

Department of Employee Trust Funds
STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL

CHAPTER 6 – COBRA, CONTINUATION and CONVERSION

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601 Overview of COBRA, Continuation and Conversion

Participants and their eligible dependents covered under the State Employee Group Health Insurance program have options available to them for the continuation of health insurance coverage in the event eligibility for group coverage ends. The following provides an overview of those options:

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that the State Group Health Insurance program offer subscribers (employees) and their covered dependents temporary extension of coverage for a maximum of 36 months following specific events, referred to as “qualifying events,” as described in Subchapter 602. The extension of coverage allows subscribers and their covered dependents to continue receiving benefits identical to those provided to active employees at the group rate.

Continuation

Wisconsin statutes (Wis. Stat. §40.51 (3-4), § 632.897) allow subscribers and their covered dependents to continue their coverage for up to 18 months following specified events. This right to continue coverage allows subscribers and their covered dependents to receive benefits identical to those provided to active employees at the group rate.

NOTE: Where Federal (COBRA) and State (continuation) law differ, the law most favorable to the participant will apply. When used in this chapter, “continuation” refers to the State or Federal legislation resulting in the most favorable outcome to the participant, unless otherwise specified.

Conversion

Conversion coverage is available to participants who have been covered under the State Employee Group Health Insurance program for at least three months upon termination. Participants may elect to convert to individual (non-group) coverage upon the loss of eligibility for group coverage, i.e., when they reach the maximum length of continuation of group coverage or in lieu of continuation coverage. Participants electing conversion coverage do not need to provide evidence of insurability (i.e. be underwritten) but must apply within 30 days after group coverage terminates. The benefits and rates for conversion coverage are different than the benefits and rates for continuation coverage. Employees should contact the health plan with questions regarding conversion.

602 Persons Eligible for Continuation (Qualified Beneficiaries)

Under Federal law, when group health insurance coverage would otherwise end because of a life event known as a “qualifying event,” employees and their covered spouse and dependent children become “qualified beneficiaries” and must be offered continuation coverage. (Refer to Subchapter 605 for employer responsibilities.)

- A. Employees must be offered continuation coverage in the event coverage is lost due to either of the following events:
- Termination of employment (for reasons other than gross misconduct), including retirement. The exception is when an employee retires and elects to take an immediate annuity and continue health insurance. (Refer to Chapters 7 and 8.)
 - Completion of the maximum prepayment periods of 36 months while on a leave of absence or layoff (Refer to Subchapters 312 and 313).
- B. The spouse of an employee with family coverage in the State Employee Group Health Insurance program becomes a qualified beneficiary as a result of any of the following qualifying events:
- Death of spouse (employee). (Refer to Chapter 10 on Employee Death.)
 - Divorce. Coverage as a dependent spouse continues until the later of:
 - The end of the month in which the employer provides notification of continuation rights (*Continuation - Conversion Notice* [ET-2311]). (Refer to Subchapter 603.)
 - OR
 - The end of the month in which the divorce is entered/final.
 - Spouse (employee) loses coverage for reasons listed above in A.
- C. Each eligible dependent child of an employee with family coverage in the State Employee Group Health Insurance program becomes a qualified beneficiary as a result of any of the following qualifying events:

- Death of parent/step-parent (employee). (Refer to Chapter 10 on Employee Death.)
 - Dependent eligibility status ceases under the State Group Health Insurance program. (Refer to the chart in Subchapter 606 for examples.)
 - Parents become divorced resulting in loss of eligibility.
 - Parent (employee) loses coverage for reasons listed above in A.
- D. An eligible dependent grandchild of an employee with family coverage in the State Group Health Insurance program becomes a qualified beneficiary when losing eligibility as a result of the dependent child (grandchild's parent) turning age 18. Coverage for the grandchild terminates at the end of the month in which the dependent child turns 18.
- E. An eligible disabled dependent, over age 19, of an employee with family coverage in the State Group Health Insurance program becomes a qualified beneficiary upon loss of disabled status. Coverage terminates at the end of the month in which it is determined the disabled status ceases.

NOTE: When a voluntary change in coverage from a family plan to a single plan is done in anticipation of a divorce, the spouse and dependent children are eligible for continuation coverage when the divorce is final. The effective date for continuation coverage in this case is the date of the divorce. In all other cases, voluntary cancellation does not create a continuation enrollment opportunity.

