



Consumer Federation of America

CENTER for
ECONOMIC
JUSTICE | FAIR ACCESS
FAIR TREATMENT

March 18, 2020

Dear Commissioner:

We write to urge you to direct auto insurers in your state to provide premium offset payments to policyholders whose driving has been affected by COVID-19 – specifically, for those policyholders whose miles driven has declined and will continue to remain lower than anticipated at the time of policy rating for the foreseeable future. Without a return of premium to the millions of Americans who are sheltering in place or have otherwise significantly reduced their driving, consumers will be paying unreasonable and excessive premiums based on outdated estimates of miles driven. Premium offset payments are an efficient way to provide this appropriate relief while retaining insurers’ ability to snap back to prior pricing when mileage returns to the levels on which current rates are based.

Directing auto insurers to provide such relief is reasonable and necessary and urgent action is needed. It is reasonable – and actuarially sound – to direct the proposed offset payments because miles driven is one of the primary determinants of claim frequency. In fact, in a 2016 paper with colleagues from South Korea and Taiwan, Dr. Jean Lemaire (Harry J. Loman Professor of Insurance and Actuarial Science at the Wharton School of the University of Pennsylvania) found that “by far, mileage is the most accurate variable that insurers could introduce.”ⁱ Of course, it is also entirely intuitive to any motorist: if you drive fewer miles, you are less likely to be in a moving accident. Indeed, the vast reduction in drivers on the road and miles driven will have a dramatic impact on claim frequency. Imagine if the population density of New York City transformed into the population density of Idaho overnight. In terms of drivers on the road, that is exactly what is happening in many urban and suburban areas.

All insurers, directly or indirectly, use some measure of miles driven to determine rates, so the actions to contain COVID-19, which have radically reduced driving in America, will result in savings to the system that can be quantified and returned to American consumers.

For millions of Americans impacted by COVID-19 social distancing measures – who are no longer driving to work because they have been directed to work from home or their employer has closed down – the annual mileage on which their auto insurance premium is based has suddenly and dramatically become incorrect. If a policy was rated based on commuting to work, then anyone who is staying home and only driving to the market for supplies is paying a premium that is now excessive.

To illustrate, assume a premium based on 1,000 mile/month (12,000 annual miles) and, due to social distancing, the mileage now decreases to 200 mile/month (2,400 annual miles). Assume that the premium, all other things constant, for a policy based on 12,000 miles annually is \$1,500 and the premium for 2,400 miles annually is \$900 – a difference of \$600 annually. In this illustration, the insurer would make a premium payment offset of \$50 per month so long as COVID-19 restrictions are in place and miles driven are reduced.

From a claims perspective, the impact is instantaneous. As videos of empty avenues in Manhattan and wide-open freeways in California make clear, the number of daily car accidents in America must have fallen precipitously over the last several days and will certainly continue to stay low for weeks and perhaps months to come. As the frequency of accidents dwindles, the savings to the insurance pool should be returned to the people who have paid for coverage based on an assumed risk level that has been made inaccurate as a result of COVID-19.

This premium relief will ensure that rates are not excessive. Failure of insurers to offset premiums will provide insurers with a windfall – premiums based on claim costs associated with a substantially overestimated amount of miles driven.

Unlike the typical variation from the estimate of mileage for any individual driver, which does not require a widescale response, this relief is necessary because the social distancing directives of local, state and federal governments have resulted in massive swaths of the population working at home instead of commuting to their offices, workers being laid off due to business closures, and people being quarantined. The auto insurance premium relief is particularly crucial for those who have lost their incomes due to businesses closing.

Urgent action is needed to both provide critical relief to drivers impacted by COVID-19 social distancing measures and to avoid windfall profits for insurers due to excessive rates.

We urge you to take the following actions:

1. Direct auto insurers in your state to contact their policyholders and offer premium relief to any policyholder who can demonstrate or attest that their miles driven has been impacted by COVID-19 safety measures.
2. Direct insurers that such premium relief is permitted by state law and is not a rebate.
3. Direct insurers to file with your department the notices they will send to policyholders and the process and timing they will use to provide relief.
4. Direct insurers to report on a monthly basis anonymized information on each request for relief received, including
 - a. Date of request,
 - b. ZIP Code of policyholder,
 - c. Original annual premium of policy,
 - d. Whether request was granted or rejected,
 - e. If rejected the reason for rejection, and

- f. If granted the amount of premium relief.
5. Encourage drivers to contact their auto insurers for relief as part of your Department's COVID-19 consumer outreach and education.

On behalf of hundreds of consumers organizations, we thank you for your consideration and request your response to this letter by March 23, 2020. We can be reached via email at CFA@ConsumerFed.org.

Sincerely,



J. Robert Hunter, FCAS, MAAA
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ⁱ Lemaire, J., Park, S.C. & Wang, K.C. 2016, "The Use of Annual Mileage as a Rating Variable," ASTIN Bulletin, vol. 46, no. 1, pp. 39-69. doi: 10.1017/asb.2015.25, retrieved, with distinct pagination, from <http://www.actuaries.org/ASTIN/Colloquia/Hague/Papers/Lemaire.pdf>



Consumer Federation of America

CENTER for
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FAIR TREATMENT

March 30, 2020

Dear Commissioner,

We urge you to take action on key P&C insurance consumer protection issues arising from COVID-19 and federal and local government responses to the pandemic, particularly the excessive premiums being charged to individuals and businesses for lines of insurance that base rates on factors such as miles driven, payroll, and receipts.

Before getting into the details of why you need to act now to give insurance buyers options for temporary relief from illegally excessive premiums during the COVID-19 crisis, we want to thank those of you who have taken action to prohibit cancellation of policies and other steps to provide critical relief for many individuals and businesses (most of which are listed in a compendium of state responses compiled by Sidley Austin LLP, found at <https://www.sidley.com/en/insights/newsupdates/2020/03/compendium-of-us-state-insurance-department-responses-to-the-covid19-pandemic>).

As you know, millions of consumers and businesses are affected by this extraordinary outbreak – hundreds of thousands have been and will become infected, but hundreds of millions are dramatically affected by social distancing requirements of state and local governments. Millions of workers have been laid off and thousands of businesses have been forced to close. These workers and businesses will experience a variety of financial hardships through no fault of their own with enormous consequences for their insurance coverages.

While certain lines of insurance will see an increase in claims and claim costs, other lines will see radical decreases in claims and claims costs. With that in mind, we ask your further action on the following:

1. Premium Relief Resulting from Radical Changes in Exposure
2. Imposing a Moratorium on the use of Insurance Credit Scoring
3. Monitor Credit-Related Insurance Markets Closely

1. Premium Relief Resulting from Radical Change in Exposure

On March 18, 2020, we sent you a letter (attached) urging you to take action to provide temporary premium offset payments to policyholders whose exposure to loss has been greatly reduced by the COVID-19 crisis. We particularly pointed out that miles driven have declined sharply in most of the nation by “stay at home” orders and other actions to prevent spread of the

novel coronavirus. Allowing current premiums to remain in place would produce huge windfall profits to insurers and further stress policyholders, millions of whom have been laid off or are getting reduced incomes. Simply put, without your action in lines where rates are based on exposures such as miles driven, payroll, and receipts, current premium charges are illegal during the duration of the COVID-19 crisis because they are significantly excessive.

Personal auto insurance is not the only type of insurance experiencing a dramatic reduction in exposure. Businesses whose premium is based on employee count or measures of serving the public such as receipts and who have been forced to close are also experiencing radical reductions in exposure – changing the exposure basis used when the policies were originally written.

The Alaska Division of Insurance has taken an action – through Bulletin B 20 10¹, which squarely addresses this issue. In its bulletin, the Director writes:

Many property and casualty insurance policies calculate premiums based on exposure estimates made at the time the policy is issued. Examples of common exposure bases include miles driven, sales revenue, receipts, or payroll. Due to the far-reaching effects of the COVID-19 outbreak and local, state, and federal governments' responses, for many policyholders, initial estimates are expected to be much higher than the exposure actually realized. Recognizing there are other difficult-to-quantify effects of the COVID-19 outbreak that will affect exposure to loss in the near term, insurers are encouraged to allow policyholders to self-audit and self-report changes in their exposure or risk profile and adjust premiums accordingly

We urge you to use the Alaska action as a starting point, a model for action in your state. But, as our earlier letter points out, further action by insurance regulators is needed to address rates that have become excessive and unfairly discriminatory.

1. Direct insurers in your state to contact their policyholders and offer premium relief to any policyholder who can demonstrate or attest that their exposure basis has been impacted by COVID-19 safety measures.
2. Direct insurers that such premium relief is permitted by state law and is not a rebate.
3. Direct insurers to file with your department the notices they will send to policyholders and the process and timing they will use to provide relief.
4. Direct insurers to report on a monthly basis anonymized information on each request for relief received, including
 - a. Date of request,
 - b. ZIP Code of policyholder,
 - c. Original annual premium of policy,
 - d. Whether request was granted or rejected,

¹ Found at https://www.commerce.alaska.gov/web/Portals/11/Pub/INS_B20-10.pdf

- e. If rejected the reason for rejection, and
 - f. If granted the amount of premium relief.
5. Encourage drivers to contact their auto insurers for relief as part of your Department's COVID-19 consumer outreach and education.

