Extending Group Health Plan Coverage to Non-Employee Directors and Board Members: Key Considerations for Employers

By: Kate Belyayeva

Employers increasingly receive requests from directors or board members, but are not common law employees, to participate in the employer's group health plan. While the desire to extend benefits to key stakeholders is understandable, this arrangement raises significant legal, tax, and regulatory issues that employers must carefully evaluate before proceeding. As discussed below, although it may be possible in limited circumstances to structure coverage for non-employee directors and board members, doing so often introduces significant compliance risk, financial exposure, and administrative complexity.

Background

Employer-sponsored group health plans are designed primarily for common-law employees and their dependents. Federal law, including the Employee Retirement Income Security Act of 1974 ("ERISA"), the Internal Revenue Code of 1986 (the "Code"), and the Affordable Care Act, generally ties both eligibility and favorable tax treatment to the existence of an employment relationship.
Non-employee directors and board members are typically compensated on a Form 1099 basis and are akin to self-employed individuals for benefits purposes. As a result, they generally are not eligible to participate in employer-sponsored health coverage on the same tax-favored basis as employees. For instance, non-employees are not permitted to participate in a cafeteria plan under Code Section 125 or exclude employer-provided health coverage from income under Code Section 106. Accordingly, any employer-paid coverage provided to a non-employee director would generally be treated as taxable compensation, and any premiums paid by the director must be paid on an after-tax basis. Notwithstanding these limitations, some employers have considered whether plan documents may be amended to include non-employee directors or board members as an eligible class, particularly in the context of self-insured arrangements. While this may be technically feasible, extending group health plan coverage to non-employee directors and board members raises a number of important considerations.

Key Considerations

- **Plan Eligibility and Design Constraints**

Most group health plan documents define eligibility by reference to employment status and service-based criteria, such as full-time status or hours worked. Non-employee directors and board members typically do not satisfy these definitions. Therefore, extending coverage would require a formal amendment to the group health plan to create a new class of eligible individuals.
Self-insured plans generally offer greater flexibility in this regard; however, fully insured plans are subject to the terms of the underlying insurance policy, which often restrict eligibility to employees and their dependents. As a result, employers with fully insured arrangements may have limited or

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no ability to extend coverage to non-employees, unless the carrier expressly agrees.

- **Stop-Loss Insurance Considerations**

Employers sponsoring self-insured group health plans commonly maintain stop-loss insurance to limit exposure to large claims. Stop-loss carriers establish their own eligibility criteria, which typically align with common-law employee status. If a stop-loss carrier declines to cover non-employee directors, the employer would be responsible for any claims incurred by those individuals without the benefit of stop-loss protection. This can result in significant (and potentially uncapped) financial exposure. For example, if a self-insured employer extends coverage to a small number of non-employee directors and those individuals are excluded from stop-loss coverage, a single high-cost claim could result in substantial out-of-pocket liability for the employer. For this reason, engaging the stop-loss carrier is often a threshold issue in evaluating whether to extend coverage to non-employee directors or board members.

- **MEWA Risk**

A key threshold issue is whether the inclusion of non-employee directors or board members could cause the arrangement to be treated as a multiple employer welfare arrangement ("MEWA") under ERISA Section 3(40). MEWA status generally arises where a plan provides benefits to individuals who are not employees of the sponsoring employer or its controlled group. If a plan is classified as a MEWA, it may become subject to state insurance regulation in addition to federal oversight. This can include Form M-1 filing requirements, licensing obligations, and, in many jurisdictions, insurer-level funding, reserve, and solvency requirements. In practice, these requirements are often not feasible for employer-sponsored arrangements, particularly where the plan is self-insured. Thus, employers should determine whether the individuals in question have a sufficient employment nexus to avoid MEWA classification.

- **Tax Implications**

The tax treatment of coverage provided to non-employee directors or board members is significantly less favorable than for employees. Because non-employees are not eligible to participate in a cafeteria plan, any premium contributions must be made on an after-tax basis. In addition, employer contributions toward coverage generally constitute taxable income to the director, which can result in a meaningful increase in the director's tax liability without a corresponding tax benefit. Employers should also consider whether the provision of taxable health benefits may have implications for payroll reporting, withholding, and related administrative processes.

