

(g) *Special requirements relating to the Family and Medical Leave Act.* An employee taking leave under the Family and Medical Leave Act (FMLA) (Public Law 103-3 (107 Stat. 6)) may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

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(i) * * *

(3) *Dependent.* A dependent means a dependent as defined in section 152, except that, for purposes of accident or health coverage, any child to whom section 152(e) applies is treated as a dependent of both parents, and, for purposes of dependent care assistance provided through a cafeteria plan, a dependent means a qualifying individual (as defined in section 21(b)(1)) with respect to the employee.

(4) *Disability coverage.* Disability coverage means coverage under an accident or health plan that provides benefits due to personal injury or sickness, but does not reimburse expenses incurred for medical care (as defined in section 213(d)) of the employee or the employee's spouse and dependents. For purposes of this section, disability coverage includes payments described in section 105(c).

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(8) *Qualified benefits plan.* * * * A plan does not fail to be a qualified benefits plan merely because it includes an FSA, assuming that the FSA meets the requirements of section 125 and the regulations thereunder.

(9) *Similar coverage.* Coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide coverage for major medical are considered to be similar coverage. For purposes of this definition, a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA. A plan may treat coverage by another employer, such as a spouse's or dependent's employer, as similar coverage.

(j) *Effective date—(1) General rule.* Except as provided in paragraph (j)(2) of this section, this section is applicable for cafeteria plan years beginning on or after January 1, 2001.

(2) *Delayed effective date for certain provisions.* The following provisions are applicable for cafeteria plan years beginning on or after January 1, 2002: paragraph (c) of this section to the extent applicable to qualified benefits other than an accident or health plan or a group-term life insurance plan; paragraph (d)(1)(ii)(B) of this section

(relating to a spouse, former spouse, or other individual obtaining accident or health coverage for an employee's child in response to a judgment, decree, or order); paragraph (f) of this section (rules for election changes as a result of cost or coverage changes); and paragraph (i)(9) of this section (defining similar coverage).

§ 1.125-4T [Removed]

Par. 3. Section 1.125-4T is removed.

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Approved: December 15, 2000.

Jonathan Talisman,

Acting Assistant Secretary of the Treasury (Tax Policy).

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[TD 8928]

RIN 1545-AW94

Continuation Coverage Requirements Applicable to Group Health Plans

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations that provide guidance on certain issues that arise in connection with the COBRA continuation coverage requirements applicable to group health plans. The regulations in this document supplement final COBRA regulations published on February 3, 1999, in the **Federal Register**. The regulations will generally affect sponsors and administrators of, and participants in, group health plans, and they provide plan sponsors and plan administrators with guidance necessary to comply with the law.

DATES: *Effective date:* These regulations are effective January 10, 2001.

Applicability dates: For dates of applicability, see the discussion under the heading **EFFECTIVE DATE** in this preamble.

FOR FURTHER INFORMATION CONTACT: Yurlinda Mathis at 202-622-6080 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) imposes continuation coverage

requirements on group health plans in certain situations. This document contains amendments to the COBRA health care continuation coverage regulations in 26 CFR part 54. Proposed regulations interpreting COBRA were published in the **Federal Register** on June 15, 1987 (52 FR 22716). On February 3, 1999, final COBRA regulations were published in the **Federal Register** (64 FR 5160) (the 1999 final regulations), and a notice of proposed rulemaking (REG-121865-98) was published the same day (64 FR 5237) for certain issues not addressed in the final regulations (the 1999 proposed regulations). A public hearing was held on June 8, 1999. In addition, written comments responding to the notice of proposed rulemaking and to the final regulations were received. After consideration of all the comments, the proposed regulations are adopted as amended by this Treasury decision. The revisions are discussed below.

Explanation and Summary of Comments

Small Employer Plan Exception

Group health plans maintained by an employer that had fewer than 20 employees on a typical business day in the previous calendar year are not subject to COBRA. The 1999 proposed regulations relating to plans maintained by an employer with fewer than 20 employees in the previous calendar year are adopted as final regulations without change. Unlike the 1987 proposed regulations, the 1999 proposed regulations use a full-time equivalency method in counting part-time employees for purposes of determining if an employer had fewer than 20 employees. Several commenters expressed disapproval of this approach or inquired why it was being considered.