2. Impose a Moratorium on Insurance Credit Scoring

The continued use of credit scoring by insurers will penalize consumers who are the victims of COVID-19 and the massive economic and medical costs of the virus and government response. From an actuarial standpoint, the basis for the immediate moratorium is that insurance credit scoring has become a clearly unfairly discriminatory underwriting, tier placement, and rating factor. Whatever basis insurers may have used to justify their credit-based insurance scores in times past cannot hold when declining credit scores is symptomatic of policyholders' diminished exposure (not working and not driving, for example), exactly the opposite of what credit-based insurance models predict will happen.

While some states have provisions in their insurance credit scoring models for consumers to challenge their insurance credit scores due to life events, such a provision is not found in many state statutes. Nor should it be the burden of consumers to address this, given that most likely do not even know that their credit impacts their policy in any way.

Predictive models are developed based on historical data -- the data are mined to see what factors are most predictive of a particular outcome. If the training data are biased, incorrect, incomplete – or not representative of the future experience – the model will reflect and perpetuate the bias in the data. In the case of insurance credit scoring, historical data will not reflect the current and near future credit experience of many consumers who have been laid off, whose business has closed, who have essentially stopped driving, who have major medical bills due to COVID-19 and more.

In the case of insurance credit scoring, it is profoundly unfair to penalize drivers, homeowners, or renters with higher insurance premiums, because they were the victims of COVID-19 or are contending with the various government responses thereto. Further, there is no question that insurance credit scores will suffer. Rate filings we reviewed illustrate, among other things, that insurance credit scoring, at best, can segment historical experience, but cannot be relied upon as predictive of future experience, especially in a time such as this. The filings also show that consumers will suffer because of negative factors tied to economic conditions, generally, and COVID-19 impact, specifically, including, but not limited to:

- Months since recent delinquency – consumers without a paycheck or on unemployment or with high medical bills are far more likely to have a delinquency. Almost all bankruptcies are a result of medical debt (with the majority occurring for those with insurance, job loss, and divorce)

- Months since oldest trade opened – consumers without a paycheck or on unemployment are far more likely to turn to credit to pay bills.
- Utilization of open bank revolving trades
- Number of trades opened in last 6 months
- Number of open credit card trades verified in last 12 months with utilization > 75% – this one particularly punishes lower income consumers whose trade lines have modest limits.
- Months since most recent collections
- Number of trades 30 or more day past due in last 12 months
- Number of inquiries in last 24 and last 3 months
- Number of home equity trades

The moral unfairness of credit scoring is clear, but so is the actuarial unfairness. We know insurance claims for some lines of insurance, including personal auto, will be dropping overnight as people shelter in place, stop commuting to work, stop going to public social events. So, as insurance claims are dropping generally – and for people who have stopped driving, specifically – many of these same people will see their credit scores worsen because their lost income or costs incurred as result of COVID-19. Past history will not be a predictor of future performance when conditions change significantly, as they have.

We ask that you use your authority to direct insurers to stop using insurance scores based on credit through the end of the year and require insurers to use no worse than a neutral insurance score – meaning a score that doesn't penalize a consumer for credit experience, a score that would produce the same premium as if the insurer did not utilize credit for underwriting or rating. The moratorium should last until regulators have independently gathered sufficient data – not relying upon data cherry picked by insurers – to meaningfully assess the actuarial relationship between credit and risk of loss.

3. Closely Monitor Credit-Related Insurance Markets

There are a number of credit-related insurance products for which claims or exposures may increase, including credit involuntary unemployment, credit life insurance and force-placed insurance.

We bring this to your attention because these coverages have long been a source of consumer abuse. For example, we saw massive overcharges due to insurer kickbacks to lenders and servicers during the Great Recession. For another example, credit life and credit unemployment insurance are often sold by lenders who are affiliated (through captive reinsurance arrangements) with the insurers obligated to pay the claims. Consequently, we ask that you monitor these markets closely to ensure legitimate claims are paid and that price gouging does not occur. Just as states utilize special data calls in the aftermath of a hurricane or

flood to monitor claim settlement performance of insurers, we suggest similar monthly data calls of credit-related insurers to monitor the effects of a catastrophic event for these lines of business.

CFA and CEJ Are Ready to Help

Between our two organizations, we have decades of actuarial, economic and policy experience with all types of insurance and expertise in advanced analytics. Our organizations are also part of networks with hundreds of other consumer-oriented organizations, giving us the ability to tap our network to find the expertise you may need. If we can help, please let us know.

Sincerely,



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CEJ Discussion of Disparate Impact in Insurance

June 2020

What is Disparate Impact Unfair Discrimination?

Disparate impact refers to policies, practices and outcomes that have the effect of discriminating against protected classes. Disparate impact refers to a different type of unfair discrimination from disparate treatment. Disparate treatment means discriminating directly on the basis of prohibited characteristics, while disparate impact, also known as disparate effect, refers to discrimination based on practices that have the effect of discriminating on the basis of prohibited characteristics.

While a controversial issue in financial services regulation, disparate impact has been recognized as a form of prohibited unfair discrimination by numerous courts, including the U.S. Supreme Court in a 2015 decision. Justice Kennedy wrote

Recognition of disparate-impact claims is also consistent with the central purpose of the FHA, which, like Title VII and the ADEA, was enacted to eradicate discriminatory practices within a sector of the Nation's economy. Suits targeting unlawful zoning laws and other housing restrictions that unfairly exclude minorities from certain neighborhoods without sufficient justification are at the heartland of disparate-impact liability. See, e.g., *Huntington v. Huntington Branch, NAACP*, 488 U. S. 15, 16–18. Recognition of disparate-impact liability under the FHA plays an important role in uncovering discriminatory intent: it permits plaintiffs to counteract unconscious prejudices and disguised animus that escape easy classification as disparate treatment.

The Court holds that disparate-impact claims are cognizable under the Fair Housing Act upon considering its results-oriented language, the Court's interpretation of similar language in Title VII and the ADEA, Congress' ratification of disparate-impact claims in 1988 against the backdrop of the unanimous view of nine Courts of Appeals, and the statutory purpose.

The Supreme Court case dealt with a disparate impact claim under the federal Fair Housing Act which prohibits discrimination in housing on the basis on the basis of race, color, religion, sex, familial status, or national origin. In addition to recognizing disparate impact as a type of unfair discrimination covered by the FHA, courts have also recognized that unfair discrimination in home insurance – whether disparate treatment or disparate impact – is also covered by the FHA.

Why is Explicit Recognition of Disparate Impact as Unfair Discrimination in Insurance against Protected Classes Reasonable and Necessary?

- 1. If discriminating intentionally on the basis of prohibited classes is prohibited – e.g., insurers are prohibited from using race, religion or national origin as underwriting, tier placement or rating factors – why would practices that have the same effect be permitted?*

Example of Disparate Impact in insurance: In the 1990's, fair housing groups brought a disparate impact challenge against insurers' use of age and value of the home for underwriting. The groups argued that these underwriting guidelines discriminated against minority communities because these communities' housing was characterized by low value and old age. The challenges were largely successful and, in response, insurers developed more detailed underwriting based on, for example, age and type of electrical system and age and condition of the roof.

- 2. In an era of big data analytics, the potential for proxy discrimination has grown dramatically.*

Barocas and Selbst: *Big Data's Disparate Impact*

Advocates of algorithmic techniques like data mining argue that they eliminate human biases from the decision-making process. But an algorithm is only as good as the data it works with. Data mining can inherit the prejudices of prior decision-makers or reflect the widespread biases that persist in society at large. Often, the “patterns” it discovers are simply preexisting societal patterns of inequality and exclusion. Unthinking reliance on data mining can deny members of vulnerable groups full participation in society.

TransUnion Criminal History Scores

“TransUnion recently evaluated the predictive power of court record violation data (including criminal and traffic violations)

“Also, as court records are created when the initial citation is issued, they provide insight into violations beyond those that ultimately end up on the MVR—such as violation dismissals, violation downgrades, and pre-adjudicated or open tickets.”

What is the likelihood that TU Criminal History Scores have a disparate impact against African-Americans? Consider policing records in Ferguson, Missouri.

US DOJ Investigation of the Ferguson Police Department

Ferguson's approach to law enforcement both reflects and reinforces racial bias, including stereotyping. The harms of Ferguson's police and court practices are borne disproportionately by African Americans, and there is evidence that this is due in part to intentional discrimination on the basis of race.

Ferguson's law enforcement practices overwhelmingly impact African Americans. Data collected by the Ferguson Police Department from 2012 to 2014 shows that African Americans account for 85% of vehicle stops, 90% of citations, and 93% of arrests made by FPD officers, despite comprising only 67% of Ferguson's population.

FPD appears to bring certain offenses almost exclusively against African Americans. For example, from 2011 to 2013, African Americans accounted for 95% of Manner of Walking in Roadway charges, and 94% of all Failure to Comply charges.

