DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Part 2580

Health Care Continuation Coverage

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Request for information.

SUMMARY: This document is a request for information to assist the Department of Labor (the Department) in assessing the need for a regulation clarifying certain statutory notice requirements set forth in section 606 of Title I of the Employee Retirement Income Security Act (ERISA) and in section 4980B of the Internal Revenue Code (the Code). These statutory notice requirements were enacted as part of the continuation coverage provisions included in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The continuation coverage provisions, commonly referred to as the COBRA provisions, generally require group health plans to provide participants and beneficiaries who under certain circumstances would otherwise lose coverage (qualified beneficiaries) with the opportunity to elect to continue coverage under the plan at group rates for a limited period of time.

The Department anticipates that information and views provided by plan sponsors, plan fiduciaries, service providers to plans, plan participants and beneficiaries, and other interested persons will aid it in assessing the need for issuing a regulation to explicate the notice requirements of the COBRA provisions and the appropriate scope and content of any such regulation. A regulation on the notice requirements of the COBRA provisions would affect participants and beneficiaries (including qualified beneficiaries) of certain group health plans, as well as the sponsors and fiduciaries of such plans.

DATES: Written comments should be received by the Department of Labor on or before November 24, 1997.

ADDRESSES: Comments (preferably, at least six copies) should be addressed to the Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, Room N–5669, U.S. Department of Labor, 200 Constitution Ave., NW, Washington, DC 20210. Attn: COBRA RFI. All comments received will be available for public inspection at the Public Disclosure Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N–5507, 200 Constitution Ave., NW, Washington, DC 20210.

FOR FURTHER INFORMATION CONTACT: David Lurie, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, (202) 219–7461. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

A. Background

1. The COBRA Provisions

The COBRA provisions, sections 601 to 608 of Title I of ERISA, and the related portions of section 4980B of the Code,[1] establish the requirement that any ''group health plan'' [2] maintained by an employer that employs 20 or more employees must offer ''qualified beneficiaries'' [3] the opportunity to elect ''continuation coverage'' under the plan following certain events (qualifying events) that would otherwise result in the loss of coverage.[4]

Under section 602(2)(A), the nature of the qualifying event determines the length of continuation coverage that an employer must make available to a qualified beneficiary. If the qualifying event is either a termination or a reduction in the hours of the covered employee's employment, the period of continuation coverage is up to 18 months from the date of the qualifying event.[5] This period is extended for an additional 11 months, to make a total period of 29 months of continuation coverage, for all qualified beneficiaries with respect to a covered employee, if any of such qualified beneficiaries has been determined, pursuant to Title II or Title XVI of the Social Security Act, to have been disabled at any time within the first 60 days of continuation coverage.[6] Furthermore, in cases involving a termination or reduction of hours of employment, the occurrence of another qualifying event during the initial 18 months of continuation coverage will extend the continuation coverage period to up to 36 months from the date of the original qualifying event. In all other cases, the period of continuation coverage is generally up to 36 months from the date of the qualifying event. The occurrence of certain events subsequent to election of continuation coverage can cause the period of continuation coverage to end prior to the end of the otherwise applicable continuation coverage period.[7]

The COBRA provisions specify the nature of the continuation coverage that must be offered, the premiums that a qualified beneficiary may be required to pay as a predicate for such continuation coverage, and the manner in which plan administrators must provide qualified

[1] All references herein to ERISA sections 601–608 should be read to refer also to corresponding provisions in Code section 4980B.

[2] The term *group health plan* is defined in section 607(1) to mean an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Code) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Plans that provide substantially only long-term care services (as defined in section 7702B(c) of the Code, however, are not included. Further, although governmental plans are excepted from coverage under Title I of ERISA, *see* ERISA section 4(b)(1), COBRA amended the Public Health Service Act, 42 U.S.C. § 300bb–1 *et seq.,* to impose requirements for the provision of health care continuation coverage similar to those contained in Part 6 of Title I on certain State and local employers.