The 1987 proposed regulations contained rules about how to count part-time employees. An example can be used to illustrate how the 1987 rules were proposed to apply. In a calendar year two employers each employ 15 full-time employees and 12 part-time employees. Each part-time employee works 15 hours per week. Each employer has six typical business days each week. One employer schedules all 12 of the part-time employees to work two-and-a-half hours each typical business day per week. The other employer staggers the schedule of the part-time employees so that they each work seven-and-a-half hours on two typical business days per week, so that four part-time employees work on each typical business day. Under the 1987

proposed regulations, the part-time employees of the first employer counted as 12 employees whereas the part-time employees of the second employer counted only as four employees. In the following calendar year, a group health plan maintained by the first employer would have been subject to COBRA (because the first employer employed 27 employees on a typical business day in the preceding calendar year) but a group health plan maintained by the second employer would not have been subject to COBRA (because the second employer employed only 19 employees on a typical business day in the preceding calendar year).

The exception for employers with fewer than 20 employees reflects Congress' judgment that the costs and administrative burden associated with COBRA should not be imposed on small employers and that imposing such requirements on small employers may discourage them from providing group health coverage to their employees. There is no reason to distinguish, as the approach in the 1987 proposed regulations would have done, between two employers with identical numbers of full- and part-time employees based on the particular days that the part-time employees work.

In contrast to the result under the 1987 proposed regulations, the 1999 proposed regulations and these final regulations provide for the uniform treatment of employers employing the same number of part-time employees for equivalent periods, regardless of how the hours are scheduled. The full-time equivalency approach therefore avoids creating an incentive for employers to schedule the work of their part-time employees in a manner that is inconsistent with the convenience of the employees or the needs of the business.

One commenter asked if it is permissible to count part-time employees on an aggregate basis rather than an individual basis. On an individual basis, the number of part-time employees is computed by dividing the hours worked by each part-time employee by the hours required to be considered working full-time and then by adding all the quotients together. On an aggregate basis, the number of part-time employees is computed by adding all the hours worked by part-time employees and dividing that sum by the number of hours required for one worker to be considered working full-time. Because the two methods produce identical results, both methods are permissible.

Determination of Number of Plans

The 1999 proposed regulations relating to the determination of the number of plans that an employer or employee organization maintains are modified and reorganized. Under the 1999 proposed regulations, the number of plans is determined by the instruments governing the employer's or employee organization's arrangement or arrangements to provide health care benefits (the instruments rule). Another rule (the default rule) in the 1999 proposed regulations provides that if there are no instruments or if the instruments are unclear about whether there is one plan or more than one plan, all health care benefits (except benefits for long-term care) provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan.

Under these final regulations, these rules are reorganized so that the default rule, under which all health care benefits provided by one entity or trade or business are treated as one plan, is presented first. The default rule applies unless 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 the arrangement or arrangements are operated pursuant to such instruments as separate plans. In effect, this rule revises the instruments rule in the 1999 proposed regulations by adding the requirement that the arrangement or arrangements must be operated pursuant to the instruments as separate plans to avoid the application of the default rule. These organizational and substantive changes from the 1999 proposed regulations were developed at the suggestion of and with substantial assistance from the U.S. Department of Labor, Pension and Welfare Benefits Administration.

Health Flexible Spending Arrangements

The 1999 proposed regulations relating to health flexible spending arrangements (health FSAs) are adopted with one minor change and one addition. The minor change is the cross-reference in which a health FSA is defined. The 1999 proposed regulations cite the definition in proposed regulations under section 125. These final regulations cite the definition in section 106(c)(2) of the Internal Revenue Code. (Regulations published recently under section 125 also use the section 106(c)(2) definition. See 65 FR 15548, 15553 (March 23, 2000).)

The one addition is a clarification that, to the extent a health FSA is obligated to make COBRA continuation coverage available to a qualified beneficiary, all the general COBRA continuation coverage rules apply in the same way that they apply to coverage under other group health plans, including the rule for how plan limits on coverage apply to someone on COBRA continuation coverage. This addition was made in response to the request of one commenter and numerous inquiries about how the annual election of a certain dollar amount by an employee under a health FSA applies once there is a qualifying event.

Several commenters were pleased with the limited exception from the COBRA rules for health FSAs under the 1999 proposed regulations and asked that the final regulations go even further. They requested that when participants under a health FSA experience a qualifying event (and the benefits under the health FSA are excepted benefits under sections 9831 and 9832), the final regulations should allow the health FSA to compute the contributions made during that plan year on the participant's behalf, reduce that amount by reimbursements already made during the plan year, and—instead of requiring the health FSA to offer COBRA continuation coverage in those cases in which there is a positive balance—allow the participant to spend whatever balance remains during the remainder of the plan year without requiring or allowing additional contributions. However, such an approach is inconsistent with the requirements under sections 125 and 4980B and thus has not been adopted.

One commenter requested that the final regulations clarify that the applicable premium includes any employer subsidy. The statute makes clear that the applicable premium is computed based on the total cost of coverage, regardless of whether paid by the employer or employee. The regulations generally do not address how to calculate the applicable premium. However, the example for the health FSA exception makes clear that the maximum amount a plan is permitted to charge for COBRA coverage under a health FSA includes any employer subsidy.