Our investigation indicates that this disproportionate burden on African Americans cannot be explained by any difference in the rate at which people of different races violate the law. Rather, our investigation has revealed that these disparities occur, at least in part, because of unlawful bias against and stereotypes about African Americans.

3. *Disparate Impact is Particularly Suited to Insurance: Disparate Impact Analysis is Consistent with State Regulatory Requirements Regarding Unfair Discrimination and with Actuarial Justification Used by Insurers.*

State insurance laws and regulation typically require prohibit rates and other practices that are unfairly discriminatory. For pricing (underwriting, tier placement, rating factors), unfair discrimination is generally understood as a statistical or actuarial measure – consumers of similar risk and hazard are treated differently.

Actuarial justification is a statistical test – that a particular characteristic of the consumer, vehicle, property or environment is correlated with a particular outcome, like pure premium (average claim cost). The same statistical test can be used to evaluate and minimize disparate impact. Stated differently – if a particular correlation and statistical significance is used to justify, say, insurance credit scoring, those same standards of correlation and statistical significance are reasonable evidence of disparate impact and unfair discrimination on the basis of prohibited factors.

In addition, the ability of insurers to identify and minimize disparate impact can be easily built into the development of pricing, marketing or claim settlement models by including consideration of prohibited characteristics as control variables in the development of the model and then omitting these prohibited characteristics when the model is deployed.

Consider the simple model

$$b_0 + b_1X_1 + b_2X_2 + b_3X_3 + e = y$$

Say that X_1 , X_2 + X_3 are miles driven, driving record and credit score and we are trying to predict y – the frequency of an auto claim.

Let's assume that all three X s are statistically significant predictors of the likelihood of a claim and the b values are how much each X contributes to the explanation of claim.

b_0 is the “intercept” – a base amount and e is the error term – the portion of the explanation of the claim not provided by the independent variables.

Now, let’s add a control variable for race:

$$b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y$$

R_1 is a control variable – by including race in the model development, the correlation of the X s to race is statistically removed and the new b values are now the contribution of the X s, independent of their correlation to race, to explaining the likelihood of a claim

When the model is deployed, the variable for race is removed – the X s remain, but the b values now minimize disparate impact.

Recognizing disparate impact as unfair discrimination in insurance is both reasonable and beneficial:

- Minimizes Disparate Impact – Stop the Cycle of Perpetuating Historical Discrimination.
- Promotes Availability and Affordability for Underserved Groups
- Improves Cost-Based Insurance Pricing Models
- Improve Price Signals to Insureds for Loss Mitigation Investments
- Help Identify Biases in Data and Modelers / Improve Data Insights
- Improve Consumer Confidence of Fair Treatment by Insurers

How Does the Current HUD Rule Address Disparate Impact Unfair Discrimination? Why Does the Proposed HUD Rule Effectively Eliminate Disparate Impact?

In 2013 HUD finalized a revised rule codifying its enforcement practices regarding disparate impact (“disparate effects”).¹ The rule codified the three-part burden shifting test:

This rule formally establishes the three-part burden-shifting test for determining when a practice with a discriminatory effect violates the Fair Housing Act. Under this test, the charging party or plaintiff first bears the burden of proving its prima facie case that a practice results in, or would predictably result in, a discriminatory effect on the basis of a protected characteristic. If the charging party or plaintiff proves a prima facie case, the burden of proof shifts to the respondent or defendant to prove that the challenged practice is necessary to achieve one or more of its substantial, legitimate, nondiscriminatory interests. If the respondent or defendant satisfies this burden, then the charging party or plaintiff may still establish liability by proving that the substantial, legitimate, nondiscriminatory interest could be served by a practice that has a less discriminatory effect.

¹ <https://www.hud.gov/sites/documents/DISCRIMINATORYEFFECTRULE.PDF>

Disparate impact insurance claims under the FHA have been rare. When brought, typically by a fair housing organization, the charging party must provide a substantive basis for the allegation and such basis has typically included statistical tests. If the charging party meets its burden of demonstrating possible disparate impact unfair discrimination, the defendant insurer has the opportunity to, one, demonstrate that the statistical evidence support the disparate impact claim is flawed, and, two, that the challenged practice serves a substantial, legitimate and nondiscriminatory purpose. Finally, the burden then shifts to the charging party to demonstrate that the legitimate purpose can be accomplished in a manner with a lesser disparate impact on the protected class or classes.

In 2019, HUD proposed revisions to the disparate impact rule that would effectively eliminate disparate impact as unfair discrimination by adding a variety of new requirements and defenses, including, but not limited to the following::

- Identify a specific, identifiable practice as opposed to simply identifying the disparate impact. This provision would eliminate a disparate impact claim that demonstrated disparate impact, but failed to pinpoint the specific industry practice causing it. Given that insurers have come to rely more and more on third party data and algorithms that are treated as confidential, the ability of a charging party to pinpoint the specific cause of the disparate impact is unlikely and unreasonable.

As discussed further, below, the nature of insurer underwriting, pricing and claims settlement practices has changed dramatically over the past few decades. Thirty years ago, the vast majority of risk characteristics and factors used for pricing were included in regulatory filings and transparent to regulators and consumers. But in recent years, the use of proprietary third-party data sources and algorithms and the introduction of “rating tiers” as unfiled underwriting guidelines have made insurer practices far less transparent to regulators and even less transparent to consumers.

- Change the order of burdens to require the charging party to initially plead that a practice is arbitrary, artificial and unnecessary. In the current rule, this burden on the charging party comes only after the insurer has explained why the practice is legitimate and necessary. The proposed change asks the charging party for the impossible – to rebut a business necessity claim without having access to the business necessity explanation.
- Require new standards of evidence – a “robust causal link” and “injury is directly caused by the challenged policy or practice.” These standards effectively preclude any disparate impact challenge because they require the charging party not just to identify disparate impact but also pinpoint the precise practice that is causing the disparate impact. Consider the following example. A fair housing organization, the charging party could, performs statistically-valid testing and produces statistical-valid evidence of disparate impact upon, say, African-Americans in the offer of rental insurance. Under the current rule, the charging party would have met its prima facie burden. Under the proposed rule, the charging party would not meet the various new burdens because the charging party

has not pin-pointed the specific underwriting guideline or algorithm used by the insurer causing the disparate impact.

- Justify disparate impact simply by reliance on a third-party model or algorithm. The proposed rule allows the defendant to defeat the disparate impact claim – even if the charging party has somehow met the new requirements to establish a prima facie case of discriminatory effect simply by relying upon a third party model:

Failure to allege a prima facie case. A defendant, or responding party, may establish that a plaintiff's allegations do not support a prima facie case of discriminatory effect under paragraph (b), if

(2) Where a plaintiff alleges that the cause of a discriminatory effect is a model used by the defendant, such as a risk assessment algorithm, and the defendant:

(i) Provides the material factors which make up the inputs used in the challenged model and shows that these factors do not rely in any material part on factors which are substitutes or close proxies for protected classes under the Fair Housing Act and that the model is predictive of credit risk or other similar valid objective;

(ii) Shows that the challenged model is produced, maintained, or distributed by a recognized third party that determines industry standards, the inputs and methods within the model are not determined by the defendant, and the defendant is using the model as intended by the third party; or

(iii) Shows that the model has been subjected to critical review and has been validated by an objective and unbiased neutral third party which has analyzed the challenged model and found that the model was empirically derived and is a demonstrably and statistically sound algorithm which accurately predicts risk or other valid objectives, and that none of the factors used in the algorithm rely in any material part on factors which are substitutes or close proxies for protected classes under the Fair Housing Act;

The third-party model or algorithm defense is flawed for several reasons. Most important, it eliminates disparate impact as unfair discrimination. Subpart (i) says that a practice based on a third-party model or algorithm is fair – and cannot have a disparate impact – as long as the prohibited factors are not used in the model. This is contrary to the very definition and spirit of disparate impact – that superficially-neutral factors or practices can lead to disparate effects. Under subpart (i), the TransUnion criminal history score, discussed above, would pass muster, even though this algorithm clearly reflects and perpetuates the discrimination that anti-discrimination laws are intended to stop.

Subpart (ii) removes any responsibility by the insurer for the outcomes of its practices as long as those practices are based on a third-party model. This is contrary to insurance regulatory practice which makes insurers responsible for third-party tools the insurer may use. Even in situations where the regulator permits the insurer to rely on third party certification of a model that is done subject to regulatory review of the model through filings by vendors or advisory organizations.

Subpart (iii) removes any requirement that a third-party modeler test its model for disparate impact. The result is that an insurer can rely upon a third-party model even if that that modeler has done nothing to examine or minimize disparate impact in its model. All three subparts of this defense provision reflect a profound and fundamental misunderstanding of both disparate impact and the nature of complex, multi-variate models used by insurers (and others) today.

APCIA Arguments against Recognition of Disparate Impact Based on Faulty Assumptions

APCIA opposes recognition of disparate impact as unfair discrimination in insurance. APCIA's arguments can be distilled to the following:

State laws require rates to be not excessive, not inadequate and not unfairly discriminatory. These standards require cost-based pricing. Recognition of disparate impact would prevent insurers from utilizing neutral factors that are predictive of risk and loss and, thus, undermine the business of insurance and conflict with existing state laws.