- **ERISA and COBRA Considerations**

ERISA applies to employee welfare benefit plans maintained for the benefit of employees. Including non-employees in an ERISA-covered plan raises questions regarding participant status and fiduciary obligations, including the requirement that plan assets be used for the exclusive benefit of participants and beneficiaries. Furthermore, the application of COBRA continuation coverage to non-employee directors and board members is uncertain. COBRA is generally triggered by qualifying events tied to employment, such as termination of employment or a reduction in hours. It is unclear how these rules would apply to individuals who do not have an employment relationship with the plan sponsor.

- **Worker Classification and Litigation Risk**

Extending employee benefits to non-employees may create additional risk in the worker classification context. Providing health coverage could be cited as evidence supporting a claim that the individual should be treated as a common-law employee for tax or labor law purposes. In addition, employers should consider potential claims from other independent contractors or service providers who are not offered similar benefits, as well as the possibility of challenges from current employee-participants under ERISA's fiduciary standards.

Practical Implications

From a practical perspective, extending group health plan coverage to non-employee directors and board members may result in:

- Increased administrative burden associated with plan amendments, carrier negotiations, and compliance oversight;
- Potentially significant financial exposure, particularly where stop-loss coverage is unavailable;
- Less favorable tax treatment for both the employer and the director/board member; and
- Heightened regulatory scrutiny, particularly in the event of MEWA classification.

In many cases, employers may achieve their objectives through alternative approaches that present less legal and regulatory risk, which may include providing a taxable stipend to assist with the cost of individual market coverage.

Conclusion

While it may be possible in certain circumstances to extend group health plan coverage to non-employee directors and board members, doing so is rarely straightforward and often presents material legal, financial, and administrative challenges. Employers considering this structure should conduct a thorough analysis of plan design constraints, stop-loss coverage, MEWA risk, tax implications, and ERISA compliance considerations. In many cases, additional compensation to a director or board member may provide a more practical and lower-risk path to achieving the employer's objectives.

IRS Updates FAQs Related to Educational Assistance Programs

By Abby Blankenship

On April 20, 2026, the Internal Revenue Service (IRS) issued Fact Sheet 2026-10 (the "Fact Sheet"), providing updated guidance on educational assistance programs under Section 127 of the Internal Revenue Code (the "Code").

Background

Section 127 of the Code permits employers to provide up to $5,250 per year in tax-free qualified educational assistance benefits to employees. These benefits include tuition, fees, and similar expenses; books, supplies, and equipment; and, effective March 27, 2020, principal and interest payments on qualified education loans.
To qualify as a section 127 educational assistance program, the plan must be in writing and satisfy certain additional requirements. The IRS has made a sample plan available on its website for employers to use as a reference.

Updates for 2026

For the most part, the FAQs in the Fact Sheet restate prior guidance published in Fact Sheet 2024-22 (the "2024 FAQs"). However, there are a few notable substantive updates:

1. Clarification of Timing Rules for Educational Expenses

The Fact Sheet revises prior guidance regarding the timing of reimbursements for educational expenses other than student loans. The 2024 FAQs stated that expenses had to be paid by the employee in the same calendar year in which the employer provided reimbursement.

The Fact Sheet removes this requirement and instead provides that expenses simply "must not have been incurred prior to employment." Since many employers reimburse educational expenses in the calendar year after the employee paid them, this clarification should reduce uncertainty regarding the timing of reimbursements.

2. Student Loan Payments Are Permanently Tax-Free

The 2024 FAQs provided that tax-free educational assistance benefits included employer payments of qualified education loan principal and interest made "after March 27, 2020, and before January 1, 2026 (unless extended by future legislation)."

The new Fact Sheet removes this sunset date entirely, confirming that employer payments of both principal and interest on an employee's student loans (up to the $5,250 annual cap) are now a permanent tax-free benefit.

In addition, the Fact Sheet provides that, unlike the other educational expenses detailed above, student loans may have been incurred prior to employment and still qualify. Specifically, the Fact Sheet states that "it does not matter when the qualified education loan was incurred," meaning employees may receive assistance for loans taken out before joining their current employer.

3. Cost-of-Living Adjustment to the $5,250 Limit

As noted above, employers are permitted to provide up to $5,250 per year in tax-free educational assistance, which was the statutory limit prior to the enactment of the 2025 One Big Beautiful Bill Act (OBBA). This cap remains unchanged for 2026.