One commenter requested that the final regulations clarify that a health FSA is obligated to make COBRA continuation coverage available only in connection with qualifying events that are a termination of employment or reduction of hours of employment. This suggestion is not adopted in the final

regulations because it is inconsistent with the statute. If health care expenses incurred for a spouse or dependent child of an active employee can be reimbursed under a health FSA, but, were it not for the COBRA continuation coverage rules, would not be reimbursed after the death of the employee, the divorce from the employee, or a dependent child's ceasing to be a dependent child under the generally applicable requirements under the health FSA, then the spouse or dependent child has experienced a qualifying event and is entitled to continue coverage under the health FSA to the same extent as they would following termination of the employee's employment.

Increase in Premium Loss of Coverage

The 1999 final regulations provide, in describing what constitutes a loss of coverage for determining whether a qualifying event has occurred, that any increase in premium or contribution that must be paid for coverage as a result of one of the events that can be a qualifying event is a loss of coverage. Several commenters questioned why this rule was adopted and pointed out that it creates administrative burdens in two situations without apparently providing any advantage to the people whose premium is being increased. The two situations concern retiring employees and full-time employees reducing their work hours to become part-time employees. In both situations, often employers will grant the employees access to the same coverage but will require them to pay a premium that is higher than what active employees pay though still significantly less than the 102 percent rate permitted under COBRA. The commenters wondered why it is necessary to provide these individuals with a COBRA notice if it is always advantageous for the individual to take the other coverage. They suggested that a loss of coverage should not be considered to have occurred if employees (or other qualified beneficiaries) can get access to the same coverage for less than the applicable premium under COBRA.

The IRS and Treasury were mindful of these situations before they adopted the rule in the 1999 final regulations. However, if a mere increase in premium were not considered a loss in coverage, the person whose premium is being increased would not be entitled by law to a 60-day election period nor to a 45-day period after the election for making the first premium payment. Although in many cases a qualified beneficiary might prefer a lower premium over these procedural protections under

COBRA, in some cases these procedural protections might be more valuable. The likelihood of the COBRA procedural protections being more valuable than the lower premium becomes substantial as the amount required to be paid for part-time or retiree coverage approaches the amount of the applicable premium. Accordingly, the final regulations retain the rule in the 1999 final regulations so as not to deprive qualified beneficiaries of potentially valuable rights.

Termination of Coverage in Anticipation of a Qualifying Event

The 1999 final regulations provide that if coverage is reduced or eliminated in anticipation of an event, the elimination or reduction is disregarded in determining whether the event causes a loss of coverage. The regulations provide examples of an employer eliminating an employee's coverage in anticipation of a termination of employment and of an employee eliminating a spouse's coverage in anticipation of a divorce.

One commenter requested a clarification that a reduction or elimination more than six months before an event could not be considered to be in anticipation of the event. However, in many cases where coverage is eliminated by an employee in anticipation of a divorce, the divorce will follow the elimination by more than six months. Whether a reduction or elimination of coverage is in anticipation of a qualifying event is a question to be resolved based on all the relevant facts and circumstances. Thus, these final regulations do not amend the rule in the 1999 final regulations to limit the window during which an anticipatory reduction or elimination can be considered to have occurred.

The commenter also requested a clarification that the coverage the qualified beneficiary is entitled to in such a situation is the coverage the qualified beneficiary had before coverage was reduced or eliminated. The general rule in the 1999 final regulations for determining what is COBRA continuation coverage applies in this situation. Under the rule in the 1999 final regulations, the qualified beneficiary will generally be entitled to the coverage that the qualified beneficiary had before the qualifying event. However, if between the date of the elimination or reduction in coverage and the date of the qualifying event coverage is modified for similarly situated non-COBRA beneficiaries, then the modified coverage must be made available to the qualified beneficiary.

Moving Outside Region of Region-Specific Coverage

The 1999 final regulations require employers and employee organizations to make alternative coverage available to qualified beneficiaries moving outside the service area of a region-specific benefit package. One commenter asked for a clarification that the alternative coverage must be made available immediately and cannot be deferred until the beginning of the plan's next open enrollment period. These final regulations clarify that the alternative coverage must be made available not later than the date of the qualified beneficiary's relocation, or, if later, the first day of the month following the month in which the qualified beneficiary requests the alternative coverage.

