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Health Care Reform Makes Calculating COBRA Premiums More Crucial

Paul M. Hamburger

December 12, 2010 — Under health care reform, several new rules depend on the ability to calculate the applicable COBRA premium. For example, there is a reform requirement to provide a value of coverage on each employee's Form W-2. This requirement has been deferred until 2012 at the earliest. Nevertheless, when it becomes law, employers will have to add the value of certain coverage to the Form W-2 based on the "COBRA cost."

Another instance in which the COBRA cost of coverage is relevant is in determining whether a grandfathered plan (one in existence on March 23, 2010) loses its grandfathered status. Under agency regulations, grandfather status can be lost if the employer contribution to the plan declines by more than five percentage points. In evaluating the cost of coverage for this purpose, COBRA principles are to apply.

As these examples illustrate, knowing how to calculate the COBRA premium is going to be important under the new health care reform regime. Accordingly, the IRS is expected to issue guidance in this area. In the meantime, here are the basic rules. (For more information, see Tab 1400 of the *Guide*.)

What Is the 'Applicable Premium'?

As all administrators know, COBRA allows qualified beneficiaries to elect to continue their coverage under a group health plan if their coverage would otherwise end because of certain events, including the employee's death, voluntary or involuntary termination of employment (except for gross misconduct), reduction in hours of employment, divorce or legal separation and entitlement to Medicare benefits. If a qualified beneficiary elects COBRA coverage, the plan is allowed to charge up to 102 percent of the "applicable premium" for the coverage. In certain cases where a qualified beneficiary is determined to be disabled as of a termination or reduction in hours of employment, the plan is allowed to charge up to 150 percent of the "applicable premium." (See sidebar for a definition of this term.)

No regulations explain the statutory term "applicable premium." Furthermore, except for some limited legislative history providing broad outlines for premium calculations (as discussed below), no definitive guidance exists for actually calculating these premiums.

'Applicable Premium' Defined

The "applicable premium" for COBRA purposes is the cost to the plan of providing coverage for similarly situated nonCOBRA beneficiaries with respect to whom a qualifying event has not occurred. This cost includes both the employer and employee portions of the coverage cost during the relevant coverage period. As an example of existing guidance, in December 1995 the IRS issued Revenue Ruling 96-8, which discusses the relative premium amounts (that is, single vs. family premiums) that can be charged to qualified beneficiaries based on their elections. However, this ruling does not elaborate on the methodology to be used in calculating the underlying premiums. It simply explains how to apply those premiums to single or family coverage.

In the absence of more definitive guidance, plans and employers seeking to calculate COBRA premiums are required to follow a reasonable good faith interpretation of the statute and legislative history.

Statutory Rules

In the insured plan context, the general statutory definition of "applicable premium" has been assumed to mean the actual premium charged by the insurance company for the type of coverage otherwise provided to active employees.

Example. If an insurance company charges $150 per month for single coverage and $400 per month for family coverage, it is generally assumed that the COBRA premium could be as high as $150 per month plus 2 percent for single coverage or $400 per month plus 2 percent for family coverage.

In the self-insured plan context, however, the statute provides more specific rules. Under a general premium calculation rule, the applicable COBRA premium for any period of coverage is supposed to equal "a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries." This estimate is supposed to be determined on an actuarial basis and take into account "such factors as the Secretary [of the Treasury] may prescribe in regulations." To date, there are no such regulations. In the absence of these regulations, several different practices have developed based on reasonable actuarial principles.

Under an alternative approach, the applicable premium for a 12-month period is calculated based on "the cost to the plan for similarly situated beneficiaries" for the preceding 12-month period. This cost is adjusted by the percentage increase or decrease in the "implicit price deflator of the gross national product" for the 12-month period ending on the last day of the sixth month of the preceding determination period. This alternative method cannot be used where "significant" differences exist between the coverage during the determination periods being compared, or in the employees covered by the plan during those periods.

An employer is not required to follow the alternative methodology. In fact, it is not even possible to follow it, as it is written, for several reasons:

1. Many of the statutory terms are not accurately defined (for example, terms such as "cost," "similarly situated beneficiaries" and "significant" differences in coverage are all not defined).
2. According to the U.S. Department of Commerce, the cost-of-living adjustments called for in the COBRA statutory language are no longer calculated in the same manner as when the statutory language was originally written. Instead, employers that wish to follow this alternative methodology must try to approximate that type of implicit price deflator adjustment based on other published factors.

Given the lack of regulatory guidance defining the key statutory terms and the lack of a clear cost-of-living standard, many self-insured administrators have rejected the alternative calculation method. Instead, they follow an actuarially based calculation method as prescribed under the more general COBRA rule for self-insured plans.

Legislative History

The COBRA legislative history also does not add much to round out the analysis. Instead, the legislative history provides broad parameters for the calculation methodology. For example, in defining "similarly situated" individuals, Congress intended that plans would consider the nature and type of coverage provided (for example, high or low option, single or family coverage, etc.), and "if appropriate, regional differences in health care." On the other hand, plans cannot define similarly situated individuals by reference to their medical conditions. Nor can plans group individuals by reference to classifications that would violate other federal laws (such as race or sex discrimination laws). Finally, plans are specifically not allowed to group individuals "to inappropriately increase the cost of continuation coverage for qualified beneficiaries who are rank-and-file employees (or their beneficiaries)."

Case Law on Premium Calculation

There is only one reported court case that has considered the methodology of calculating COBRA premiums — *Draper v. Baker Hughes Inc.*, see ¶1900. Although *Draper* involved an insured plan, the court provided some useful insights into premium calculations for all plans. In *Draper*, the employer paid a single premium for its entire plan, which covered employees at divisions and subsidiaries around the world. All active employees were charged the same premium for coverage, regardless of where they were employed. However, in calculating COBRA premiums, the employer allocated costs on a location-by-location basis. Thus, COBRA premiums for individuals at locations with high medical claims were higher than premiums for individuals at locations with lower medical claims.

One qualified beneficiary sued the employer, claiming that the COBRA premiums were inappropriately calculated. The court analyzed the problem by focusing on the statutory language concerning the "cost to the plan" for "similarly situated beneficiaries" covered under the same plan as the qualified beneficiaries. Essentially, the court held that because the employer had negotiated for a single employer-wide premium from the insurer for the entire plan, it had to allocate its COBRA premiums on the same basis. Essentially, *Draper* confirms that COBRA premiums must be calculated on a plan-wide basis and may not result in cost allocations designed for the purpose of inflating COBRA premiums artificially.

Application to Specific Facts

Employers and advisors looking at how to calculate COBRA premiums need to consider all this information and decide on an appropriate methodology based on actual plan terms. At this point, many practices have developed in this area that might or might not be appropriate in light of the available guidance. As health care reform guidance is issued, employers and advisors should watch carefully for more definitive rules in the area of calculating COBRA premiums and be prepared to change their calculation methodologies accordingly.

Paul M. Hamburger, Esq., is a partner in the Washington, D.C., office of the law firm Proskauer Rose LLP. He is a member of Thompson's Health Plan Advisory Board, and is author and contributing editor of the COBRA Guide, *the* Pension Plan Fix-It Handbook *and the* Guide to Assigning and Loaning Benefit Plan Money, *all published by Thompson Publishing Group.*