However, beginning in 2027, the OBBA provides that the annual limit will be adjusted each year to account for cost-of-living (COLA) increases, rounded to the nearest $50. The Fact Sheet reflects this change and incorporates OBBA's cost-of-living adjustment provisions.

Employer Takeaways

The Fact Sheet 2026-10 largely reinforces existing guidance under Section 127 while providing several helpful clarifications for both employers and employees. Moving forward, employers should review their existing program documents and administrative practices to make sure they align with the updated guidance.

Maternity Care Coding Overhaul: What Employer Health Plans Need to Know About CPT 2027

By Dawnielle Wright

Effective January 1, 2027, the coding structure for maternity care services will undergo the most significant transformation in more than three decades. The American Medical Association (AMA) is deleting the global codes that have bundled all pregnancy services into a single billing unit and replacing them with a combination of evaluation and management (E/M) codes and new code categories to capture specific stages of a pregnancy. For employer-sponsored health plans and their carriers and administrators, this change is not merely a billing technicality; it will affect how maternity claims are processed, how plan costs are tracked, and how benefits are communicated to plan participants.

Background

For roughly thirty years, maternity care in the United States has been billed under a global obstetric code structure. Under this model, a single Current Procedural Terminology (CPT) code bundles the entire course of a patient's maternity care into one charge, typically submitted at the time of delivery. While administratively straightforward, this approach has significant limitations. Global codes are normally billed when a baby is delivered, which can keep insurers in the dark about their members' pregnancies. The bundled structure also fails to reflect how maternity care is actually delivered today, often by multiple, sometimes unaffiliated providers across

antepartum, labor, delivery, and postpartum phases, in different clinical settings, and increasingly via telehealth.

Pregnancy care is now routinely delivered by multiple, sometimes unaffiliated care teams, patients are frequently transferred from rural hospitals to facilities equipped to manage higher-risk obstetric and neonatal cases, and today's bundled codes do not adequately reflect such care. Specialty societies, including the American College of Obstetricians and Gynecologists (ACOG), advocated for the change, and the AMA convened a workgroup to evaluate the existing codes and develop a new framework.

What is Changing

In total, 17 codes will be deleted, 12 codes will be added, and six codes will be revised, with new subsections and revised guidelines also included. Beginning January 1, 2027, maternity care can be reported granularly on the basis of four phases of care: antepartum, labor management, delivery, and postpartum.

Under the new framework, antepartum care will be reported per encounter using standard evaluation and management codes rather than bundled into a global charge. Labor management will be reported separately from delivery care, enabling more precise attribution of services across providers and care settings. Delivery codes will cover the delivery itself. Postpartum care will also be reported using E/M codes on an encounter basis, with all existing global postpartum codes deleted.

The new codes should give insurers more information, including when a member gets pregnant, that could help them ensure expecting mothers get adequate prenatal care, or know if mothers had complications during delivery that could necessitate follow-up services.

Why This Matters for Employer Plan Sponsors

The shift from global to encounter-based maternity coding has direct implications for employer-sponsored health plans across several dimensions.

First, claims volume and processing complexity will increase. Under the global model, a single claim is submitted at delivery. Under the new framework, multiple claims will be submitted across the course of a pregnancy; one for each antepartum visit, separate claims for labor management and delivery, and additional claims for postpartum care. Carriers and TPAs will need updated claims processing systems to handle this volume and to apply correct benefit provisions to each code type.

Second, plan cost and utilization data will change in form. Global codes have historically obscured the granular cost of individual maternity services. The new encounter-based structure will generate a far greater data set, enabling better tracking of prenatal visit frequency, postpartum follow-up rates, and complication-related services. Over time, this should improve plan sponsors' ability to analyze maternity benefit utilization and design evidence-based coverage policies.

Third, prior authorization and benefit design provisions may need to be revisited. Plan provisions that reference specific global CPT codes will need to be updated to reflect the new code structure. ACOG recommends that health plans begin the transition from the global obstetric payment model by using evaluation and management codes without limitations or preauthorization requirements for antepartum visits no later than September 1, 2026, to avoid undue administrative burdens and incorrect billing.

Timeline and Transition Considerations

To ensure that key stakeholders, including physicians, payers, medical coders, and electronic health record vendors, have sufficient time to prepare, the AMA released the new codes early and is building awareness and offering education about the revisions. The AMA will be hosting a webinar for coding professionals, scheduled for June 2, 2026.