Another commenter expressed concern that a plan might have to incur extraordinary costs (such as negotiating for a separate network of providers in an indemnity plan with a preferred provider organization, or establishing a separate schedule of usual, customary, and reasonable costs) to provide coverage in areas to which a qualified beneficiary might relocate but in which there were no active employees of the employer or employee organization. The rule in the 1999 final regulations does not require employers or employee organizations to incur extraordinary costs to extend coverage to qualified beneficiaries in areas in which the employer or employee organization does not have active employees. In the case of an indemnity plan with a preferred provider organization, the plan need only provide benefits at the standard rate (that is, not at the rate for preferred providers) to a qualified beneficiary who moves outside the service area of the preferred provider network. Similarly, a plan is not required to establish a separate schedule of usual, customary, and reasonable costs solely for qualified beneficiaries who reside in a region where no active employees work or reside (regardless of whether this is to the qualified beneficiary's benefit or detriment based on prevailing costs in the region where the qualified beneficiary resides). Accordingly, these final regulations do not modify the rule in the 1999 final regulations based on this commenter's concern.

When COBRA Continuation Coverage Must Become Effective

The 1999 final regulations provide that, in the case of an indemnity or reimbursement arrangement, claims incurred during the election period do not have to be paid before the election

(and, if applicable, payment for the coverage) is made. In the case of indemnity or reimbursement arrangements that allow retroactive reinstatement of coverage, the 1999 final regulations provide that coverage for qualified beneficiaries can be terminated and then reinstated when the election is made. One commenter asked if these two rules mean that coverage must be reinstated at the time of the election even if payment is not made but that no claims need be paid under that coverage until payment for the coverage is made. The commenter pointed out that this would pose a problem for employers and employee organizations maintaining insured plans in that they would have to pay the insurer premiums for the coverage even if payment for the coverage was never made (whereas the insurer would never have to pay any claim under the coverage). These final regulations clarify this rule by explicitly providing that in the case of indemnity plans and reimbursement arrangements that allow retroactive reinstatement of coverage, coverage can be terminated and later reinstated when the election (and, if applicable, payment for the coverage) is made. Thus, under these final regulations, the rules for when coverage must be reinstated and when claims must be paid are the same.

Maximum Coverage Period

The 1999 proposed regulations relating to the maximum coverage period are adopted as final regulations with a minor change to a cross-reference.

Insignificant Underpayments

The 1999 final regulations prescribe how plans are to treat payments for COBRA continuation coverage that are short by an amount that is not significant. They require the plan to treat the payment as full payment unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period for payment of the deficiency. The regulations provide as a safe harbor that a period of 30 days after the notice is provided is a reasonable period for this purpose.

Many commenters requested that the regulations specify what is considered a significant amount. These final regulations provide that a shortfall is not significant if it is no greater than the lesser of \$50 (or another amount specified by the Commissioner in guidance of general applicability) or 10 percent of the required amount.

Several commenters also requested that the regulations specify a period

shorter than 30 days for payment of the deficiency to be considered timely, but these final regulations do not adopt this suggestion. The regulations require only that a plan grant a reasonable period for payment of the deficiency. In some circumstances, a period shorter than 30 days may be reasonable. However, in other circumstances, a shorter period might not be reasonable. The IRS and Treasury believe it is useful to provide the certainty of a safe harbor, but they do not believe that a period shorter than 30 days is sufficiently long in all cases.

Business Reorganizations

The 1999 proposed regulations relating to business reorganizations are adopted as final regulations with two clarifications. The proposed regulations provide that, in an asset sale (which is defined as the sale of substantial assets such as a plant or division or substantially all the assets of a trade or business), a purchaser of assets is considered a successor employer if the seller ceases to provide any group health plan to any employee in connection with the sale and if the buyer continues the business operations associated with those assets without substantial change or interruption. Several inquiries raised the question whether this rule applies if the assets are purchased as part of a bankruptcy proceeding. The final regulations clarify this rule for assets purchased in bankruptcy by providing that a buying group does not fail to be a successor employer in connection with an asset sale merely because the sale takes place in connection with a bankruptcy proceeding. Thus, the general rule for determining whether a buyer is a successor employer applies in bankruptcy the same way that it does outside of bankruptcy.

These final regulations also clarify that asset sale includes not only sales but other transfers as well.