[3] Section 607(3) defines *qualified beneficiary* generally as any person, other than a covered employee, who, on the day before the qualifying event for that employee, was a beneficiary under the plan as the spouse or dependent child of the covered employee. In the case of a qualifying event that is the termination or reduction of hours of the covered employee, the term also includes the covered employee. In the case of a qualifying event that is the bankruptcy of the plan sponsor, the term *qualified beneficiary* includes the covered employee if he or she had retired on or before the date of substantial elimination of coverage, and any individual who, on the day before the qualifying event, was a beneficiary under the plan as the surviving spouse of the covered employee. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) expanded the definition of qualified beneficiary contained in section 607(3) to include children who are born to or placed for adoption with the covered employee during the duration of continuation coverage.

[4] Section 603 defines a *qualifying event* as any of the following: 1) the death of the covered employee; 2) the termination (other than by reason of gross misconduct) or reduction in hours of the covered employee's employment; 3) the divorce or legal separation of the covered employee from the employee's spouse; 4) the covered employee's becoming entitled to benefits under Medicare; 5) a dependent child's ceasing to be a dependent under the terms of the plan; or 6) the bankruptcy of the employer from which the covered employee retired. Section 607 defines other relevant terms, such as ''covered employee'' and ''group health plan,'' for the purposes of the COBRA provisions.

[5] A group health plan may, pursuant to section 607(5), provide instead that the period of continuation coverage (and the period during which the employer must notify the plan administrator of a qualifying event) will begin on the date the qualified beneficiary loses coverage, rather than the date of the qualifying event.

[6] Prior to enactment of HIPAA, section 602(2) provided that a qualified beneficiary would be entitled to the 11-month disability extension only if he or she was disabled at the time that the covered employee suffered the termination or reduction in hours of employment. HIPAA also amended section 602(2) to clarify that the 11-month disability extension applies to the non-disabled family members of a disabled qualified beneficiary who meets the requirements for the extension, provided those family members are also entitled to continuation coverage.

[7] For example, a qualified beneficiary's right to continuation coverage will cease if an employer ceases to provide group health coverage to its employees, if the qualified beneficiary fails to pay required premiums in a timely fashion, or if the qualified beneficiary becomes covered under another group health plan that does not contain any invalidating pre-existing condition exclusions or limitations. *See* § 602(2) (B), (C), (D).

beneficiaries with the opportunity to elect continuation coverage and to pay any required premiums. *See* sections 602, 604, 605.

Section 606 establishes a series of related notice requirements that ultimately trigger, under section 605, the beginning of the period of time during which the qualified beneficiary may elect continuation coverage (the election period). These notice requirements are described in detail in Section 2, below.

Section 608 grants the Secretary of Labor generally the authority to issue regulations to carry out the provisions of Part 6 of Title I of ERISA. In order to avoid duplicate and perhaps inconsistent regulations, the Conference Report accompanying COBRA [8] provides that the Secretary of Labor is authorized to promulgate regulations implementing the disclosure and reporting requirements of COBRA, while the Secretary of the Treasury is authorized to issue regulations defining the required continuation coverage.[9] The Conference Report further stated that pending the promulgation of regulations, employers would be required to operate ''in good faith compliance with a reasonable interpretation of the substantive rules and notice requirements' H. Rep. 99–453 at 562–63.

2. COBRA Notices

Section 606 of ERISA provides for a series of related notices, beginning with the requirement for a general notice of the rights provided under COBRA and culminating with an individualized notice to a qualified beneficiary entitled to elect continuation coverage.

(a) *Initial Notice.* Section 606(a)(1) requires a group health plan to provide to each covered employee and spouse of the employee (if any) at the time of commencement of coverage under the plan [10] a written notice describing the rights provided under COBRA.[11]

(b) *Notice of Qualifying Event.* Section 606 (a)(2) and (a)(3) require that the plan administrator of a group health plan be notified that a qualifying event has occurred. The nature of the qualifying event determines whether this notice obligation falls on the employer of a covered employee or on the covered employee or qualified beneficiary. If the qualifying event is the death of the covered employee, the termination or reduction of hours of the covered employee's employment,[12] the covered employee's becoming entitled to Medicare, or a bankruptcy proceeding of the employer, section 606(a)(2) requires the employer of the covered employee to provide notice of the qualifying event to the plan administrator. The employer must provide this notice within 30 days of the date the event occurs.[13] If the qualifying event is the divorce or legal separation of the covered employee or a dependent child's ceasing to be a dependent under the terms of the plan, section 606(a)(3) requires the covered employee or qualified beneficiary to provide the notice of qualifying event to the plan administrator.[14] The covered employee or qualified beneficiary must provide this notice within 60 days of the date the qualifying event occurs.[15]