For employer plan sponsors, the key transition milestones to be aware of are the September 1, 2026 date by which ACOG recommends health plans transition antepartum visit processing to E/M codes, and the January 1, 2027 effective date for the full new code set. Fully-insured plan sponsors should confirm with their carrier that transition planning is underway and that systems will be updated in advance of the January 1, 2027 effective date. Self-funded plan sponsors should raise these questions directly with their TPA and should review plan documents and benefit summaries for provisions that reference specific maternity care CPT codes that will be deleted.

Conclusion

The CPT 2027 maternity care coding overhaul is a significant change to health plan claims. While the effective date is January 1, 2027, the transition work should begin well before then. Employer plan sponsors would be well-served to raise this topic with carriers and TPAs now, while there is adequate time to prepare.

Compliance Corner: Primer on COBRA Rules for Employer-Sponsored Group Health Plans

By Abby Blankenship

The continuation coverage rules for group health plans were added to federal law by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Even though this Act covered a wide range of subjects, the acronym "COBRA" has become synonymous with the continuation coverage rules.

COBRA is administered by three federal agencies: the Department of Labor ("DOL"); Internal Revenue Service ("IRS"); and Department of Health and Human Services ("HHS"). The DOL and IRS share interpretive and enforcement authority with respect to private-

sector group health plans, while HHS has interpretive and enforcement authority with respect to state and local governmental group health plans. In addition, the federal courts have interpreted COBRA through various claims brought by plan participants and beneficiaries.

The financial consequences of failing to comply with COBRA can be significant. In addition to ERISA penalties of up to $110 per day for each COBRA election notice failure and IRS excise taxes equal to $100 per day per qualified beneficiary for general COBRA failures, courts may also impose other remedies, including damages equal to the amount of a qualified beneficiary's non-covered medical bills, reduced by the COBRA premiums the individual would have had to pay for the missed COBRA coverage period. Because of the potential consequences, and because COBRA failures are often difficult, from a practical standpoint, to correct when discovered internally, we recommend that employers review their COBRA procedures on a regular basis to ensure compliance, and reach out to their benefits consultants and/or legal counsel for assistance with any COBRA questions or concerns.

What Employers are Subject to COBRA?

Almost all employer-sponsored group health plans are subject to COBRA's continuation rules; however, there are some exceptions for federal governmental plans and certain church plans. Additionally, under an exemption for small employers, COBRA does not apply to an employer's plan if the employer had fewer than 20 employees on at least 50% of its typical business days during the previous calendar year. In determining whether an employer's plans are exempt from COBRA under the small employer exemption, employees of related companies are grouped together, and both full-time and part-time employees are counted. In short, each part-time employee counts as a fraction of an 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. However, there are many complicated nuances in determining whether the small employer exemption applies. If your organization may qualify for the exemption, we recommend seeking the advice of your benefits consultant and/or legal counsel to confirm.

What Plans are Subject to COBRA?

Generally, a plan is a group health plan that is subject to COBRA if it provides medical care and is maintained by an employer for its employees. ERISA defines "medical care" by reference to Code § 213(d), under which medical care means amounts paid for: (i) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (ii) transportation primarily for and essential to medical care; or (iii) insurance, including amounts paid as premiums under Medicare Part B. In additional to major medical plans, examples of group health plans that may be subject to COBRA include dental plans, vision plans, prescription drug plans, health reimbursement arrangements (HRAs), some health flexible spending accounts (FSAs), some employee assistance programs (EAPs), and some wellness programs.

Qualifying Events: What Triggers COBRA?

To be eligible for COBRA coverage, an individual must experience a "qualifying event," which is a specified event that causes a covered employee (or the covered employee's spouse or dependent child) to lose coverage under a COBRA-covered group health plan. The type of qualifying event determines who the qualified beneficiary is and how long COBRA coverage must be offered. The following are COBRA qualifying events if they result in a loss of coverage:

- Voluntary or involuntary termination of employment other than by reason of gross misconduct;
- Reduction of hours of employment;
- Divorce or legal separation of the covered employee from his/her spouse;
- Death of the covered employee;
- A dependent child ceasing to be a dependent under the generally applicable requirements of the plan;
- A covered employee becoming entitled to Medicare; and
- An employer's bankruptcy, but only with respect to health coverage for retirees and their families.