Comments were received about other aspects of the proposed rules for business reorganizations. Several commenters requested additional guidance on the amount of assets that would constitute "substantial assets" for purposes of the asset sale rules. The final regulations retain the definition in the proposed regulations. This definition is intended to be flexible enough to apply reasonably to the myriad situations in which this issue arises. The asset sale rules, including the definition of asset sale, are similar to the various formulations of successor employer rules that have been fashioned by the courts for various labor law purposes, adapted to the peculiar circumstances that the COBRA

continuation coverage requirements create. In those cases, as in the final rule, a case-by-case approach is favored. See, for example, *Golden State Bottling Co. v. NLRB*, 414 U.S. 168 (1973); *Howard Johnson Co. v. Detroit Local Joint Executive Board, Hotel & Restaurant Employees & Bartenders International Union*, 417 U.S. 249 (1974); *John Wiley & Sons, Inc. v. Livingston*, 376 U.S. 543 (1964); *NLRB v. Burns International Security Services, Inc.*, 406 U.S. 272 (1972); *Fall River Dyeing & Finishing Corp. v. NLRB*, 482 U.S. 27 (1987); *EEOC v. MacMillan Bloedel Containers, Inc.*, 503 F.2d 1086 (6th Cir. 1974); *In re National Airlines, Inc.*, 700 F.2d 695 (11th Cir. 1983); *Upholsterers' International Union Pension Fund v. Artistic Furniture of Pontiac*, 920 F.2d 1323 (7th Cir. 1990); *Central States, Southeast & Southwest Areas Pension Fund v. PYA/Monarch of Texas, Inc.*, 851 F.2d 780 (5th Cir. 1988).

One commenter requested clarification that the cessation of a plan shortly before an asset sale is in connection with the sale (and thus that the buying group would be responsible for making COBRA continuation coverage available to M&A qualified beneficiaries in connection with the sale if the buying group is a successor employer). The regulations have not been modified for this request. In many circumstances, cessation of a plan shortly before an asset sale would be considered to be in connection with the sale. However, there may be cases in which the plan was being terminated for an unrelated reason. The application of this rule in any particular case depends on all the relevant facts and circumstances.

The preamble to the 1999 proposed regulations included a description of a potential rule that the IRS and Treasury were considering adopting and solicited comments on that potential rule. The rule would have provided that no loss of coverage occurs, and thus no qualifying event occurs, if a purchaser of assets maintains substantially the same plan for continuing employees for what would otherwise be the maximum coverage period (generally 18 months). The IRS and Treasury also acknowledged in the 1999 preamble concerns about protecting the rights of qualified beneficiaries in this situation. After consideration of the comments, the IRS and Treasury have determined not to adopt such a special rule. Thus, under these final regulations, in an asset sale, employees who terminate employment with the seller and who no longer get health coverage from the seller experience a qualifying event with respect to the seller's plan even though

they are employed by the buyer at the same jobs they had with the seller and have the same health coverage through the buyer.

Like the 1999 proposed regulations, these final 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. However, it is intended that, in general, the principles reflected in the rules in the final regulations for transfers of ownership interests in corporate entities should apply in a similar fashion in analogous cases involving the transfer of ownership interests in noncorporate entities.

Employer Withdrawals From Multiemployer Plans

The 1999 proposed regulations relating to employer withdrawals from a multiemployer plan are adopted with two changes and two additional examples to illustrate the rules as changed. The general approach of the 1999 proposed regulations is retained. However, the proposed rule renders an employer who stops contributing to a multiemployer plan responsible for making COBRA continuation coverage available to qualified beneficiaries associated with that employer only if the employer establishes a new plan to cover active employees formerly covered under the multiemployer plan. Several commenters suggested that the employer should also be responsible for COBRA if the coverage provided to employees formerly covered under the multiemployer plan comes from an existing plan of the employer (rather than from a new plan). The final rules have been revised to apply the general approach to existing plans as well as to new plans.

The 1999 proposed regulations also place a threshold condition on the obligation of an employer or subsequent multiemployer plan to make COBRA coverage available to existing qualified beneficiaries associated with the withdrawing employer. That threshold is that the employer or subsequent multiemployer plan must cover a significant number of the employer's employees formerly covered under the multiemployer plan. Several commenters requested further guidance on what a significant number was in this context. Some of them also wanted to know what purpose this threshold condition serves. The intent in imposing this threshold condition in the proposed regulations was to leave responsibility for COBRA compliance with the existing multiemployer plan in a case where, for example, only one or two of

the employees formerly covered under the multiemployer plan were transferred into management and became covered under a plan of the employer for which union employees were not eligible. The final rule has been revised to more clearly accomplish this intent. This threshold condition has been revised so that the employer plan or subsequent multiemployer plan has responsibility for COBRA compliance once coverage under the plan is available to a class of employees formerly covered under the multiemployer plan. New examples illustrate the application of this standard.