There are several problems with APCIA's argument.

State Insurance Regulators Believe They Currently Have Authority to Stop Disparate Impact Unfair Discrimination – But Regulatory Standards for Regulators and Insurers Are Lacking

Most state regulators believe they currently have authority to stop insurer practices which have the effect of discriminating against protected classes even if the prohibited class characteristics are not explicitly being used. Examples demonstrating such regulatory belief include:

- The New York Department of Financial Services Circular Letter 2019-01: Use of External Consumer Data and Information Sources in Underwriting for Life Insurance.² *“Based on its investigation, the Department has determined that insurers’ use of external data sources in underwriting has the strong potential to mask the forms of discrimination prohibited by these laws. Many of these external data sources use geographical data (including community-level mortality, addiction or smoking data), homeownership data, credit information, educational attainment, licensures, civil judgments and court records, which all have the potential to reflect disguised and illegal race-based underwriting that*

² https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2019_01

violates Articles 26 and 42. . . . an insurer should not use an external data source, algorithm or predictive model in underwriting or rating unless the insurer can establish that the underwriting or rating guidelines are not unfairly discriminatory in violation of Articles 26 and 42.”

- The *NAIC Market Regulation Handbook* in the chapter discussing global objectives of market analysis states:

Identify underwriting and rating variables that may have a significant disparate impact or are proxy variables for prohibited characteristics: *Some variables may serve to disproportionately deny coverage to specific geographic markets and may also lack strong actuarial justification.*³

Although state insurance regulators believe they have the authority to stop proxy discrimination, there are currently no regulatory standards for what constitutes such discrimination, what types of analysis and tools can serve as appropriate evidence or what practices insurers or third-party vendors of algorithms can employ to demonstrate efforts to minimize disparate impact.

APCIC Incorrectly Argues That Efforts to Minimize Disparate Impact Will Necessarily and Substantially Impair Cost-Based Pricing

APCIA’s foundational argument – that recognition of disparate impact must impair cost-based pricing and, therefore, undermine the business of insurance and violate state laws – is incorrect. APCIA’s claim is based on a concept that recognition of disparate impact would prevent insurers (in pricing) from using factors that have a correlation to expected losses. This reflects a fundamental misunderstanding how to recognize disparate impact, how to minimize disparate impact and how insurer pricing has changed over the past 30 years.

Historically, insurers did not utilize multi-variate analyses to a great extent. That means, historically, insurers would look at the relationship between a particular rating factor and expected losses and do the same for the next rating factor – described as a univariate approach because analysis was based one factor at a time. For some large insurers or advisory organizations who had large enough data sets to meet credibility standards, we might have seen two factors analyzed.

Over the last three decades, univariate analysis has been replaced by multi-variate analysis – the analysis of multiple factors simultaneously to evaluate each factor’s contribution to claims (or other value to be predicted.) Today, this analysis is done through a variety of statistical techniques, including generalized linear models. Multi-variate analysis has significant benefits over traditional univariate analysis in at least two major ways.

³ *NAIV Market Regulation Handbook, 2017 Edition* at page 67.

First, multi-variate analysis helps to remove the effects of correlation among the rating factors. Stated differently, if say, geographic rating and multi-car discounts were analyzed separately, there might be some double-counting because multi-car discounts might be much more prevalent in certain geographic rating territories. Multi-variate analysis, by analyzing the various factors simultaneously, helps remove such double counting and permits the identification of each factor's unique contribution to explaining risk of loss (or other predicted outcome).

Second, multi-variate analysis permits the use of "control variables" to reduce the effect of other influences on the rating factors. For example, many auto and home insurers today utilize a GLM or similar model to create a nationwide rating model. In building these models, the insurers will typically use a control variable to account for different state's effects – for example, for auto insurance, different tort systems and different minimum insurance requirements. By including a control variable for state – the statistical model removes some of the state effects from other variables, leaving the results of those other variables a better and more accurate indication of those variables independent relationship with the predicted outcome.

Recognizing disparate impact as unfair discrimination in insurance will improve – and not impair – cost-based pricing or other insurance applications. For example, by explicit recognition of the variables for protected classes as control variables in the insurer's model development, the insurer can better identify the unique contribution of other rating or predictive variables to the predicted outcome because the correlation between those variables and protected class characteristics has been minimized by using the protected class characteristics as control variables.

APCIA's Incorrectly Argues That Any Practice That Does Not Explicitly Utilize or is Based Upon Protected Class Characteristics is Neutral and Cannot Have a Disparate Impact.

Running throughout APCIA's arguments is the concept that any factor other than those explicit descriptors of prohibited classes are neutral. As noted above, it is universally understood that factors other than protected-class descriptors can be correlated with and/or serve as a proxy for the prohibited class descriptors. This is the case because so-called "facially neutral" factors can reflect historical discrimination or serve as a proxy for the prohibited class characteristics. It makes no more sense to claim that factor X cannot have a discriminatory effect on a protected class because it is not an explicit descriptor of the protected class than to claim that factor X cannot have be predictive of claims because it is not an explicit descriptor of claims.

APCIA's claim is particularly wrong in the current era of multivariate models used by insurers. It has long been a staple of actuarial standards of practice that justification for any particular rating factor requires only a demonstration of correlation or significant statistical relationship. In an era of multi-variate models, the method of demonstration is to examine statistical measures of the model, including, for example, the coefficient of predictive variable / rating factor (is it large enough to be meaningful?) and the statistical significance of the variable (is there a strong statistical relationship between the variable and the predicted outcome?).

Stated differently, the method to justify that a particular rating factor is not unfairly discriminatory and meets both statutory and actuarial standards is to demonstrate a significant statistical relationship or correlation. It is both logical and reasonable that the same type of test of statistical significant or justification be available for assessing unfair discrimination.

~~Adopted by the Life Insurance and Annuities (A) Committee — Dec. 11, 2016
Adopted by the Life Actuarial (A) Task Force — Nov. 17, 2016~~

Actuarial Guideline XLIX-A – Draft [ACLI DRAFT, JUNE 4, 2020]

**THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION
TO POLICIES WITH INDEX-BASED INTEREST SOLD AFTER [greater of 5
months after LATF adoption and 3 months after EX/Plenary Adoption*]**

Background

The *Life Insurance Illustrations Model Regulation* (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an ~~external~~ index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for inforce illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

- (1) Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
- (2) Limits the policy loan leverage shown in an illustration.
- (3) Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective ~~as follows:~~ for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption].

- ~~i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.~~
- ~~ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.~~
- ~~iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.~~

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

- i. The policy is subject to Model #582.
- ~~ii. Interest credits are linked to an external index or indices.~~
- ii. The policy offers Indexed Credits.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

- i. The ~~credited rate~~Annual Rate of Indexed Credits for each Index Account does not exceed the lesser of the maximum ~~credited rate~~Annual Rate of Indexed Credits for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the ~~credited rate~~Annual Rate of Indexed Credits for each Index Account shall not exceed the average of the maximum ~~credited rate~~Annual Rate of Indexed Credits for the illustrated scale and the guaranteed ~~credited rate~~Annual Rate of Indexed Credits for that account. However, the ~~credited rate~~Annual Rate of Indexed Credits for each Index Account shall never be less than the guaranteed ~~credited rate~~Annual Rate of Indexed Credits for that account.
- ii. If the illustration includes a loan, the illustrated ~~rate credited to the loan balance does~~Policy Loan Interest Credited Rate shall not exceed the illustrated ~~loan charge~~Policy Loan Interest Rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.
- iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedges for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. "Charges of any kind cannot be used to increase the Annual Net Investment Earnings Rate.

C. Annual Rate of Indexed Credits: The total annualized Indexed Credits expressed as a percentage of the account value used to determine the Indexed Credits.

~~B-D.~~ Benchmark Index Account: An Index Account with the following features:

- i. The interest calculation is based on the percent change in S&P 500[®] Index value only, over a one-year period using only the beginning and ending index values. (S&P 500[®] Index ticker: SPX)
- ii. An annual cap is used in the interest calculation.
- iii. The annual floor used in the interest calculation shall be 0%.
- iv. The participation rate used in the interest calculation shall be 100%.
- v. Interest is credited once per year.
- ~~vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy's Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.~~

- ~~vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.~~
- ~~vi. The Hedge Budget used to determine the cap in 3 (C) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind cannot be used to increase the annual cap.~~
- ~~vii. There are no enhancements or similar features that provide additional Indexed Credits, including but not limited to experience refunds, multipliers, or bonuses.~~
- viii. There are no limitations on the portion of account value allocated to the account.
- ~~ix. A single Benchmark Index Account will be determined for each policy. This can be either an Index Account offered with the illustrated policy or determined according to Section 4(A)(ii) for purposes of complying with this regulation. A policy shall have no more than one Benchmark Index Account.~~

~~C.E. Fixed Account: An account where the credited rate is not tied to an external index or indices~~ there are no Indexed Credits.