A loss of coverage occurs when an individual ceases to be covered under the group health plan under the same terms and conditions that were in effect immediately before the qualifying event. In addition to having a complete loss of coverage under a plan (for example, due to a termination of employment), a loss of coverage for purposes of COBRA eligibility could also include an increase in required premiums or reduction in benefits following a triggering event.

Duration of COBRA Coverage

COBRA coverage generally extends for up to 18 or 36 months from the date of the qualifying event. The maximum COBRA coverage period depends on the type of qualifying event. The maximum coverage period generally is measured from the date of the qualifying event, regardless of when during the subsequent election period the individual elects to begin COBRA coverage. A plan sponsor also may choose to measure the maximum coverage period from the date that plan coverage is lost instead of the date of the qualifying event, which can extend the maximum period of coverage; however, an employer that wants to extend COBRA beyond the period required by law should seek written approval from the insurer (for fully insured plans) or stop-loss carrier (for self-funded plans), as applicable.

When the qualifying event is the covered employee's termination of employment (other than for gross misconduct) or a reduction in hours, qualified beneficiaries are eligible for 18 months of COBRA coverage. For all other qualifying events, except in the case of the employer's bankruptcy, qualified beneficiaries are eligible for *36 months* of COBRA coverage.

Although the maximum coverage period generally is either 18 months or 36 months, it can be extended in certain instances. For example, when the initial qualifying event is a covered employee's termination of employment or reduction of hours, COBRA coverage may be extended beyond the original 18-month period, by up to 11 months (for a total of no more than *29 months*), if a qualified beneficiary is determined under the Social Security Act ("SSA") to have been disabled at any time during the first 60 days of COBRA coverage, and he/she properly notifies the plan within 60 days of the disability determination. Additionally, COBRA coverage may extend beyond the original 18-month period by up to an additional 18 months (for a total of 36 months), if a second qualifying event occurs during the initial 18-month period (or initial 29-month period, if a disability extension is in effect), where the second qualifying event has a 36-month maximum coverage period (i.e., death, divorce or separation, entitlement to Medicare, or a dependent child ceasing to be a dependent).

A group health plan may terminate COBRA before the end of the maximum coverage period if:

- The employer ceases to maintain any group health plan;
- A qualified beneficiary does not timely pay premiums;
- A qualified beneficiary becomes covered under another group health plan after electing COBRA coverage;
- A qualified beneficiary becomes covered under Medicare after electing COBRA;
- A qualified beneficiary whose disability extends the coverage period to 29 months is determined not to be disabled before the end of the extended coverage period; or
- A qualified beneficiary's COBRA is terminated for cause (e.g., for submitting fraudulent claims) on the same basis as would apply to a similarly situated non-COBRA beneficiary under the plan.

If COBRA coverage is terminated early, the plan must provide the qualified beneficiary an early termination notice (as discussed below).

COBRA Notices and Timeframes

Group health plans must furnish covered employees and their dependents with certain notices addressing their COBRA rights. These include an initial notice (aka, general notice), qualifying event notice, election notice, notice of unavailability of COBRA coverage, and notice of early termination of COBRA coverage. The DOL has published model general and election notices, which are periodically updated on the Employee Benefits Security Administration (EBSA) website.

The *initial notice (aka, general notice)* communicates to plan participants their general COBRA rights and obligations. Plan administrators must provide the initial notice to covered employees and their spouses when plan coverage first begins. The DOL's COBRA regulations provide that this requirement is generally met if the initial notice is delivered *within 90 days* after coverage begins.

Depending on the type of qualifying event, either the employer or the qualified beneficiary must provide a *qualifying event notice* to the plan administrator, giving notice that a qualifying event has occurred. In situations where the employer is also the plan administrator, a qualified beneficiary may provide notice to the employer (and notice by the employer to the plan administrator is unnecessary). If the employer is not the plan administrator, the employer must notify the plan administrator *within 30 days* of the following qualifying events: termination of employment; reduction of hours; enrollment in Medicare; the employee's death; or the employer's bankruptcy.

