

COBRA Premium Determination

Statutory Background

The COBRA law has special rules for determining COBRA premiums for self-funded health care plans. The premiums shall be a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries determined on an actuarial basis taking into account factors that shall be prescribed by regulations.

The COBRA law permits the plan administrator to choose between one of two methods of determining COBRA premiums for a self-funded plan: The actuarially-determined method and the part cost method.

Actuarially-Determined Method

This is a method by which an *actuary* would perform such computation taking into account factors to be prescribed by regulations. By *actuary*, we would presume the law means a qualified actuary (minimally being a member of the American Academy of Actuaries).

The regulations, directed by the law to be issued, have never been so issued. COBRA Commentators are universally agreed that the law did not mean that a *nonactuary* could compute actuarially determined COBRA premiums by following what would be asserted to be *actuarial* methodology.

Past Cost Method

This method projects past claims forward to the upcoming plan year and spreads such claims cost among plan participants. This past cost method must be modified where there are significant changes in benefits, eligibility, census, etc between the old and the upcoming plan year. Inflation factors used in the projections are defined in COBRA law. Because this method is so simple, it is not further discussed. While not recognized by the COBRA law, the so called Fully Insured Equivalent Method is further discussed along with the reasons why the writer believes the Method carries with it some potential problems for the plan administrator.

Discussion Of Actuarially-Determined Method

Since actuaries are trained and qualified to project claims experience, based upon the past, into the future, by *model building*, the COBRA law permits such to be done by an actuary in computing COBRA premiums for the upcoming plan year. The actuary would, in the process of *model building* contemplate a large number of factors. Examples are as follows:

- Benefit content (old and upcoming plan)
- Benefit modifications
- Monetary inflation
- Claim reserves
- Census trends, family content, etc.
- Plan sponsor's fixed costs
Direct: Stop-loss premiums, administration fees etc.
Internal: Employer's *inside* costs which are plan-related
- Number/nature of *shockers* or laseder participants
- Actuarial value of the so-called aggregating specific stop-loss modification
- Monte Carlo simulations to measure likelihood of stop-loss terms being too liberal or conservative
- Slippage between contractual and delivered stop-loss benefits
- Complexities with benefit design
High or low plan options
Non-core benefits (dental, vision, e.g.)
Separate COBRA for Rx
Multiple tiers
- Complexities with multiple risk pools (as needed retirees).

Advantages of Actuarial Determination. A few of the advantages or by-products to the plan sponsor of having such determination are as follows:

- Funding Factors developed
- Obtaining estimates of claim reserves as a by-product
- Benefit content comparisons (high-low, e.g.)
- Pricing ancillary or non-core benefits (dental, vision, disability)
- Pricing of managed care programs
- Stop-loss reviews, particularly with Monte Carlo simulations
- Miscellaneous by-products (participant contributions, e.g.)
- Avoidance of such premiums being challenged by regulators or attorneys
- Being able to vary by age/geography (so long as plan is appropriately amended).

Discussion Of Fully Insured Equivalent Method

From the outset of COBRA, the practice of some practitioners has been to base COBRA premiums on the terms of stop-loss (funding factors and spec/agg premiums).

Some, but far from all, of those who use this method contemplate the terms of stop-loss; examples include:

- Aggregate factors may have a 15%-20% or 25% corridor
- Terms may be 12/12, paid, etc. with some covered persons being *lasered*.

Often, COBRA premiums represent the *worst case scenario* of the plan sponsor whereby COBRA premiums are, as a consequence, significantly overstated.

A very strong case may be made against using the fully insured equivalent method for these reasons:

- **Multiple Tiering**. Occasionally, up to six tiers are seen. To achieve parity, family content/experience studies are needed.
- **Multiple Options**. Occasionally, up to 3 or 4 options are available under a single aggregate stop-loss factor. This circumstance requires a benefit content analysis which is not a routine chore.
- **Lasered Participant**. The additional cost to the employer for lasering should be covered by the COBRA premiums. Claims experience analysis is needed to actuarially determine such added costs.
- **Aggregating Specific**. Where the specific claims, in total, are below such limit, the claims are paid by the employer; if the specific claims, in total, exceed such limit, the claims are paid by the stop-loss carrier. This is an obvious added exposure to the employer which should be actuarially measured and included in the COBRA costs. Data to support any COBRA premium increases for such stop-loss modification is needed.
- **Specific-Only Stop-Loss**. The Fully Insured Equivalent Method obviously fails when there is no aggregate factor to use as an estimate of the projected claims. Actuarial projections should be used in place thereof.
- **Active v. Retiree Risk Pools**. Where both active and retirees (over 65) are mixed in the self-funded plan experience for stop-loss and other reasons, a COBRA difficulty arises. COBRA does not apply to retirees (in most cases). The correct method of handling such situation is to have a bifurcated risk pool, one for actives and one for retirees. Early retirees should be treated as COBRAs.
- **Miscellaneous**. Such additional challenges as core v. non-core benefits and carve-outs should be measure and included as COBRA costs.