F. Index Account: An account where some or all of the amounts credited are Indexed Credits.

G. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor greater than zero on an Index Account are included.

H. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This total annualized amount should be consistent with the hedging program of the company.

I. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.

J. Policy Loan Interest Rate: The current annual interest rate as defined in the policy that is charged on any Loan Balance. This does not include any other policy charges.

~~D.K. Policy Loan Interest Credited Rate: The annualized interest rate is tied to an external index or indices.~~ credited that applies to the portion of the account value backing the Loan Balance:

- i. For the portion of the account value in the Fixed Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate

[OPTION FOR CONSIDERATION: Please see commentary on these approaches in the ACLI Comment Letter; language for Option 1 and Option 2 may need to be tightened up:

Option 1: ii. For the portion of the account value in an Index Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the Annual Rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account.

Option 2: ii. For any portion of the account value in an Index Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the total of the Annual Rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements that impact such values, net of any applicable Supplemental Hedge Budget for that account.]

L. Supplemental Hedge Budget: For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account

. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. Illustrated Scale

The ~~credited rate~~total Annual Rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:

- A. Calculate the geometric average annual credited rate for ~~each applicable~~the Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.
- i. If the insurer offers ~~an applicable~~a Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the ~~applicable~~ Benchmark Index Account in 4 (A).
 - ii. If the insurer does not offer ~~an applicable~~a Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of ~~at~~the Benchmark Index Account, and shall use that cap in 4 (A).

B. For ~~each applicable the~~ Benchmark Index Account, ~~the Annual Rate of Indexed Credits shall not exceed the minimum of (i) and (ii):~~

- ~~iii.~~i. the arithmetic mean of the geometric average annual credited rates calculated in 4 (A) ~~shall be the maximum credited rate(s) for the illustrated scale.~~
- ii. 145% of the Annual Net Investment Earnings Rate.

C. For ~~any other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall~~ Account that is not the Benchmark Index Account in 3 (C), the Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

- i. The Annual Rate of Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the Index Account.
- ii. The Annual Rate of Indexed Credits should reflect the fundamental characteristics of the Index Account and the ~~parameters shall have the~~ appropriate relationship to the expected risk and return of the ~~applicable~~ Benchmark Index Account. ~~In no event~~The illustration actuary shall use actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

B-D. For the ~~credited~~ Purposes of compliance with Section 6 (C) of Model #582, the Supplemental Hedge Budget is subtracted from the illustrated rate before comparing to the earned interest rate underlying the Disciplined Current Scale as it is supported by policy charges and not the earned interest rate ~~for the illustrated scale exceed the applicable rate calculated in 4 (B).~~

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

~~A.~~ If an insurer engages in a hedging program for ~~index based interest~~ Indexed Credits, the assumed earned interest rate underlying the disciplined current scale for the policy, inclusive of all general account assets, both hedge and non-hedge assets, that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed ~~44.5~~:

i. the Annual Net Investment Earnings Rate, plus

ii. 45% of the lesser of (1) and (2):

1. Hedge Budget minus any annual ~~net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding floor.~~

2. The minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account.

These amounts should be adjusted for timing differences to ensure that fixed interest is not earned on the hedge cost. The assumed return on hedges ~~for index based credits) allocated to support~~ shall only be used in the disciplined current scale testing to support the illustrated Index Credits in the policy.

Guidance Note: The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate underlying the disciplined current scale.

For a product with multiple Index Accounts with different Hedge Budgets, a maximum rate in 5.A. should be calculated for each set of accounts with different Hedge Budgets.

~~A.B.~~ If an insurer does not engage in a hedging program for ~~index based interest~~ Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the ~~annual net investment earnings rate of the general account assets allocated to support the policy~~ Annual Net Investment Earnings Rate.

~~B.C.~~ These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy's account value.

~~C.~~ If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

6. Policy Loans

If the illustration includes a loan, the illustrated ~~rate credited to the loan balance~~ Policy Loan Interest Credited Rate shall not exceed the illustrated ~~loan charge~~ Policy Loan Interest Rate by more than 100 basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 5%.

7. Additional Standards

The basic illustration shall also include the following:

- A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.
- B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

- C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical ~~interest rates~~Indexed Credits using current index parameters for the most recent 20-year period.

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Model COBRA Continuation Coverage Election Notice
Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage election notice that the Plan may use to provide the election notice. To use this model election notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model election notice to be good faith compliance with the election notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model election notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

Model COBRA Continuation Coverage Election Notice
(For use by single-employer group health plans)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice has important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on [enter date] due to [check appropriate box]:

- | | |
|--|---|
| <input type="checkbox"/> End of employment | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee | <input type="checkbox"/> Divorce or legal separation |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of dependent child status |

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on [*enter date*] and can last until [*enter date*].

[*Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].*]

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don’t provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <http://www.dol.gov/ebsa/publications/cobraemployee.html>.

How much does COBRA continuation coverage cost?

COBRA continuation coverage will cost: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]*

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period¹ to sign up, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>. These rules are different for people with End Stage Renal Disease (ESRD).

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security

Administration (EBSA) website at <http://www.dol.gov/ebsa> or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: *[Enter Name and Address]*

This Election Form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than *[enter date]*.

If you don't submit a completed Election Form by the due date shown above, you'll lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the *[enter name of plan]* (the Plan) listed below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

[Add if appropriate: Coverage option elected: _____]

b. _____

[Add if appropriate: Coverage option elected: _____]

c. _____

[Add if appropriate: Coverage option elected: _____]

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact *[enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan]* to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due *[enter due day for each monthly payment]* for that coverage period. *[If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:].* If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan *[select one: will or will not]* send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period *[or enter longer period permitted by Plan]* to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. *[If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]*

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[enter appropriate payment address]

Model COBRA Continuation Coverage General Notice Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information: must pay or aren't required to pay*] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to *[enter name of employer sponsoring the Plan]*, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;];* or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days *[or enter longer period permitted under the terms of the Plan]* after the qualifying event occurs. You must provide this notice to: *[Enter name of appropriate party]*. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]*

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]

FAQs on COBRA Continuation Health Coverage for Workers



U. S. Department of Labor
Employee Benefits Security Administration

Q1: What is COBRA continuation health coverage?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions amend the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to require group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated.

Q2: What does COBRA do?

COBRA requires continuation coverage to be offered to covered employees, their spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. COBRA continuation coverage is often more expensive than the amount that active employees are required to pay for group health coverage, since the employer usually pays part of the cost of employees' coverage and all of that cost can be charged to individuals receiving continuation coverage.

Q3: What group health plans are subject to COBRA?

The law generally applies to all group health plans maintained by private-sector employers with 20 or more employees, or by state or local governments. The law does not apply to plans sponsored by the Federal Government or by churches and certain church-related organizations. In addition, many states have laws similar to COBRA, including those that apply to health insurers of employers with less than 20 employees (sometimes called mini-COBRA). Check with your state insurance commissioner's office to see if such coverage is available to you.

Q4: Are there alternatives for health coverage other than COBRA?

If you become entitled to elect COBRA continuation coverage when you otherwise would lose group health coverage under a group health plan, you should consider all options you may have to get other health coverage before you make your decision. There may be more affordable or more generous coverage options for you and your family through other group health plan coverage (such as a spouse's plan), the Health Insurance Marketplace, or Medicaid.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you or your dependents are losing eligibility for group health coverage, including eligibility for continuation coverage, you may have a right to special enroll (enroll without waiting until the next open season for enrollment) in other group health coverage. For example, an employee losing eligibility for group health coverage may be able to special enroll in a spouse's plan. A dependent losing eligibility for group health coverage may be able to enroll in a different parent's group health plan. To have a special enrollment opportunity, you or your dependent must have had other health coverage when you previously

declined coverage in the plan in which you now want to enroll. You must request special enrollment within 30 days from the loss of your job-based coverage.

Losing your job-based coverage is also a special enrollment event in the Health Insurance Marketplace (Marketplace). The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments), and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Eligibility for COBRA continuation coverage won't limit your eligibility for Marketplace coverage or for a tax credit. You can apply for Marketplace coverage at [HealthCare.gov](https://www.healthcare.gov) or by calling 1-800-318-2596 (TTY 1-855-889-4325). To qualify for special enrollment in a Marketplace plan, you must select a plan within 60 days before or 60 days after losing your job-based coverage. In addition, during an open enrollment period, anyone can enroll in Marketplace coverage. If you need health coverage in the time between losing your job-based coverage and beginning coverage through the Marketplace (for example, if you or a family member needs medical care), you may wish to elect COBRA coverage from your former employer's plan. COBRA continuation coverage will ensure you have health coverage until the coverage through your Marketplace plan begins.

Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can apply for and enroll in Medicaid or CHIP any time of year. If you qualify, your coverage begins immediately. Visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 (TTY 1-855-889-4325) for more information or to apply for these programs. You can also apply for Medicaid by contacting your state Medicaid office and learn more about the CHIP program in your state by calling 1-877-KIDS-NOW (543-7669) or visiting [insurekidsnow.gov](https://www.insurekidsnow.gov).