Several commenters expressed concern that the proposed regulations would require multiemployer plans to begin investigating why an employer stops contributing to the multiemployer plan and to determine whether the withdrawing employer subsequently covered union (or former union) employees under a single employer plan. Concern was also expressed that the proposed regulations would require the multiemployer plan to keep employer-by-employer data for qualified beneficiaries receiving COBRA continuation coverage. The IRS and Treasury recognized when they proposed these rules that in many industries it is impracticable for multiemployer plans to determine whether an employer that stops contributing to a multiemployer plan covers union employees under its own plan and that it is impracticable to maintain employer-specific data on employees and qualified beneficiaries. If a multiemployer plan finds it easier to make COBRA coverage available for the maximum coverage period, these final regulations do not require the plan to start gathering information that is difficult to assemble. Such a plan can comply with the COBRA continuation coverage requirements by making COBRA continuation coverage available to existing qualified beneficiaries in accordance with the general rules for the duration of COBRA continuation coverage (in § 54.4980B-7).

One commenter requested clarification of the proposed rules if an employer establishes a plan for employees formerly covered under the multiemployer plan but applies a waiting period before the employees are eligible for coverage under that plan. These final regulations clarify that the employer's obligation does not arise until the employer makes coverage available. Thus, the multiemployer plan would be responsible for COBRA coverage until the waiting period under the employer's plan had expired for a

class of employees formerly covered under the multiemployer plan.

Several commenters submitted substantially similar comments requesting that the rules be revised so that a multiemployer plan no longer receiving contributions from a certain employer would not be required to make COBRA continuation coverage available to any qualified beneficiaries affiliated with that employer. Such an approach, however, would not resolve the problem of qualified beneficiaries not having access to COBRA coverage, and the statutory basis for such a position is questionable in situations in which none of the statutory reasons for ending a plan's obligation to make COBRA coverage available to a particular qualified beneficiary is present. The final regulations do not adopt this suggestion.

The IRS and Treasury received an inquiry about who has the obligation to make COBRA continuation coverage available to existing qualified beneficiaries in a situation that reverses the situation addressed in the proposed rules, one in which employees cease to be covered under a plan maintained by their employer and commence to be covered under a multiemployer plan. In such a situation, the existing qualified beneficiaries should get the same coverage that similarly situated nonCOBRA beneficiaries are receiving, that is, the coverage under the multiemployer plan. The 1999 final regulations suggest this result in describing what COBRA continuation coverage is. However, the language used in the 1999 final regulations can be read to suggest that this is the result only when coverage is under the same plan: "If coverage *under the plan* is modified for similarly situated nonCOBRA beneficiaries, then the coverage made available to qualified beneficiaries is modified in the same way." (Q&A-1(a) of § 54.4980B-5; emphasis added.) These final regulations delete the phrase "under the plan" from the quoted language to make clear that if coverage for the similarly situated nonCOBRA beneficiaries is modified by switching from one plan to another, then coverage for the qualified beneficiaries is modified by switching to the other plan too. Although this amendment is being made due to an inquiry about a switch from a single-employer plan to a multiemployer plan, it applies in any situation in which coverage for nonCOBRA beneficiaries is terminated under one plan and commences under another, including those situations in which a single employer maintains both plans.

COBRA and FMLA

The 1999 proposed regulations relating to how COBRA applies in connection with leave taken under the Family and Medical Leave Act of 1993 (FMLA) are adopted as final regulations with one minor addition. One commenter observed that the 1999 proposed regulations suggest by way of cross reference in an example that the Labor regulations in 29 CFR part 825, not the COBRA regulations, determine when FMLA leave ends. This commenter requested that this suggestion in an example be made express in the text of the rules. The final regulations add in the text of the rules (preceding the examples) that the end of FMLA leave is not determined under these regulations but under the regulations in 29 CFR part 825.

Effective Date

This Treasury decision applies with respect to qualifying events occurring on or after January 1, 2002, except as provided in the following paragraphs.

Paragraphs (d), (e), and (f) in Q&A-5 of § 54.4980B-2 (relating to the counting of employees for purposes of the small employer plan exception) are applicable beginning January 1, 2002 for determinations made with reference to the number of employees in calendar year 2001 or later.

Q&A-4 of § 54.4980B-7 (describing the maximum coverage period) is applicable with respect to individuals who are qualified beneficiaries on or after January 1, 2002. (See Q&A-1(f) of § 54.4980B-3, under which an individual ceases to be a qualified beneficiary once the plan's obligation to provide COBRA continuation coverage to the individual has ended.)

Q&A-1 through Q&A-8 of § 54.4980B-9 (containing rules for business reorganizations) are applicable with respect to business reorganizations that take effect on or after January 1, 2002.

Q&A-9 and Q&A-10 of § 54.4980B-9 (containing rules for employer withdrawals from a multiemployer plan) are applicable with respect to cessations of contributions that occur on or after January 1, 2002. For this purpose, a cessation of contributions occurs on or after January 1, 2002 if the employer's last contribution to the plan is made on or after January 1, 2002.