603 Employee Responsibilities

Employees and/or the qualified beneficiaries (Refer to Subchapter 602) are responsible for informing the employer of a qualifying event in which an employee and/or dependent loses eligibility for coverage under the State Group Health Insurance program. Under Federal COBRA law, if the employer is not notified within 60 days of (1) the event that caused the loss of coverage, or (2) the end of the period of coverage, whichever is later, the right to continuation coverage is lost. Under State continuation law, separate requirements may allow notification after the 60-day period in limited divorce circumstances.

In the event of a divorce, if an employee does not advise their employer of their divorce, coverage for the ex-spouse and any stepchildren continues if the family premium continues to be paid. The ex-spouse must then be given the right to continue coverage even if notice is given beyond 60 days following the divorce. Should the employee fail to advise the employer of divorce within 60 days of the event, the employer must provide notice to stepchildren that they are ineligible to continue coverage as a qualified beneficiary of the employee. Coverage terminates the end of the month in which the employer provides the notice of the right to continue coverage (*Continuation -*

Conversion Notice (ET-2311) to the ex-spouse and any stepchildren. In this situation, employers must check with ETF on the length of continuation coverage that is available.

Note: The ex-spouse is eligible to continue coverage under a single contract or a family contract with eligible dependents. The stepchildren are not eligible to continue coverage under a single contract of their own because notice of the divorce was not given to the employer within 60 days of the divorce. If the stepchildren meet the criteria of being an eligible dependent and the ex-spouse applies for family coverage as a continuant, the stepchildren can be included as covered dependents on the ex-spouse's family contract.

604 Qualified Beneficiary Responsibilities

Qualified beneficiaries are responsible for the following when electing continuation or conversion coverage:

- Submitting the *Continuation - Conversion Notice* (ET-2311) and the *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) to ETF. Both forms (an employee need only submit a *Continuation - Conversion Notice* unless requesting a change in coverage) must be sent to ETF (i.e., postmarked) **no later than 60 days from the termination of their coverage or within 60 days of the date they were notified by their employer, whichever is later**. If qualified beneficiaries do not elect continuation coverage within the 60-day period, their coverage under the State Group Health Insurance program will end.
- Paying premium to the health plan when billed by the health plan.
- Reporting any changes affecting coverage, for example, address change, birth or adoption. If continuation coverage is elected, changes must be reported to ETF; if conversion coverage is elected, changes must be reported to the health plan.
- Subscribers and their insured dependents continuing coverage must enroll in Medicare Part A and B when first eligible. A copy of the Medicare card must be submitted to ETF.

605 Employer Responsibilities

Within 5 days of being notified of the "qualifying event," the employer is responsible for providing the following documents to qualified beneficiaries notifying them of their right to continue group coverage or convert to individual coverage:

- *Continuation - Conversion Notice* (ET-2311), with the employer sections completed as described in Subchapter 608.
- *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302). This form is needed to enroll in continuation or conversion. However the employee does not need to complete the application if continuing the coverage already in effect.

The employee must still complete and return the *Continuation - Conversion Notice*.

NOTE: A continuation notice be provided within the 5 period even when it is determined the qualified beneficiary is not entitled to continuation coverage (for example, notice of the qualifying event was not provided to the employer within the required time period). (Refer to Subchapter 608 for information on providing notice.)

The employer is responsible for informing qualified beneficiaries of the following:

- If electing continuation coverage, the completed *Continuation - Conversion Notice* and *Group Health Insurance Application* forms must be sent to ETF (i.e., postmarked) **no later than 60 days after the date of the notice or 60 days after coverage ends, whichever is later.**
- If electing continuation coverage, the health plan will bill the continuant(s) directly.
- If electing continuation coverage and the continuants are moving or will move to a different county for more than 3 months, they are eligible to transfer to another health plan without restrictions, provided the application is received within 30 days after the move. The application must be returned to the employer if the change would be effective before the termination of coverage paid through the employer; otherwise, the application must be returned to ETF. If the application is not received within 30 days after the move, coverage is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.

Note: When completing the monthly health insurance reports (refer to Chapter 5), the employer must remove terminated employees from active coverage effective the end of the month through which premiums are paid regardless of whether the employee elects COBRA or not.