If you or your dependent elects COBRA continuation coverage, you will have another opportunity to request special enrollment in a group health plan or a Marketplace plan if you have a new special enrollment event, such as marriage, the birth of a child, or if you exhaust your continuation coverage. To exhaust COBRA continuation coverage, you or your dependent must receive the maximum period of continuation coverage available without early termination. Keep in mind if you choose to terminate your COBRA continuation coverage early with no special enrollment opportunity at that time, you generally will have to wait to enroll in other coverage until the next open enrollment period for the new group health plan or the Marketplace.

Q5: Who is entitled to continuation coverage under COBRA?

In order to be entitled to elect COBRA continuation coverage, your group health plan must be **covered** by COBRA; a qualifying event must occur; and you must be a **qualified beneficiary** for that event.

Plan Coverage - COBRA covers group health plans sponsored by an employer (private-sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

Qualifying Events - Qualifying events are events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage.

The following are qualifying events for covered employees if they cause the covered employee to lose coverage:

- Termination of the employee's employment for any reason other than gross misconduct; or
- Reduction in the number of hours of employment.

The following are qualifying events for the spouse and dependent child of a covered employee if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee's employment for any reason other than gross misconduct;
- Reduction in the hours worked by the covered employee;
- Covered employee becomes entitled to Medicare;
- Divorce or legal separation of the spouse from the covered employee; or
- Death of the covered employee.

In addition to the above, the following is a qualifying event for a dependent child of a covered employee if it causes the child to lose coverage:

- Loss of dependent child status under the plan rules. Under the Affordable Care Act, plans that offer coverage to children on their parents' plan must make the coverage available until the adult child reaches the age of 26.

Qualified Beneficiaries - A qualified beneficiary is an individual covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. Only certain individuals can become qualified beneficiaries due to a qualifying event, and the type of qualifying event determines who can become a qualified beneficiary when it happens. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child. In certain cases involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee's spouse or former spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary. An employer's agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Q6: How do I become eligible for COBRA continuation coverage?

To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you worked and the health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.

Q7: How do I find out about COBRA coverage?

Group health plans must provide covered employees and their families with certain notices explaining their COBRA rights. Your COBRA rights must be described in the plan's Summary Plan Description (SPD), which you should receive within 90 days after you first become a participant in the plan. In addition, group health plans must give each employee and spouse who becomes covered under the plan a general notice describing COBRA rights, also provided within the first 90 days of coverage.

Before a group health plan must offer continuation coverage, a qualifying event must occur, and the plan must be notified of the qualifying event. Who must give notice of the qualifying event depends on the type of qualifying event.

The employer must notify the plan if the qualifying event is the covered employee's termination or reduction of hours of employment, death, entitlement to Medicare, or bankruptcy of a private-sector employer. The employer must notify the plan within 30 days of the event.

You (the covered employee or one of the qualified beneficiaries) must notify the plan if the qualifying event is divorce, legal separation, or a child's loss of dependent status under the plan. The plan must have procedures for how to give notice of the qualifying event, and the procedures should be described in both the general notice and the plan's SPD. The plan can set a time limit for providing this notice, but it cannot be shorter than 60 days, starting from the latest of: (1) the date on which the qualifying event occurs; (2) the date on which you lose (or would lose) coverage under the plan due to the qualifying event; or (3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and procedures for doing so.

If your plan does not have reasonable procedures for how to give notice of a qualifying event, you can give notice by contacting the person or unit that handles your employer's employee benefits matters. If your plan is a multiemployer plan, notice can also be given to the joint board of trustees, and, if the plan is administered by an insurance company (or the benefits are provided through insurance), notice can be given to the insurance company.

When the plan receives a notice of a qualifying event, it must give the qualified beneficiaries an election notice which describes their rights to continuation coverage and how to make an election. This notice must be provided within 14 days after the plan receives notice of the qualifying event.

Q8: How long do I have to elect COBRA coverage?

If you are entitled to elect COBRA coverage, you must be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

Each of the qualified beneficiaries for a qualifying event may independently elect COBRA coverage. This means that if both you and your spouse are entitled to elect continuation coverage, you each may decide separately whether to do so. The covered employee or spouse must be allowed to elect on behalf of any dependent children or on behalf of all of the qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

Q9: If I waive COBRA coverage during the election period, can I still get coverage at a later date?

If you waive COBRA coverage during the election period, you must be permitted later to revoke your waiver of coverage and to elect continuation coverage as long as you do so during the election period. Then, the plan need only provide continuation coverage beginning on the date you revoke the waiver.

In addition, certain Trade Adjustment Assistance (TAA) Program participants have a second opportunity to elect COBRA continuation coverage. Individuals who are eligible and receive Trade Readjustment Allowances (TRA), individuals who would be eligible to receive TRA, but have not yet exhausted their unemployment insurance (UI) benefits, and individuals receiving benefits under Alternative Trade Adjustment Assistance (ATAA) or Reemployment Trade Adjustment Assistance (RTAA), and who did not elect COBRA during the general election period, may get a second election period. This additional, second election period is measured 60 days from the first day of the month in which an individual is determined eligible for the TAA benefits listed above and receives such benefit. For example, if an individual's general election period runs out and he or she is determined eligible for TRA (or would be eligible for TRA but have not exhausted UI benefits) or begin to receive ATAA or RTAA benefits 61 days after separating from employment, at the beginning of the month, he or she would have approximately 60 more days to elect COBRA. However, if this same individual does not meet the eligibility criteria until the end of the month, the 60 days are still measured from the first of the month, in effect giving the individual about 30 days. Additionally, a COBRA election must be made not later than 6 months after the date of the TAA-related loss of coverage. COBRA coverage chosen during the second election period typically begins on the first day of that period. More information about the Trade Act is available at doleta.gov/tradeact/.

Q10: Under COBRA, what benefits must be covered?

If you elect continuation coverage, the coverage you are given must be identical to the coverage currently available under the plan to similarly situated active employees and their families (generally, this is the same coverage that you had immediately before the qualifying event). You will also be entitled, while receiving continuation coverage, to the same benefits, choices, and services that a similarly situated participant or beneficiary is currently receiving under the plan, such as the right during open enrollment season to choose among available coverage options. You will also be subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Any change made to the plan's terms that apply to similarly situated active employees and their families will also apply to qualified beneficiaries receiving COBRA continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation coverage, the child is automatically considered to be a qualified beneficiary receiving continuation coverage. You should consult your plan for the rules that apply for adding your child to continuation coverage under those circumstances.

Q11: How long does COBRA coverage last?

COBRA requires that continuation coverage extend from the date of the qualifying event for a limited period of 18 or 36 months. The length of time depends on the type of qualifying event that gave rise to

the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

When the qualifying event is the covered employee's termination of employment or reduction in hours of employment, qualified beneficiaries are entitled to 18 months of continuation coverage.

When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents can last until 36 months after the date the employee becomes entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date his/her employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for his/her spouse and children would last 28 months (36 months minus 8 months). For more information on how entitlement to Medicare impacts the length of COBRA coverage, contact the Department of Labor's Employee Benefits Security Administration at [askebsa.dol.gov](https://www.askebsa.dol.gov) or by calling 1-866-444-3272.

For other qualifying events, qualified beneficiaries must be provided 36 months of continuation coverage.

Q12: Can continuation coverage be terminated early for any reason?

A group health plan may terminate coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis;
- The employer ceases to maintain any group health plan;
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of the open enrollment period. For more information on alternatives to COBRA coverage, see question 4 above.

Q13: Can I extend my COBRA continuation coverage?

If you are entitled to an 18 month maximum period of continuation coverage, you may become eligible for an extension of the maximum time period in two circumstances. The first is when a qualified beneficiary is disabled; the second is when a second qualifying event occurs.

Disability - If any one of the qualified beneficiaries in your family is disabled and meets certain requirements, all of the qualified beneficiaries receiving continuation coverage due to a single qualifying event are entitled to an 11-month extension of the maximum period of continuation coverage (for a total maximum period of 29 months of continuation coverage). The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension.

The requirements are:

1. that the Social Security Administration (SSA) determines that the disabled qualified beneficiary is disabled before the 60th day of continuation coverage; and
2. that the disability continues during the rest of the 18-month period of continuation coverage.

The disabled qualified beneficiary or another person on his or her behalf also must notify the plan of the SSA determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 days, starting from the latest of: (1) the date on which SSA issues the disability determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (4) the date on which the qualified beneficiary is informed, through the furnishing of the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The plan can require qualified beneficiaries receiving the disability extension to notify it if the SSA makes such a determination, although the plan must give the qualified beneficiaries at least 30 days after the SSA determination to do so.

The rules for how to give a disability notice and a notice of no longer being disabled should be described in the plan's SPD (and in the election notice if you are offered an 18-month maximum period of continuation coverage).

Second Qualifying Event - If you are receiving an 18-month maximum period of continuation coverage, you may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event that is the death of a covered employee, the divorce or legal separation of a covered employee and spouse, a covered employee's becoming entitled to Medicare (in certain circumstances), or a loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused you to lose coverage under the plan in the absence of the first qualifying event. If a second qualifying event occurs, you will need to notify the plan.