(c) *Notice of Right to Elect Continuation Coverage.* Section 606(a)(4) requires a plan administrator to notify qualified beneficiaries of their right to elect continuation coverage.[16] This notice must be provided within 14 days of the date on which the administrator receives the notice that a qualifying event has occurred.[17] Pursuant to section 605(1), a qualified beneficiary must be provided a period of at least 60 days, beginning on the later of the date of the loss of coverage due to the qualifying event or the date the notice of the right to elect continuation coverage was sent, within which to elect continuation coverage.

(d) *Social Security Disability Notice.* Section 602 provides that, if a qualified beneficiary becomes disabled, as determined under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation coverage, he or she is entitled to a total of up to 29 months of continuation coverage, rather than only 18 months of continuation coverage. Section 606(a)(3) provides that, in order to obtain the 11-month extension, such a qualified beneficiary must notify the plan administrator of the determination of disability within 60 days after the date of such determination. Section 602 also requires that this notice be provided before the end of the original 18-month period of continuation coverage. The qualified beneficiary must also notify the plan administrator of any final determination that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of the date of such determination.

[8] H. Rep. No. 99–453, 99th Cong., 1st Sess. (December 18, 1995).

[9] The Conference Report indicates further that the Secretary of Health and Human Services, who is to issue regulations implementing the continuation coverage requirements for State and local governments, must conform the actual requirements of those regulations to the regulations issued by the Secretaries of Labor and the Treasury. *Id.* at 562–63. Pursuant to its authority, the Treasury Department has proposed certain regulations relating to continuation coverage. *See* Prop. Treas. Reg. § 1.162–26 (52 Fed. Reg. 22716, June 15, 1987).

[10] Advisory Opinion 94–17 (April 9, 1994) states that a group health plan is required to provide the initial notice required by section 606(a)(1) only to individuals who may at some time become entitled to elect continuation coverage under the plan, *i.e.*, someone who is or becomes covered under the plan. Accordingly, a group health plan is required to provide the initial notice to a covered employee's spouse only if, and at the time, the spouse commences coverage under the plan.

[11] On June 26, 1986, the Department issued ERISA Technical Release 86–2 (TR 86–2), ''Guidance on Group Health Continuation Coverage Notification Provisions,'' to provide for use by employers a model initial notice satisfying the requirements of section 606(a)(1). TR 86–2 emphasizes that use of the model notice is not the only method of achieving good faith compliance with a reasonable interpretation of the initial notice requirement. Additionally, TR 86–2 provides guidance with respect to certain procedural issues not addressed by the statute and the Department's view of good faith compliance in the absence of regulations. First, TR 86–2 states that sending a notice by first-class mail to the last known address of a covered employee and his or her spouse (if any) would evince a good faith effort at compliance. Second, TR 86–2 states that, if a spouse's last known address is the same as the covered employee's, a single mailing addressed to both would be considered to be in good faith compliance with the requirement set forth in 606(a)(1). Finally, TR 86–2 states that if an employer (or plan administrator) determines that a spouse no longer resides with the covered employee, good faith compliance could be achieved by a separate, first-class mailing to the last known address of the spouse.

[12] In the case of a multiemployer plan, the requirement that the employer notify the plan administrator of the termination or reduction in hours of the covered employee's employment is satisfied if the plan provides that the plan administrator will determine the occurrence of such a qualifying event.

[13] If the plan is a multiemployer plan, this notice must be given within the time period set by the plan.

[14] Prop. Treas. Reg. § 1.162–26, Q&A 33, states that this notice is to be provided to the ''employer or other plan administrator.''

[15] Prop. Treas. Reg. § 1.162–26, Q&A 33, states that if the notice is not sent to the employer or other plan administrator within 60 days after the later of the date of the qualifying event or the date that the qualified beneficiary would lose coverage, the group health plan does not have to offer the qualified beneficiary continuation coverage.

[16] Advisory Opinion 90–16 (May 3, 1990) states that the administrator of a group health plan cannot be relieved, by delegation, contract, or otherwise, of responsibility for providing the notice required by section 606(a)(4).