606 Notice Requirement Illustration Chart

The following chart illustrates a timetable for providing notices related to continuation coverage for common scenarios:

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Child turns 19 and is not a full-time student.	3/15/06	12/31/06	3/1/07	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Grandchild Eligibility Ends as Child-Parent turns 18	6/10/06	6/30/06	8/29/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Student Status Terminates for 20-Year Old Dependent	6/2/06	12/31/06	3/1/07	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Divorce Decree is Entered	04/03/06	End of the month in which continuation notice is given	06/02/06 If continuation notice is given late, check with ETF	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Plan Determines Dependent Over Age 19 No Longer Meets Disabled Status	8/25/06	8/31/06	10/30/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice from employer
Dependent Marries	5/7/06	5/31/06	7/30/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice from employer
Employee Terminates Employment	6/16/06	7/31/06	9/29/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer

607 Continuation Coverage Information

The benefits and limitations of coverage under continuation are identical to those provided to active employees. Participants enrolled in continuation coverage (continuants) must select the health plan already in effect at the time of termination of active coverage. Should the qualified beneficiary not reside in the same county as the subscriber, the qualified beneficiary may elect a health plan in their county of residence when enrolling in continuation coverage, even if the subscribers health plan is available in the qualified beneficiary's county. Continuants are allowed to change health plans during the annual Dual-Choice Enrollment period or following a residential move out of the county.

Continuation coverage may be in effect for up to 36 months. However, continuation coverage may be terminated early for any of the following reasons and cannot be reinstated:

- The premium for continuation coverage is not paid when due.

- The subscriber becomes covered under another group health plan that does not restrict coverage for pre-existing conditions, for example, cancer, diabetes, etc. (A subscriber who refuses health insurance offered by another employer will not be affected.)
- A spouse is divorced from a covered employee and subsequently remarries and is covered through their new spouse's group health plan.
- Qualified beneficiary voluntarily cancels continuation coverage.

Continuants may elect to convert to individual coverage (conversion at non-group rates) upon reaching the maximum continuation coverage period. Continuants are responsible for knowing when group continuation coverage ends and must contact their health plan directly to make application for conversion coverage within 30 days after group coverage terminates.

608 Instructions on Completing the *Continuation - Conversion Notice* (ET-2311)

The employer must complete the employer portions of the *Continuation - Conversion Notice* before providing it to qualified beneficiaries. The following instructions describe the employer portions of the form:

- A. On the Instructions cover sheet, check the appropriate box indicating whether the qualified beneficiary is eligible to elect continuation coverage. For example, if the employer does not receive notice within 60 days following the termination of coverage for a dependent who married, the dependent is not eligible for continuation coverage.
- B. On the notice, complete the required information.
 - In the box located in the upper right hand corner, list the
 - a. Employee Social Security Number
 - b. Employee Name (Last, First)
 - c. Employee's Birthdate (MM/DD/CCYY)
 - d. Group #.
 - Complete the **Applicant/Qualified Beneficiary Information** by listing the address of the qualified beneficiary(ies) using the address indicated on the *Health Insurance Information Change* form (ET-2329) that is completed by the employee when deleting a dependent/former spouse when there are other eligible dependents. Deleting the sole dependent or all dependents constitutes a change from family to single coverage. In this case, the employee must complete a *Group Health Insurance Application* (ET-2301 or ET-2302 for Graduate Assistants) instead of the *Health Information Change* form.

Note: If the qualified beneficiaries are the former spouse and/or step-children whose deletion is the result of a divorce, a copy of the *Continuation - Conversion*

Notice provided to the qualified beneficiaries must be attached to the Group Health Insurance Application or the Health Insurance Information Change form received from the employee and forwarded to ETF.

- Identify the relationship of the qualified beneficiary(ies) to the employee by checking the following boxes that apply:
 - a. Employee
 - b. Spouse/Former Spouse
 - c. Dependent Child(ren)

List the name in the space provided of the Spouse/Former Spouse and name(s) of the Dependent Child(ren), when checking those boxes.

NOTE: Per Federal COBRA law, notice is to be provided to each qualified beneficiary. For example, an employee with family coverage terminates employment; the employer must provide notice to all covered family members. When qualified beneficiaries reside at the same address, complete one notice indicating relationship and names of all qualified beneficiaries. When qualified beneficiaries reside at different addresses, complete one notice per address, indicating the qualified beneficiary(ies) residing at the address listed.

- In the **To Be Completed by Employer Prior to Giving to the Applicant** box, list the following:

Item 1: If the qualified beneficiary(ies) is (are) not eligible to elect continuation coverage, explain the reason why. If the qualified beneficiary(ies) is (are) eligible for continuation coverage, leave blank.