Section 54.4980B-10 (relating to the interaction of COBRA and FMLA leave) is applicable with respect to FMLA leave that begins on or after January 1, 2002.

Special Analyses

It has been determined that this Treasury decision 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 is not required. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these regulations is Russ Weinheimer, Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the IRS and Treasury Department participated in their development.

List of Subjects in 26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 54 is 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 entry for Q-2 of § 54.4980B-1 in the "List of Questions".
4. Revising the entries for Q-3 and Q-6 of § 54.4980B-2 in the "List of Questions".
5. Revising the entry for Q-4 of § 54.4980B-7 in the "List of Questions".
6. Adding entries for the section headings for §§ 54.4980B-9 and 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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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?

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§ 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?

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Par. 3. Section 54.4980B-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) in A-1.

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

3. Removing the last sentence of paragraph (c) in A-1 and adding two sentences in its place.

4. Revising Q&A-2.

The addition and revision read as follows:

§ 54.4980B-1 COBRA in general.

* * * * *

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.

Q-2: What standard applies for topics not addressed in §§ 54.4980B-1 through 54.4980B-10?

A-2: For purposes of section 4980B, for topics relating to the COBRA continuation coverage requirements of section 4980B that are not addressed in §§ 54.4980B-1 through 54.4980B-10 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in section 4980B.

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 the introductory text 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 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.

* * * * *

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 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.

* * * * *

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.

* * * * *

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.)

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.

§ 54.4980B-3 [Amended]

Par. 5. Section 54.4980B-3 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)(3) in A-1.
2. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the first sentence of paragraph (g) in A-1.
3. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the first and second sentences of paragraph (a)(1) in A-2.
4. Removing the language "54.4980B-8" and adding "54.4980B-10" in its

place in the first sentence of paragraph (a)(2) in A-2.

5. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in the first and last sentences in paragraph (b) in A-2.

6. Removing the language "54.4980B-8" and adding "54.4980B-10" in its place in A-3.

7. Removing the language "section 9801(f)(2), and § 54.9801-6T(b)" and adding "and section 9801(f)(2)" in its place in the last sentence of paragraph (b) in A-1.

8. Removing the language "and § 54.9801-6T(b)" in the second sentence of paragraph (i) in Example 1 of paragraph (h) of A-1.

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.

4. Removing the language "section 9801(f)(2), and § 54.9801-6T(b)" and adding "and section 9801(f)(2)" in its place in paragraph (i) in Example 4 of paragraph (g) in 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. Section 54.4980B-5 is amended by:

1. Revising paragraph (a) of A-1.
2. Revising paragraph (b) in A-4.
3. Removing the language "and § 54.9801-6T" in the second sentence of paragraph (a) in A-5.

The revisions read as follows:

§ 54.4980B-5 COBRA continuation coverage.

* * * * *
A-1: (a) If a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any

immediate or deferred loss of coverage) must be offered an opportunity to elect to receive the group health plan coverage that is provided to similarly situated nonCOBRA beneficiaries (ordinarily, the same coverage that the qualified beneficiary had on the day before the qualifying event). See Q&A-3 of § 54.4980B-3 for the definition of similarly situated nonCOBRA beneficiaries. This coverage is COBRA continuation coverage. If coverage is modified for similarly situated nonCOBRA beneficiaries, then the coverage made available to qualified beneficiaries is modified in the same way. If the continuation coverage offered differs in any way from the coverage made available to similarly situated nonCOBRA beneficiaries, the coverage offered does not constitute COBRA continuation coverage and the group health plan is not in compliance with COBRA unless other coverage that does constitute COBRA continuation coverage is also offered. Any elimination or reduction of coverage in anticipation of an event described in paragraph (b) of Q&A-1 of § 54.4980B-4 is disregarded for purposes of this Q&A-1 and for purposes of any other reference in §§ 54.4980B-1 through 54.4980B-10 to coverage in effect immediately before (or on the day before) a qualifying event. COBRA continuation coverage must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

* * * * *

A-4: * * *

(b) If a qualified beneficiary participates in a region-specific benefit package (such as an HMO or an on-site clinic) that will not service her or his health needs in the area to which she or he is relocating (regardless of the reason for the relocation), the qualified beneficiary must be given, within a reasonable period after requesting other coverage, an opportunity to elect alternative coverage that the employer or employee organization makes available to active employees. If the employer or employee organization makes group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating, then that coverage is the alternative coverage that must be made available to the relocating qualified beneficiary. If the employer or employee organization does not make group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the

qualified beneficiary is relocating but makes coverage available to other employees that can be extended in that area, then the coverage made available to those other employees must be made available to the relocating qualified beneficiary. The effective date of the alternative coverage must be not later than the date of the qualified beneficiary's relocation, or, if later, the first day of the month following the month in which the qualified beneficiary requests the alternative coverage. However, the employer or employee organization is not required to make any other coverage available to the relocating qualified beneficiary if the only coverage the employer or employee organization makes available to active employees is not available in the area to which the qualified beneficiary relocates (because all such coverage is region-specific and does not service individuals in that area).