The rules for how to give notice of a second qualifying event should be described in the plan's SPD (and in the election notice if you are offered an 18-month maximum period of continuation coverage). The plan can set a time limit for providing this notice, but the time limit cannot be shorter than 60 days from the latest of: (1) the date on which the qualifying event occurs; (2) the date on which you lose (or would lose) coverage under the plan as a result of the qualifying event; or (3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

Q14: Is a divorced spouse entitled to COBRA coverage from their former spouses' group health plan?

Under COBRA, participants, covered spouses and dependent children may continue their plan coverage for a limited time when they would otherwise lose coverage due to a particular event, such as divorce (or legal separation). A covered employee's spouse who would lose coverage due to a divorce may elect continuation coverage under the plan for a maximum of 36 months. A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation. After being notified of a divorce, the plan administrator must give notice, generally within 14 days, to the qualified beneficiary of the right to elect COBRA continuation coverage.

Q15: Who pays for COBRA coverage?

Your group health plan can require you to pay for COBRA continuation coverage. The amount charged to qualified beneficiaries cannot exceed 102 percent of the cost to the plan for similarly situated individuals covered under the plan who have not incurred a qualifying event. In determining COBRA premiums, the plan can include the costs paid by employees and the employer, plus an additional 2 percent for administrative costs.

For qualified beneficiaries receiving the 11-month disability extension, the COBRA premium for those additional months may be increased to 150 percent of the plan's total cost of coverage for similarly situated individuals.

COBRA charges to qualified beneficiaries may be increased if the cost to the plan increases but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay the required premiums on a monthly basis if you ask to do so, and the plan may allow you to make payments at other intervals (for example, weekly or quarterly). The election notice should contain all of the information you need to understand the COBRA premiums you will have to pay, when they are due, and the consequences of late payment or nonpayment.

When you elect continuation coverage, you cannot be required to send any payment with your election form. You can be required, however, to make an initial premium payment within 45 days after the date of your COBRA election (that is the date you mail in your election form, if you use first-class mail). Failure to make any payment within that period of time could cause you to lose all COBRA rights. The plan can set premium due dates for successive periods of coverage (after your initial payment), but it must give you the option to make monthly payments, and it must give you a 30-day grace period for payment of any premium.

You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all COBRA rights.

If the amount of a payment made to the plan is incorrect but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices.

Some employers may subsidize or pay the entire cost of health coverage, including COBRA coverage, for terminating employees and their families as part of a severance agreement. If you are receiving this type of severance benefit, talk to your plan administrator about how this impacts your COBRA coverage or your special enrollment rights.

Q16: What is the Health Coverage Tax Credit and can it help me pay for COBRA?

Certain individuals may be eligible for a refundable Federal income tax credit that can help with qualified monthly premium payments. The Health Coverage Tax Credit (HCTC), while available, may be used to pay for specified types of health insurance coverage (including COBRA continuation coverage).

Those potentially eligible for the HCTC include workers who lose their jobs due to the negative effects of global trade and who are eligible to receive certain benefits under the Trade Adjustment Assistance (TAA) Program, as well as certain individuals who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). The HCTC pays 72.5 percent of qualified health insurance premiums, with individuals paying 27.5 percent. For more information on TAA, visit doleta.gov/tradeact/.

Individuals who are eligible for the HCTC may claim the tax credit on their income tax returns at the end of the year. The tax credit also may be available as an advance monthly payment beginning in 2017. Qualified family members of eligible TAA recipients or PBGC payees who enroll in Medicare, pass away, or finalize a divorce, are eligible to receive the HCTC for up to 24 months from the month of the event. Individuals with questions about the Health Coverage Tax Credit should visit IRS.gov/HCTC.

Q17: If I did not make the premium payment on time and my coverage was canceled what can I do?

You may want to contact your plan and ask if they will reinstate your coverage; however, if your coverage was terminated for not making the payment within the grace period, the plan is not required to reinstate your coverage. If you believe your coverage was canceled inappropriately, you can contact an EBSA benefits advisor electronically at askebsa.dol.gov or call 1-866-444-3272 for assistance.

Q18: How do I file a COBRA claim for benefits?

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. You should submit a claim for benefits in accordance with these rules. Claims procedures must be described in the Summary Plan Description. Contact the plan administrator for more information on filing a claim for benefits.

Q19: Can I receive COBRA benefits while on FMLA leave?

The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Coverage provided under the FMLA is not COBRA coverage, and taking FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under

FMLA ceases, such as when an employee taking FMLA leave decides not to return to work and notifies an employer of his or her intent not to return to work. Further information on the FMLA is available on the Website of the U. S. Department of Labor's Wage and Hour Division at dol.gov/whd or by calling toll-free 1-866-487-9243.

Q20: I have both Medicare and COBRA coverage, how do I know which will pay my benefits?

Medicare is the Federal health insurance program for people who are 65 or older and certain younger people with disabilities or End-Stage Renal Disease. If you are enrolled in Medicare as well as COBRA continuation coverage, there may be special coordination of benefits rules that determine which coverage is the primary payer of benefits. Check your Summary Plan Description to see if special rules apply or ask your plan administrator. For more information on Medicare, visit Medicare.gov or call 1-800-MEDICARE.

Q21: Am I eligible for COBRA if my company closed or went bankrupt and there is no health plan?

If there is no longer a health plan, there is no COBRA coverage available. If, however, there is another plan offered by the company, you may be covered under that plan. Union members who are covered by a collective bargaining agreement that provides for a medical plan also may be entitled to continued coverage.

Q22: I am a federal employee. Can I receive benefits under COBRA?

Federal employees are covered by a law similar to COBRA. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

Q23: Where can I go if I have questions or want more information on COBRA?

COBRA continuation coverage laws are administered by several agencies. The Departments of Labor and Treasury have jurisdiction over private-sector group health plans. The Department of Health and Human Services administers the continuation coverage law as it applies to state and local governmental health plans.

The Labor Department's interpretive responsibility for COBRA is limited to the disclosure and notification requirements of COBRA. If you need further information on your rights under a private-sector plan, or about ERISA generally, contact the Employee Benefits Security Administration (EBSA) electronically at askebsa.dol.gov or call toll free 1-866-444-3272.

The Internal Revenue Service, Department of the Treasury, has issued regulations on COBRA provisions relating to eligibility, coverage and payment. Both the Departments of Labor and Treasury share jurisdiction for enforcement of these provisions.

The Centers for Medicare and Medicaid Services offer information about COBRA provisions for public-sector employees. You can write them at this address:

**Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C1-22-06
Baltimore, MD 21244-1850.**

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, DC 20515

January 21, 2020

The Honorable Alex Azar II
Secretary
U.S. Department of Health and Human Services (HHS)
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Eugene Scalia
Secretary
U.S. Department of Labor (DOL)
200 Constitution Ave NW
Washington, DC 20210

RE: Interaction between COBRA Benefits and Medicare Eligibility and Enrollment

Dear Secretary Azar and Secretary Scalia:

We write regarding challenges facing workers and retirees that can result in needless penalties and unnecessary out-of-pocket expenses. For Americans who receive coverage under a group health plan subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the transition to coverage under COBRA accompanied by eligibility for Medicare can be confusing and ultimately costly. We encourage the Department of Health and Human Services (HHS) and the Department of Labor (DOL) immediately to begin collaborating on solutions to mitigate the financial risks facing Americans who are eligible for coverage under Medicare.

As you know, COBRA grants temporary continuation of coverage to those enrolled in group health plans when coverage would otherwise end upon the occurrence of a qualifying event (e.g., termination of employment other than by reason of gross misconduct). For Americans who are also Medicare-*enrolled* when coverage begins under COBRA, Medicare is the primary payer and plans subject to COBRA become secondary.

For qualified beneficiaries who become Medicare-*eligible* but have yet to enroll in either Part A or Part B, group health plans can reevaluate any paid claims. Most often, individuals are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many retirees are unexpectedly exposed to out-of-pocket liability for any costs paid under COBRA benefits on or after date of Medicare eligibility and penalties for late enrollment in Medicare. Some of this risk would be eliminated if COBRA notices addressed the interaction with Medicare, and vice versa. Unfortunately, such information is not required under either Medicare or COBRA, and thus, transparency and clear information about the interaction between the two is lacking.

In light of the high out-of-pocket costs that can result for Medicare-eligible COBRA beneficiaries, we ask you to develop a strategy to address this issue effectively. Medicare enrollment and penalties, secondary payment rules, and COBRA are complicated concepts – the convergence of these issues require increased effort from HHS and DOL to coordinate and develop informative and clear communications for affected Americans.

If COBRA and Medicare notices address the programs' interactions, including the potential for financial liability, the number of Americans who are unaware of the steps they should take to avoid late enrollment penalties, delayed benefits, and unexpected out-of-pocket costs would be reduced.