On the other hand, the covered employee or qualified beneficiary must notify the plan administrator if the qualifying event is: the employee's divorce or legal separation from his/her spouse; a beneficiary ceasing to be covered under the plan as a dependent child; a second qualifying event that occurs after a qualified beneficiary has become eligible for COBRA with a duration of 18 or 29 months; or an SSA disability determination. For qualifying events involving divorce or legal separation, a beneficiary's ceasing to be a dependent, or a second qualifying event, the timeframe for providing this notice must be *at least 60 days* after the latest of the date on which (i) the qualifying event occurs, (ii) the qualified beneficiary loses (or would lose) coverage under the plan due to the qualifying event, and (iii) the qualified beneficiary is informed, through the furnishing of the plan's SPD or the initial notice, of the responsibility to provide the notice and the plan's procedures for doing so. Special notice timing rules apply with regard to SSA disability determinations (as briefly discussed above, under *Duration of COBRA Coverage*).

When a qualifying event occurs (and after the qualifying event notice is provided to the plan administrator), the plan administrator must furnish an *election notice* to each qualified beneficiary (including the covered employee, covered spouse, and any covered dependent child) who loses plan coverage in connection with the qualifying event. The election notice gives qualified beneficiaries information regarding their rights and obligations with reference to a given qualifying event, and it generally must be furnished by the plan administrator *within 14 days* of receiving the qualifying event notice. However, when the employer is also the plan administrator, and the qualifying event is one for which the employer has the obligation to notify the plan administrator, the rules generally allow the employer/plan administrator to combine the 14-day election notice and 30-day qualifying event notice timeframes into one; so, the employer simply must furnish the election notice to the qualified beneficiaries *within 44 days* of the qualifying event.

If a plan administrator receives a qualifying event notice from an individual and determines that the individual is ineligible for COBRA coverage, the plan administrator must provide a *notice of the unavailability of COBRA coverage* to the person who was expecting to receive the COBRA coverage, within 14 days of receiving the qualifying event notice, explaining why COBRA is being denied.

When a group health plan intends to terminate coverage earlier than the maximum coverage period for a particular qualifying event, the plan administrator must provide the qualified beneficiary a *notice of early termination of COBRA coverage*. This notice must be written in a manner calculated to be understood by the average participant and must be provided *as soon as practicable* after the plan's decision to terminate coverage. The notice must describe the reason that coverage is being terminated early, the date that coverage will terminate, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage (for example, a conversion right).

In addition to the above-described notice requirements, COBRA-covered group health plans also must include certain COBRA information in their summary plan descriptions ("SPDs"). Specifically, group health plan SPDs must include a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events, qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.

COBRA Premiums

Employers generally may, but are not required to, charge COBRA qualified beneficiaries up to 102% of the cost of the applicable group health plan coverage as the COBRA premium. For disability extensions, an employer may charge up to 150% of the coverage cost during the extension period. The applicable COBRA premium is based on the "cost to the plan" of providing coverage. For insured plans, the applicable COBRA premium generally is just the monthly insurance premium paid to the insurer. For self-funded plans, however, the determination is much more complex. In brief, self-funded plans must calculate their applicable COBRA premiums based on reasonable actuarial estimates of future costs or on past costs adjusted for changes in a cost-of-living index.

For health FSAs that are subject to COBRA, the applicable premium generally is the annual benefit amount elected by the participant (divided by 12 to determine the monthly amount). For HRAs, the applicable premium calculation is more complicated. To calculate

COBRA premiums for an HRA, IRS guidance generally states that the COBRA administrator must use either the (i) actuarial method or (ii) the "past-cost" method. In either case, the calculation is, more or less, based on what it costs the employer to provide the HRA to non-COBRA participants (with the ability, under COBRA generally, to charge 102% of such amount). Because the calculation of COBRA premiums (among other things) for self-funded plans, including HRAs, can be a complicated and somewhat imprecise process, employers with self-funded plans should carefully select and monitor the practices of their COBRA administrators, and discuss any questions or concerns regarding COBRA premium calculation with their benefits consultants and/or legal counsel.

COBRA Election and Payment Deadlines

A qualified beneficiary must be provided 60 days to decide whether to elect COBRA coverage. This period is measured from the later of (i) the date coverage is lost due to the qualifying event or (ii) the date the election notice is provided to the qualified beneficiary. If COBRA is elected within the 60-day period, the coverage is retroactively effective back to the date that the individual's coverage would have ended, but for the COBRA election. Each qualified beneficiary must be offered the opportunity to make an independent COBRA election. This means that if a covered employee and spouse are both eligible to elect COBRA, each individual may decide separately whether to elect. A covered employee and spouse also must be allowed to elect on behalf of any dependent children or on behalf of all the qualified beneficiaries.