Item 2: Enter the date the applicant/qualified beneficiary's coverage will end. This date will be as follows:

- a. Terminating Employee - The date through which the group health insurance premiums are currently paid.
- b. Divorced Spouse - The end of the month in which notice of continuation is given. (Refer to note in subchapter 602 if the employee voluntarily cancels family coverage in anticipation of the divorce.)
- c. Dependent Child - The date will be the end of the month in which the earliest of the following occurs:
 - Marries
 - Ceases to be dependent for support and maintenance, if over 19.

OR

The end of the calendar year in which the child:

- Turns 19 while not a full-time student.
- Ceases to be a full-time student and is older than 19.

- Turns 25 while still a full-time student.
- d. Dependent Grandchild - The end of the month in which the child (grandchild's parent) turns 18.
- e. Disabled Dependent over age 19 who loses disabled status - The end of the month in which it is determined the disabled status ceases.

Item 3: Identify the reason for coverage ending by checking the appropriate box and providing an explanation where requested.

Item 4: Enter the date (MM/DD/CCYY) of occurrence in Item 3.

Item 5: Enter the date (MM/DD/CCYY) the employer was notified of the occurrence in Item 3.

Item 6: Check the box indicating the type of coverage in effect at the time of occurrence in Item 3.

Item 7: Enter the name of the health plan in which the qualified beneficiary is currently enrolled and the full monthly premium rate for the coverage in effect.

Item 8: Enter the following information:

- a. Signature of the person completing the employer portions of the notice.
- b. Date (MM/DD/CCYY) the notice is given to the qualified beneficiary. For example: the date the notice is mailed to the qualifying beneficiary or the date the notice is physically handed to the qualifying beneficiary.
- c. Employer name and mailing address.
- d. Telephone number to contact the person completing the employer portions of the notice.

C. After completing the employer portions, retain the employer copy of the *Continuation - Conversion Notice* for your records and forward the remaining copies to the qualified beneficiary(ies) along with the *Group Health Insurance Application*. (Refer to Subchapter 604.)

If, on the basis of the most recent information available to the employer, the qualified beneficiaries reside at the same location as the employee, the employer may furnish to the employee the notice addressed to the qualified beneficiaries. If the qualified beneficiaries reside at a location different than that of the employee, the employer must mail the notice to the qualified beneficiaries.

609 Sample *Continuation - Conversion Notice* (ET-2311)

Following is a sample *Continuation - Conversion Notice* that has been completed for a 22-year old dependent whose eligibility ended due to marriage and the dependent is ineligible for continuation due to notice given to the employer after the 60-day notice period.

Department of Employee Trust Funds
Wisconsin Retirement System
P.O. Box 7931
Madison, WI 53707-7931

(Employer must check one prior to giving to the applicant/qualified beneficiary.)

- You are NOT eligible for continuation coverage. Please refer to Item 1 of the attached notice.
 You are eligible for continuation coverage. Please read instructions below.

INSTRUCTIONS

Your health insurance coverage will end on the date indicated in Item 2 of the attached notice, unless the Department of Employee Trust Funds (ETF) receives the attached notice postmarked within 60-days of the date of the employer's signature in Item 8 or within 60 days of the date your coverage ends (Item 2), whichever is later.

A CONTINUATION

Coverage under the group health insurance program will end for you and all other qualified beneficiaries (QBs) on the date entered in Item 2 of the attached notice. A QB is a person losing coverage who was covered on the date of the qualifying event entered in Item 4 of the attached notice. Under Federal Law, known as COBRA, you may continue this coverage. Continuation provides the same coverage you currently have in force and is available, in most cases, for 36 months from the date of occurrence in Item 4. At the end of the 36-month period, you may convert to a non-group policy.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal Law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you have the right under Federal Law to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

You may elect a different health plan at the time continuation is elected if you reside in a county that does not include primary providers in the subscriber's health plan. You may change health plans if you move out of the county, if your health plan ceases to be offered, or during the annual Dual-Choice Enrollment period. Please continue to reference your annual *It's Your Choice* book for additional information concerning your health insurance coverage.

Continuation coverage for you and all other QBs will cease and cannot be reinstated on the earliest of the following: 1) the date coverage ceases because premium is not paid timely; 2) the date your former employer no longer offers any group health coverage; 3) the date you and/or any covered QB become covered under another group health plan after the qualifying event on this application. (Note: If the replacement group health plan has a pre-existing conditions limitation, you remain eligible for our continuation coverage, but only until the creditable coverage to which you are entitled satisfies the pre-existing condition limitations of your replacement coverage.)