In addition, an IRS Form 1099 is required where plan coverage is provided to a non-qualified participant (self-employed, same-sex partner, e.g.). The taxable amount is the fair market value of the benefit. Fair market value would be COBRA costs less the 2%.

Special Problems

Typically there are significant challenges involved with COBRA calculations:

1. The experience is composite but the plan has high-low benefit structure. In this case, a benefit content analysis is needed.
2. Fixed costs are provided two-tier but the COBRA premiums are to be four-tier.
3. Data is composite as regards core and non-core benefits but such COBRA premiums are to be shown separately.
4. Plan sponsor wishes COBRA premiums to vary by age or geographic area.
5. Plan sponsor wishes to use COBRA for reasons beyond COBRA such as preparing 1099s to highly compensated where benefits are discriminatory; or as a basis for determining participant contributions; or for funding purposes; or for intercorporate expense transfers.
6. Stop-loss is specific-only and experience data is limited or the plan is a new plan with no prior claims experience.
7. Managed care arrangements. What are out-of-networks COBRA premiums, e.g.?
8. May COBRA premiums vary by the financial experience of sub-groups? Unless such sub-groups are separate plans, the response is *no*.

High-low Plans. Consider a situation where the claims experience is composite 300 participants but there is a Plan Option A (100 participants) and a Plan Option B (200 participants). Such situation requires a benefit content analysis by where the economic value between A and B are measured; A has a cost index of 100 while B has a cost index of .88, e.g.

Premiums Involving Multiple Tiers. Experience is typically maintained on a Composite basis; COBRA premiums are determined by tier (such tiers usually follow the bases of participant contributions). What is needed is a cost index of each tier. For example:

- Two-Tier 1; 2.4 F
- Three-Tier 1; 1.8 P+1; 2.5 F
- Four-Tier 1; 1.6 P/C; 1.8 P/S; 2.6 F
- Five-Tier 1; 1.6 P/C; 2.1 P/Children; 2.7 F

There are several observations which are relevant to these COBRA premium tiering challenges:

- Such tier as P/Child or Children is illogical in that the initial reason for P/C tier was to help the single mother; since, the number of P/Children family units has grown dramatically. AP/Children group is a family and should be so treated.
- A tier such as 1P; 2.2 P/S is illogical in that the participant and spouse may each elect COBRA as individual beneficiaries making the 2.2 premium pointless or ineffectual.

- Having the 1 premium as high as practical relative the family, e.g., is logical from a risk management standpoint when considering the ability of the COBRA participant to select against the plan by electing COBRA for sick child only but not on the other family members in good health.

Data is Composite but Core and Non-Core Premiums Needed. In such instances, it is mandatory that some serious attempt to split out the core and non-core claims be made. When not possible, an estimate is the only options. Dental, e.g., is typically 8-12 % of medical.

COBRA Premiums by Age and Geography. Nothing prevents a plan from considering age and geography as a factor in funding policy so long as such practice is formalized in the plan document. Once the plan document establishes age and/or geographic variations, such must, under the similarly situated rules, apply such to COBRA premiums.

Other Uses for COBRA Premiums. For various functions of the plan sponsor, having COBRA premiums actuarially-determined may prove useful. For Example:

- Where IRS Form 1099's are to be given to certain employees representing the economic value of their health care benefits, such COBRA premiums are used in the completion thereof.
- COBRA's are useful in setting participant contributions.
- The claims-only portion of the COBRA premium should be used when establishing funding levels.

Limited Claims Experience. For a new plan or plan for which claims experience is not available or inappropriate, such COBRA premiums must be estimated on *best evidence* basis.

Managed Care Arrangements. Where plan benefits cost indices are 100 for in-network and 80 for out-of-network, how should COBRA premiums be shown. The preferred way is to have the COBRA premium calculation assume that the COBRA beneficiary has such network option whether residing in the plan's geographic area or out of such area as a *move away*.

Financial Experience of Group. Where two divisions share a common plan (defined as one plan name, sponsor DOL number) COBRA premiums for both divisions must be the same regardless of each division's different claims experience. See *Draper V. Baker Hughes, Inc.* 892 F.Supp.1287 (E.D. Calif. 1996).

Treasury Regulations

Practitioners, from the original passage of COBRA have waited for Treasury Regulations "... Taking into account such factors as the Secretary may prescribe..." Such regulations do not appear to be scheduled for the near future.