[17] In an information letter dated April 11, 1995, the Department stated that, in cases in which the employer of employees covered by a group health plan is also the plan administrator, both the 30-day notice period for the employer's notice of a qualifying event and the 14-day period for the administrator's notice of the right to elect continuation coverage would continue to apply. Accordingly, an employer who is also the plan administrator has a maximum period of 44 days from the date on which the qualifying event occurred to provide such notice.

3. Statutory Sanctions for Failure to Comply With COBRA Notice Requirements

The COBRA provisions impose sanctions for failure to comply with certain of the notice requirements of ERISA section 606.

a. ERISA Section 502

Section 502(a)(1)(A) of ERISA permits participants and beneficiaries to bring a civil action for the relief provided in section 502(c). Section 502(c)(1) provides that a plan administrator that fails to provide an initial notice or a notice of the right to elect continuation coverage may, in the court's discretion, be held liable to the participant or beneficiary for up to $100 per day from the date of the failure to provide notice and for any other relief that the court deems proper.

b. Code Section 4980B

Code section 4980B imposes excise taxes on the employer,[18] and, in certain circumstances, a person (other than an employee) who is responsible for administering or providing benefits under the plan and whose act or failure to act caused the failure, for the failure of a group health plan to meet any of the requirements of the COBRA provisions, including the relevant notice requirements. Pursuant to section 4980B(b)(1), the amount of the tax on any failure with respect to a qualified beneficiary is $100 per day [19] for each day of non-compliance. Code section 4980B(b) establishes a number of standards relating to minimum and maximum amounts of tax and specifies situations in which the tax will not be imposed.

4. Health Insurance Portability and Accountability Act (HIPAA)

HIPAA, which was signed into law on August 21, 1996, made certain substantive changes to the COBRA provisions. Those changes became effective January 1, 1997, regardless of the date of any qualifying event. Among other changes,[20] HIPAA amended section 602(2)(D)(i), with respect to circumstances under which a group health plan may cease providing continuation coverage to a qualified beneficiary because that qualified beneficiary has become covered under another group health plan, to reflect the changes made by HIPAA with respect to preexisting condition exclusions and limitations. Specifically, the COBRA provisions mandate that, if the new plan limits or excludes coverage for any preexisting condition of the qualified beneficiary, the plan providing continuation coverage cannot cease making continuation coverage available solely due to the coverage under the new plan. However, HIPAA provides that, if the new group health plan limits or excludes coverage for preexisting conditions, but those limits or exclusions would not apply to or would be satisfied by a qualified beneficiary under the HIPAA rules limiting pre-existing coverage exclusions, the plan providing continuation coverage may cease providing it. As a separate matter, HIPAA provides that the amount of an individual's ''creditable coverage'' (*see* footnote 21) must include any period of time during the relevant look-back period for which the individual was covered by a group health plan as a result of the individual's having elected continuation coverage.

5. Interim HIPAA Regulations

On April 8, 1997, the Department, in conjunction with the IRS and the Health Care Financing Administration of the Department of Health and Human Services, published in the **Federal Register** interim rules and a proposed rule implementing certain provisions of HIPAA (62 FR 16894). The Department's interim regulation relating to certificates of creditable coverage,[21] 29 CFR 2590.701–5 (62 FR 16946, 16947), provides that a qualified beneficiary is entitled to a certificate both at the time that coverage would be lost in the absence of continuation coverage and, if the qualified beneficiary has elected continuation coverage, at the time that the continuation coverage ceases. In addition, in cases in which the person is entitled to elect continuation coverage, the first certificate must be furnished no later than the time a notice of the right to elect continuation coverage is required to be provided. The second certificate, after continuation coverage ceases, must be provided within a reasonable time after continuation coverage ceases.

B. Circumstances Suggesting a Need for Regulatory Guidance

As discussed herein, the COBRA provisions of ERISA impose obligations on employers, plan administrators, plan participants, and qualified beneficiaries regarding disclosure of information through notices and the ensuing right to elect continuation coverage. Section 606 of ERISA provides a statutory framework within which these notices have significance as a means of providing affected parties with adequate notice at appropriate times of the rights granted under the statutory scheme. The delivery of notices also delineates limited time periods during which such rights must be exercised. Failure to comply with any of the notice requirements carries consequences for the party failing to provide notice, whether in the form of potential liability to provide coverage under the group health plan, sanctions imposed on employers or plan administrators, or a loss of coverage or an opportunity to elect continuation coverage on the part of qualified beneficiaries. The Department believes the following factors suggest a possible need for guidance concerning the COBRA notice provisions.