The employee or the employee's spouse can elect continuation coverage on behalf of all of the QBs. A parent may elect to continue coverage on behalf of any dependent children. Each QB affected by this notice (i.e., who is losing coverage) has an independent right to elect coverage. Contact the employer entered on Item 8 of the notice for information about enrolling for individual coverage(s).

The employer must be notified of loss of coverage within 60 days of the event or your right to continue group coverage is lost, except in the case of divorce.

To elect continuation coverage:

1. Check box A on the attached *Continuation-Conversion Notice*; date and sign the notice.

Department of Employee Trust Funds
 P. O. Box 7931
 Madison, WI 53707-7931

CONTINUATION – CONVERSION NOTICE
 Group Health Insurance
 s. 2201 of Public Law 99-272

Employee Social Security Number <u>123-45-6789</u>	
Employee Name (Last, First) <u>Smith, Jonathan</u>	
Employee's Birthdate: (MM/DD/CCYY) <u>01/01/1960</u>	Group # <u>84999</u>

Applicant/Qualified Beneficiary Information:* (To be completed by the Employer)

123 Apple St
 Street and No.
Anytown WI 59876
 City State Zip Code

Employee
 Spouse/Former Spouse Name _____
 Dependent Child(ren) Name(s) Susie Smith

*Applicant must also complete ET-2301 or ET-2302 if electing to continue or convert coverage, unless applicant is the Employee and will be continuing the coverage in effect.

TO BE COMPLETED BY APPLICANT

Complete and return this notice ONLY if electing to continue or convert coverage.

APPLICANT: Read the instructions on the front before completing this notice. It contains important eligibility and other information concerning your rights and responsibilities. If you wish to continue your coverage, the Department of Employee Trust Funds must receive this notice postmarked within 60 days after your coverage ends or within 60 days of the date shown in Item 8 below, whichever is later.

CHECK ONE ONLY - Box A, B, C, or D. See the instructions for information which corresponds to the following elections.

- A I elect to continue coverage under the group health plan for a maximum of 36 months. I understand the health plan will bill me directly for premiums at the above address. OR
- B I elect to convert the group coverage to a non-group policy. (Conversion may be considerably more expensive and/or provide fewer benefits.) If electing this option, I understand I am subject to the health plan's conversion policy provisions. OR
- C I have 20 years of creditable service and I am eligible to apply for an immediate annuity but am not applying at this time and want to continue my insurance. OR
- D (For State participants only) I have 20 years of creditable service, and am terminating state employment. (If electing this option, the Department of Employee Trust Funds must receive this completed notice by the date shown in Item 2. below.)

DIFFERENT COUNTY: I have elected coverage and I live in a county that does not have a primary physician in the current health plan. I have indicated on the application form (ET-2301 or ET-2302) the health plan to which I am switching.

MEDICARE: Check here if you or anyone on your policy is eligible for Medicare Parts A & B. (See instructions.)

Date (MM/DD/CCYY)	Signature of Applicant	Daytime Telephone ()
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TO BE COMPLETED BY EMPLOYER PRIOR TO GIVING TO THE APPLICANT

EMPLOYER: Federal law requires this notice to be issued to qualified beneficiaries within 14 days after the date in Item 5. Complete the information above and Items 1-8 below. Refer to the *Group Health Insurance Employer Administration Manual* for further assistance.

1. Not eligible: (Reason) Notice to employer given after 60-day notice period.

2. Date applicant/qualified beneficiary's coverage ends: 7/31/06

3. Reason for coverage ending (the qualifying event): (check one)
 Employment terminated Death
 Divorce entered Dependent no longer eligible (reason) married
 Other _____

4. Date of occurrence in Item 3: 7/17/2006

5. Date employer notified of occurrence in Item 3: 12/20/2006

6. Coverage in effect at time of occurrence in Item 3: Single Family

7. Name of Health Plan Dean Health Plan Monthly Premium Rate: \$ 1090.60

8. Completed By Betty Lou Payroll Date Notice Provided (MM/DD/CCYY) 12/22/2006 Employer Name State Agency ABC Telephone (608) 123-1444
123 Any St, MADISON WI

FOR EMPLOYEE TRUST FUNDS USE

New Group Number	Continued Coverage Effective From (MM/DD/CCYY) _____ Through (MM/DD/CCYY) _____	By _____	Date (MM/DD/CCYY)
		Telephone: <u>608-264-7900</u>	