paragraph (c) of this Q & A–11, the rules in this Q & A–11 are effective for plan years beginning on or after January 1, 2010.

[T.D. 8812, 64 FR 5174, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1849, Jan. 10, 2001; T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980B–3 Qualified beneficiaries.

The determination of who is a qualified beneficiary, an employee, or a covered employee, and of who are the similarly situated nonCOBRA beneficiaries is addressed in the following questions-and-answers:

Q–1: Who is a qualified beneficiary?

A–1: (a)(1) Except as set forth in paragraphs (c) through (f) of this Q&A–1, a qualified beneficiary is—

(i) Any individual who, on the day before a qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee; or

(ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.