First, a significant amount of the relevant litigation that has occurred since enactment of the COBRA provisions has involved failures or alleged failures to comply with the notice requirements.[22] Second, many of the numerous requests that the Department has received from participants for assistance with the COBRA provisions have involved

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[18] In the case of a multiemployer plan, the tax is imposed on the plan.

[19] If there is more than one qualified beneficiary with respect to the same qualifying event, the maximum amount of tax that may be imposed on all failures on any day with respect to such qualified beneficiaries is $200.

[20] As described in footnotes 2 and 4, above, HIPAA clarified the definition of ''qualified beneficiary'' and the scope of the 11-month extension for disabled qualified beneficiaries. In addition, section 421(e) of HIPAA required group health plans subject to COBRA to notify individuals who have elected continuation coverage no later than November 15, 1996, of the changes to COBRA enacted by HIPAA. The Department issued Technical Release 96–1 on October 15, 1996, to inform employers and plan administrators of the changes in the COBRA rules made by HIPAA and of their obligation under HIPAA to notify qualified beneficiaries of such changes. The Department, as a matter of enforcement policy, deemed that supplying qualified beneficiaries with a written copy of the information contained in TR 96–1, or with a copy of TR 96–1, would constitute compliance with the notice requirement contained in section 421(e) of HIPAA if the information was sent to each qualified beneficiary by first class mail at the last known address of the qualified beneficiary by November 1, 1996.

[21] Pursuant to ERISA section 701, which was added by HIPAA, certificates of creditable coverage are required to be provided to participants and beneficiaries under group health plans under certain circumstances. These certificates serve to establish a participant's or beneficiary's period of ''creditable coverage,'' which will reduce or eliminate the period for which a group health plan can limit or exclude coverage of a preexisting condition of such participant or beneficiary.

[22] *See, e.g., Underwood* v. *Fluor Daniel, Inc.*, No. 95–3036 (4th Cir. 1997); *Stanton* v. *Larry Fowler Trucking, Inc.*, 52 F.3d 723 (8th Cir. 1995); *Bixler* v. *Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3rd Cir. 1993); *Meadows* v. *Cagle's, Inc.*, 954 F.2d 686 (11th Cir. 1992); *Kidder* v. *H&B Marine, Inc.*, 932 F.2d 347 (5th Cir. 1991); *Truesdale* v. *Pacific Holding Co./ Hay Adams Division*, 778 F. Supp. 77 (D.D.C. 1991).

allegations that employers' and plan administrators' notices have been not forthcoming or have been inadequate or confusing. Third, the COBRA provisions have been amended several times since publication of TR 86–2, reducing its value as a model for good faith compliance. Fourth, the obligations imposed on group health plans by HIPAA and other legislation with respect to coordination of continuation coverage with other statutory rights have further increased the importance of proper implementation of the COBRA notice provisions. For these reasons, the Department believes that regulatory guidance clarifying the notice requirements may aid employers and plan administrators in complying with the COBRA notice requirements and may also provide participants and beneficiaries with a better understanding of their rights and obligations.

C. Issues on Which Information is Requested

To assist the Department in assessing the need for guidance concerning the COBRA notice requirements, the Department invites interested parties to submit information relating to whether the Department should promulgate standards with regard to the content of the notices, the delivery and timing of these notices, and the consequences of either satisfying or failing to satisfy the notice requirements, and what such standards should be.

In order to assist interested parties in responding, this notice contains a list of specific questions the answers to which the Department believes would be helpful in considering guidance in this area. It is requested that the public, in responding to specific questions presented by this Notice, refer to the question number listed in this Notice. Reference to the appropriate question number will aid the Department in analyzing submissions.

The questions provided herein may not address all issues relevant to the development of the regulation. Accordingly, the Department further invites interested parties to submit additional comments on any other matters that they believe may be pertinent to the Department's consideration of guidance on this subject.