Therefore, we request the following information and data:

1. Data that reflect any identifiable overlap between Medicare-eligible individuals and COBRA beneficiaries, particularly any information on the number of potentially affected Americans, or if such data do not exist, a description of barriers to the ability of HHS and/or DOL to produce such data and what is being done to overcome them;
2. Existing legal and administrative authorities available to HHS and/or DOL to address the information gap and steps that may be taken under this legal authority, including updates to the public-facing websites of both HHS and DOL describing Medicare eligibility and enrollment and COBRA benefits; and
3. Any statutory language or other barriers that may prevent HHS or DOL from taking immediate steps to improve the information available to affected individuals.

Please provide the requested information and data by January 31, 2020.

If you have any questions, please contact the Majority Staff, Sarah Levin at (202) 225-3625, Daniel Foster at (202) 225-3725, or Samantha Satchell at (202) 225-2927; or the Minority Staff, Alyene Mlinar at (202) 225-4021, Alexis Murray at (202) 225-4527, or James Paluskiewicz at (202) 225-3641.

Thank you for your immediate attention to this matter.

Sincerely,



Richard E. Neal
Chairman
Committee on Ways and
Means

Frank Pallone, Jr.
Chairman
Committee on Energy and
Commerce



Robert C. "Bobby" Scott
Chairman
Committee on Education and
Labor



Kevin Brady
Ranking Member
Committee on Ways and
Means

Greg Walden
Ranking Member
Committee on Energy and
Commerce



Virginia Foxx
Ranking Member
Committee on Education and
Labor

Cc:

Assistant Secretary Preston Rutledge
Employee Benefits Services Administration

Administrator Seema Verma
Centers for Medicare and Medicaid Services

Commissioner Andrew Saul
Social Security Administration



January 6, 2020

Memo to: David Torian

Subject: Implied Coverage: Medicare and COBRA

I have some additional comments and recommendations on the subject of Medicare, COBRA, and the NAIC COB Model Regulation based on questions I received from task force members at the national meeting in Austin.

At the meeting I informed the Task Force of the conflicts that exists in regard to Medicare eligible individuals who have COBRA protection; Medicare eligible individuals who work for small employers; and the subsequent treatment of their health benefits based on the NAIC Coordination of Benefits Model regulation.

The COBRA Model Notice contains no information that pertains to the interaction of coverage between Medicare and COBRA. CMS provides no information in any of its consumer facing materials that pertains to being eligible for Medicare simultaneously with COBRA. The NAIC Coordination of Benefits exception pertaining to people who are eligible or who could be eligible for Medicare benefits is unfairly discriminatory.

Each of the 3 systems that control these benefits, Department of Labor, CMS, and the NAIC, is independent of the other. Corrective action in one of these systems is not dependent on any action taken by any of the other systems.

The NAIC should delete the exception for Medicare Part B in the Coordination of Benefits Model Regulation. There is no rationale for this exception in the NAIC historical record and it unfairly penalizes and discriminates against Medicare beneficiaries. The action specified in the exception, “is or could have been covered,” produces a result that is expressly prohibited in the same subsection for any other form of health benefits.

If the Task Force cannot come to consensus to remove this exception we recommend amending the current language in the following way:

Section 5. Use of Model COB Contract Provision

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

- (1) Another plan exists and the covered person did not enroll in that plan;

- (2) A person is or could have been covered under another plan, ~~except with respect to Part B of Medicare; or~~ (delete as indicated)
- (3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected; **or**
- (4) A person is eligible but not enrolled for benefits in Part B of Medicare. (add as indicated)**

This amended language is clear and would still allow insurers to pay secondary benefits when a person is actually enrolled and receiving benefits, but would not allow insurers to reduce benefits when an individual is eligible for Medicare but not yet enrolled for those benefits.

The Department of Labor still needs to revise the Model COBRA notice to inform former employees of how COBRA interacts with Medicare benefits and warn people of any potential conflicts in benefit payments.

CMS still needs to revise their consumer facing information and materials to warn Medicare eligible beneficiaries of the rules and the penalties regarding timely enrollment for benefits, and the consequences of inaction or ignoring enrollment in Medicare when exercising the right to continuation of employer health benefits.

The Senior Issues Task Force can inform the appropriate Committee Chairs of the need to amend the Model Regulation and propose this simple change in language. In addition, the SITF should consider drafting and making available documents that inform consumers, agents, and insurers of conflicts that currently exist between the two federal systems and the steps that Medicare eligible individuals should consider to make the best use of COBRA and Medicare benefits, avoid Medicare late enrollment penalties with delayed benefits, and the potential danger of recovery of mistakenly paid COBRA benefits.

In addition, recoupment actions based on eligibility for Medicare are increasingly common and needs scrutiny by state regulators to determine the legitimacy of these actions.

To summarize, here is a list of conflicting situations that effect Medicare eligible individuals:

- Medicare eligible individuals not yet enrolled for benefits under Part A or Part B prior to becoming eligible for COBRA cannot be refused COBRA coverage
- Individuals enrolled in either Medicare Part A or Part B prior to becoming eligible for COBRA cannot be refused COBRA coverage
- Medicare eligible individuals who enroll after becoming eligible for COBRA can be terminated from COBRA coverage

- Medicare eligible individuals who are actively working for employers of less than 20 employees are not covered by Medicare Secondary Payer rules and employer health care benefits are not required to be primary to Medicare coverage
- COBRA covered individuals who are eligible for Medicare but not enrolled in Medicare Part A or Part B are penalized under both COBRA and Medicare law
- COBRA benefits and Medicare eligible individuals who are enrolled in either Medicare Part A or Part B are penalized under both COBRA and Medicare law
- Medicare Secondary Payment rules do not require COBRA benefits to be primary to Medicare
- The National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model Regulation establishes the order of payments for health benefits and as currently written allows insurers to reduce payment of COBRA and other health benefits, regardless of whether Medicare benefits have been activated.

Colorectal Cancer Screening Continuum and Coverage During the COVID-19 Pandemic



Background

The Affordable Care Act (ACA) requires all private insurers (except “grandfathered” plans) and Medicaid expansion states (adult expansion populations only) to cover, without cost sharing, preventive services that receive an A or B rating from the United States Preventive Services Task Force (USPSTF). In 2016 (the most recent recommendation), the USPSTF gave an “A” rating to colorectal cancer (CRC) screening tests, including colonoscopy and stool-based tests, for adults beginning at age 50 until age 75 years. All of these stool-based tests require a follow-up colonoscopy if the test comes back positive for blood in the stool (or DNA changes, in the case of the stool DNA test).

Multiple studies have shown that individuals are less likely to seek health services, including preventive screenings, when they must pay for those services out-of-pocket. Additionally, research has shown that limiting CRC screening choices to only colonoscopy can result in a lower CRC screening completion rate compared to providing a choice between colonoscopy and a stool-based test, particularly among racial and ethnic minorities.

Colorectal Cancer Screening during the COVID-19 Pandemic

Currently, and prudently, many cancer screenings, such as colonoscopies, have been postponed. The American Cancer Society Cancer Action Network (ACS CAN) agrees that this is the best course of action to ensure that patients and healthcare providers are not unnecessarily exposed to COVID-19, and that hospitals are able to divert staff to meet the increase in patients due to the pandemic.

Due to this pandemic we have already seen dramatic decreases in screening rates. A study conducted by the Epic Health Research Network, found that colorectal cancer screenings have dropped by 86% in March alone, compared to the 2017-2019 averages. While both ACS and ACS CAN believe the best screening test is the one that actually gets done, *high-sensitivity* guaiac-based fecal occult blood test (hs-gFOBT), fecal immunochemical tests (FIT), and multi-target stool DNA test (i.e., Cologuard) are effective, non-invasive, easily accessible home-based preventive screening tests that are convenient to use and also less expensive than a colonoscopy. We believe that encouraging greater use of these non-invasive stool-based tests during the pandemic could result in higher screening rates when other screening methods are not readily available.

In most settings, only about 1 in 10 people will have an abnormal finding on stool testing (i.e. a “positive” test). The 9 of 10 individuals who have normal results can be safely removed from the screening queue for the next 12 months (for those tested with gFOBT or FIT) or up to 36 months (Cologuard). All positive results on non-colonoscopy screening tests should therefore be followed up with timely colonoscopy as part of the colorectal cancer screening process. The follow-up colonoscopy should not be considered a “diagnostic” colonoscopy, but rather an integral part of the screening process, which is not complete until the colonoscopy is performed, and therefore should be covered with no cost-sharing for individuals.

Request to Insurance Commissioners

- ACS CAN urges Insurance Commissioners and other state health officials to make the changes necessary to ensure that private insurance plans in your state suspend cost-sharing for follow-up colonoscopies so that your residents can utilize non-invasive testing methods without fear of an unexpected cost should a follow-up colonoscopy be necessary.
- ACS CAN urges you to notify providers of these changes to further encourage the usage of non-invasive tests without fear of surprise billing for their privately insured patients.
- The use of non-invasive colorectal screening tests both during pandemic, and during the first phases of the continuation of elective medical treatment and screening, can ensure that screening rates are maintained and will also allow doctors to triage those patients who are at high risk or who require a follow-up colonoscopy due to a positive result of the non-invasive tests.