With regard to payment deadlines, a qualified beneficiary cannot be required to make an initial COBRA premium payment earlier than *45 days* from the date the individual elects COBRA. Accordingly, a qualified beneficiary who elects COBRA on the last possible day of the 60-day election period can defer the first premium payment by up to 105 days after the start of the 60-day election period. However, the plan may require that an individual's first premium payment include all COBRA premiums due to that date.

Following the initial COBRA premium payment, subsequent premium due dates are established, typically on the beginning of each month. However, a minimum 30-day grace period must be allowed for receipt of later premiums. Failure to make any payment by the end of the grace period can lead to a loss of all COBRA rights, though a plan may allow for later payments to be made. COBRA does not require a plan to send out monthly bills or to notify qualified beneficiaries of overdue payments; however, some plan administrators choose to do so out of an abundance of caution and as an accommodation to the qualified beneficiaries. On the other hand, plans must notify qualified beneficiaries of changes in premiums and, as discussed above, must provide a notice of early termination of COBRA coverage as soon as practicable after a plan's decision to terminate coverage.

STAY IN THE KNOW...

- On April 1, 2026, federal agencies issued guidance extending enforcement relief for group health plans that calculate qualifying payment amounts (QPAs), the benchmark used to determine a participant's cost-sharing for surprise billing protections, using the original 2021 methodology, with relief now running through October 1, 2026. The extension reflects ongoing uncertainty created by unsettled federal litigation over whether the 2021 QPA calculation rules are legally valid. Employer plan sponsors should confirm with their carrier or TPA that QPA calculations are being handled consistently with current guidance and should monitor further developments as the October deadline approaches.

- Virginia is the latest state to enact a paid family and medical leave insurance program, with benefits beginning December 1, 2028. Eligible employees may receive up to 12 weeks of paid leave, with wage replacement of up to 80% of their average weekly wage, subject to a statutory cap. The program will be funded through employer and employee payroll contributions. Covered reasons for leave include: (1) the birth, adoption, or foster placement of a child; (2) the employee's own serious health condition; (3) to care for a covered family member with a serious health condition; (4) to care for a covered service member who is the employee's next of kin or family member; (5) qualifying exigencies arising out of a family member's active duty; and (6) to seek safety-related services for the employee or family member.

- Last month, Maine became the latest state to implement a statewide wage transparency law, "An Act to Require Employers to Disclose Pay Ranges and Maintain Records of Employees' Pay Histories," which takes effect on July 29, 2026. The new law requires Maine employers with 10 employees or more to disclose the "range of pay" with any job posting. The disclosure requirement applies to all employer job postings, whether internal or external, electronic or paper, and regardless of whether the employer uses a third-party to recruit for its openings.

This Month's Contributors

Kate Belyayeva
Associate | kbelyayeva@maynardnexsen.com | 205.488.3597

Kate joined the firm in 2022 after graduating magna cum laude from Cumberland School of Law. Her practice is largely focused on the design, implementation, and maintenance of 401(k), profit sharing, defined benefit/pension (including cash balance), employee stock ownership and welfare plans, as well as executive and deferred compensation programs.

Abby Blankenship
Associate | ablankenship@maynardnexesen.com | 205.488.3607

Abby is an Associate in Maynard Nexsen's Employee Benefits & Executive Compensation practice group. Abby is experienced in advising public and private companies on various aspects of corporate and tax law, including mergers & acquisitions, private equity & venture capital, antitrust & trade regulation, and healthcare, franchise, and name, image & likeness (NIL) matters.

Matt Stiles
Shareholder | mstiles@maynardnexesen.com | 205.254.1071

Matt has over twenty years of experience representing employers in all facets of the employment relationship, including employee benefits and executive compensation, trade secrets and restrictive covenants, SCA and federal contract employer compliance, PEO, and staffing industry law. Matt regularly advises employers and benefits consultants in strategic benefit plan design, implementation, and compliance. He has extensive experience counseling employers involved in federal and state agency investigations.

Dawnielle Wright
Law Clerk | dwright@maynardnexesen.com | 803.253.8272

Dawnielle is a 3rd year law clerk in Maynard Nexsen's Employee Benefits & Executive Compensation practice group. As a 3rd year student at Wake Forest School of Law and full-time extern, Dawnielle works closely with and learns from the attorneys in the group on a range of employee benefits and executive compensation matters.