Specific areas with respect to which the Department is interested include:

I. Initial Notice to Covered Employees and Spouses

A. What information should be required to be included in the initial notice to covered employees and spouses?

B. Would ''model'' language with respect to any of the required information be helpful?

C. Should the Department provide an updated, revised ''model'' notice to replace that published in TR 86–2?

D. In TR 86–2, the Department indicated that furnishing one initial notice to participants and spouses residing at the same address would be adequate. Should the Department continue to view this method of furnishing information to a spouse residing with a participant as sufficient?

II. Notice of Qualifying Event

A. What information should be required to be included in the notice of qualifying event?

B. In what form should this notice be required to be provided?

C. Should the required information or the required form in which this information is conveyed vary depending on whether the notice is being given by the employer or by the covered employee (or qualified beneficiary)?

D. Should the Department provide rules under which notice of a qualifying event is deemed to have been given when an employer is also the plan administrator of a group health plan, or should some formality of communications be required under such circumstances?

E. Should the Department provide a ''model'' notice of qualifying event for use by employers and qualified beneficiaries?

F. What, if any, problems have arisen in connection with compliance with this notice requirement?

III. Notice of Right to Elect Continuation Coverage

Section 605 of the COBRA provisions provides that the election period during which a qualified beneficiary may elect continuation coverage must extend for at least sixty days, measured from the later of the date on which coverage otherwise would terminate or the date on which the notice of the right to elect continuation coverage is sent to the qualified beneficiary. The plan administrator's provision of the notice of right to elect continuation coverage, therefore, initiates the qualified beneficiary's right to elect and begins the running of the period of that right. The Department, accordingly, believes that the notice of right to elect continuation coverage must provide the qualified beneficiary with the information relevant to the exercise of the right. The following questions should be considered in light of this concern.

A. What information should be required to be included in the notice of the right to elect continuation coverage?

B. For example, should the notice be required to include:

1. A description of the continuation coverage that the qualified beneficiary is entitled to elect;

2. A description of the period over which such continuation coverage would be provided;

3. A description of the premiums that the qualified beneficiary would be required to pay, including the manner in which such premiums were calculated, the dates on which payment would be due, the address to which payment should be sent, and the consequences of nonpayment;

4. An explanation of the election process, including the period of time within which an election can be made, the consequences of electing or failing to elect continuation coverage, and the possibility of rescinding an election; or

5. An explanation of any rights that might arise to cause an extension of the maximum period of continuation coverage (such as with respect to any qualified beneficiary who is determined to be disabled within the first 60 days of continuation coverage) and the notice obligations imposed on any such qualified beneficiary?

C. Is there other information that should be required to be included in the notice of right to elect continuation coverage, such as the significance of electing continuation coverage for rights granted by HIPAA or the FMLA?

D. Should significant information relevant to the decision whether to elect continuation coverage be required to be provided in the notice, or should inclusion of the information in the summary plan description (SPD), with a reference in the notice to the relevant information in the SPD, be deemed adequate?

E. Should the Department provide a ''model'' notice of right to elect continuation coverage or ''model'' language on selected subjects for use in the notice?

IV. Social Security Disability Notice

A. What, if any, problems have covered employees, qualified beneficiaries, employers, or plan administrators encountered in obtaining the 11-month extension or in administering the provisions granting the right to the 11-month extension, particularly with respect to satisfying the notice requirements imposed by sections 602(2)(v) and 606(3)?

V. Other Issues

A. What are the practical and appropriate means (e.g., written notices, electronic media, and/or oral interviews) through which the COBRA notice requirements should be satisfied?

B. What kinds of procedures should or may plan administrators establish to permit qualified beneficiaries to establish their entitlement to extensions of the period of continuation coverage, such as through the occurrence of second qualifying events or as a result of disability determinations?

C. What administrative procedures have plan administrators adopted to provide additional notices or information not expressly mandated in the COBRA provisions, but necessary or useful in the orderly implementation of continuation coverage requirements, such as to explain changes in the coverage provided under the group health plan (including changes in the issuer or service provider), to make available open enrollment or election periods provided under the plan, to enforce due dates for continuation coverage premiums, or to implement the termination of continuation coverage and make available any conversion options provided under the plan?

All submitted comments will be made part of the record of the preceding referred to herein and will be available for public inspection.

Signed at Washington, DC, this 17th day of September, 1997.

Olena Berg,

Assistant Secretary for Pension and Welfare Benefits, U.S. Department of Labor.

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