* * * * *

Par. 8. Section 54.4980B-6 is amended by:

1. Revising the *Example* in paragraph (c) of A-1.

2. Revising the first sentence in paragraph (b) of A-3.

The revisions read as follows:

§ 54.4980B-6 Electing COBRA continuation coverage.

* * * * *

A-1: * * * * *
(c) * * *

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).

* * * * *

A-3: * * *

(b) In the case of an indemnity or reimbursement arrangement, the employer or employee organization can provide for plan coverage during the election period or, if the plan allows retroactive reinstatement, the employer or employee organization can terminate the coverage of the qualified beneficiary and reinstate her or him when the election (and, if applicable, payment for the coverage) is made. * * *

* * * * *

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 beneficiary 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 the determination of 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).

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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. Section 54.4980B-8 is amended by:

- 1. Revising paragraph (c) in A-1.
- 2. Adding a new sentence at the end of paragraph (d) and paragraphs (d)(1) and (2) in A-5.

The revision and addition read as follows:

§ 54.4980B-8 Paying for COBRA continuation coverage.

* * * * *

A-1: * * *

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(c) A group health plan does not fail to comply with section 9802(b) (which generally prohibits an individual from being charged, on the basis of health status, a higher premium than that charged for similarly situated individuals enrolled in the plan) with respect to a qualified beneficiary entitled to the disability extension merely because the plan requires payment of an amount permitted under paragraph (b) of this Q&A-1.

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A-5: * * *

(d) * * * An amount is not significantly less than the amount the plan requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

(1) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii) of this chapter)); or

(2) 10 percent of the amount the plan requires to be paid.

* * * * *

Par. 11. 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 transfer 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 employee 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. A buying group does not fail to be a successor employer in connection with an asset sale merely because the asset sale takes place in connection with a proceeding in bankruptcy under Title 11 of the United States Code. 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 associated 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 makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of the employer's employees formerly covered under the multiemployer plan, the plan maintained by the employer (or the other multiemployer plan), from that date forward, 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 make group health plan coverage available to 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) The facts are the same as in *Example 1* except that *B*, one of the employees covered under *M* before *Z* stops contributing to *M*, is transferred into management. *Z* maintains a group health plan for managers and *B* becomes eligible for coverage under the plan on the day of *B*'s transfer.

(ii) Under these facts, *Z* does not make group health plan coverage available to a class of employees formerly covered under *M* after *B* becomes eligible under *Z*'s group health plan for managers. Accordingly, *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*.

Example 3. (i) Employer *Y* employs two classes of employees skilled and unskilled laborers 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* stops making contributions to *M* but continues to employ all the employees covered by the collective bargaining agreement. *Y*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Y* makes group health plan coverage available to the skilled laborers immediately after their coverage ceases under

M, but *Y* does not make group health plan coverage available to any of the unskilled laborers.

(ii) Under these facts, because *Y* makes group health plan coverage available to a class of employees previously covered under *M* immediately after both classes of employees lose coverage under *M*, *Y* alone 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 *Y*, regardless of whether the employment affiliation was as a skilled or unskilled laborer. However, the loss of coverage under *M* for those employees of *Y* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 4. (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*. *X* experiences financial difficulties and is forced into bankruptcy by its creditors. *X* continues to employ all of the employees covered by the collective bargaining agreement. *X* also continues to make contributions to *M* until the current collective bargaining agreement expires, on June 30, 2001, and then *X* stops making contributions to *M*. *X*'s employees (and their spouses and dependent children) lose coverage under *M* effective July 1, 2001. *X* does not enter into another collective bargaining agreement covering the class of employees covered by the expired collective bargaining agreement. Effective September 1, 2001, *X* 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 *X* 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 *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.

Example 5. (i) Employer *W* 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, *W* 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 *W*. The loss of coverage under *M* for those employees of *W* 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 determination of when FMLA leave ends is not made under the rules of this section. See the

FMLA regulations, 29 CFR Part 825 (§§ 825.100-825.800).) 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.

Approved: December 18, 2000.

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DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Parts 95 and 177

[USCG-1998-4593]

RIN 2115-AF72

Revision to Federal Blood Alcohol Concentration (BAC) Standard for Recreational Vessel Operators

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is revising the Federal Blood Alcohol Concentration (BAC) standard under which a recreational vessel operator