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PRICING BENEFIT COSTS FOR COBRA

By Anthony J. Houghton

This article will discuss the financial impact upon the medical plans for group policyholders, caused by the requirement to continue within the group plan employees and their dependents who become ineligible under the regular eligibility provisions.

The Consolidated Budget Reconciliation Act of 1985 (COBRA) requires employers of 20 or more employees to offer a continuance of coverage at a premium not to exceed 102% of the standard premium, for an active employee or dependent who becomes ineligible for group coverage for various reasons. With some exceptions the provisions are effective for plan years beginning on and after July 1, 1986. The continuation period is up to 18 months for employees and their dependents who terminate or work reduced hours, and up to 36 months for surviving, divorced or separated spouses and their dependents, and children who reach the limiting age for dependents, or who marry or who earn sufficient income to terminate dependency.

For some "qualifying events" the employee has 60 days to notify the employer of the event, and for other events the employer has the responsibility to notify the qualifying beneficiaries about their rights and to supply forms requesting continuation. Then the employee has another 60 days after receiving the forms to elect coverage and pay the required premiums. Each month while continuation exists there is a 30-day grace period for payment of the premium.

The exact rules for the premium structure alternatives have not been promulgated, but it appears that the most common approach will be to charge the employee rate for any single COBRA person, and to charge the family rate for two or more people with a COBRA continuance. Some plan sponsors with various locations will use premiums that vary by location and some plan sponsors will use a rate structure with separate employee, spouse, and children premiums regardless of their normal contribution basis (which may be single and family or even a composite rate per employee). The use of a demographic premium rate scale with age groups, sex, and location variations is also possible.

The latter would be easy to use when the insurance carrier list bills the group with separate rates that use age/sex/location. This type of billing is common for small groups but is not typical for groups with over 20 employees. However, the premium rates for groups with up to 100 or 200 employees frequently are developed from group manuals that use the specific age/sex/location distribution of the group to determine the composite employee and composite dependent rate as opposed to reliance upon the prior experience of the group. Therefore, the age/sex/location of each employee does influence the composite cost in these groups. For large experience rated groups the demographic factors influence the costs, although there may be no analysis of the distribution of age/sex/location and the premium demographic relationships are not used explicitly.

Regardless of the premium basis for charging the continuing insured person or persons, actuaries must determine the cost implications of including these people in the program. Because special rates using excess morbidity are not allowable, the extra cost must be built into the overall premium rate or contribution rate level.

It is my opinion that there will be extra morbidity measured by comparing the same class of insureds under COBRA continuance and active employees and their dependents. Specifically, I mean that, for a male age x or a female age y, the continuing person will have a higher benefit cost than an active person with the same sex, age and location. Some actuaries have expressed the opinion that for some groups the largest number of continuees would be ineligible children and for groups charging an average employee premium rate there would be a margin that would cover the excess morbidity, because the young adults ages 19-26 would usually have a cost that is 60% to 70% of the average employee cost. Of course, the opposite result could occur when employees ages 50 and over elect continuance in greater proportions and if these older employees were charged average employee premium rates. There would be excess benefit costs because of the normal higher utilization associated with advanced age. My comments about extra morbidity are related to costs by demographic age group and not premium adequacy because of the rating structure.

The extra morbidity cost I anticipate will be caused by anti-selection by at least some of the people eligible for continuation. The anti-selection opportunities can be grouped into several types which are described below.

1. Impaired health and/or current need for medical treatment may encourage an employee or dependent to elect coverage, and the proportion of substandard risks in the continuation group may be greater than in the exposed group.

2. The rules that permit the eligible person to wait between 60 days to over 120 days before electing coverage allow the person to decline the coverage (when there has been no expense) and to pay for coverage (when the reimbursement will exceed the premiums). Also the person whose prospective medical expense risk increases during the decision period may purchase coverage.

3. After purchase of continuation there is a known termination date, that may be the end of the maximum period, or the date when the person will become covered by another plan (which may exclude pre-existing conditions) or the date when the person can no longer afford the premiums for continuation. Knowing the benefits will end, the insured may incur as many needed medical services as possible while the coverage remains in effect.

If one anticipates something similar to the situation described above, how should the group rates applicable to both active and continued persons be set to cover the excess cost? For large experience rated groups some analyses of their particular circumstances are

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necessary because there may be a significant difference among groups. For smaller groups with pooled rates an overall model may be necessary.

We have considered two special group situations and a pool that includes groups that generally do not provide post-retirement medical benefits.

The factors that must be considered in each case are:

1. extra morbidity by type of risk,
2. turnover rate of employees and reason for turnover,
3. length of coverage period under continuation,
4. availability of post-retirement medical coverage,
5. sophistication of employees about efficient application of election.

Some of these factors are not immediately discernible, so assumptions will have to be made and experience tested to validate the assumptions.

For group ABC we assume an industrial manufacturer which does not have post-retirement medical coverage and is currently reducing its staff, especially in the middle management positions. For the next year they contemplate the current work force will drop from 1,000 people to 600 with about 250 of the terminating employees being laid off and 150 voluntarily terminating to accept other jobs.

Because of the mass restructuring one might expect a depressed state of mind, higher morbidity, a longer period before obtaining other employment, and possibly counseling to explain their insurance options.

The proportion of employees and their families taking the 18 months extension would be greater than normal. For this group a study might indicate a morbidity level of 75% in excess of the morbidity level for active employees with similar demographic characteristics. The enrollment exposure during the next year might involve 10,000 employee months of which 1,000, or 10%, are COBRA continuance months. On this basis the average monthly benefit cost may be 7.5% higher than for a group of active employees with the same age/sex distribution.

For group XYZ we assume a growing company in a business sector that is actively recruiting employees. Almost all terminating employees are accepting employment in competitive positions with other companies. The company's COBRA continuees are expected to be ineligible children, a small number of widows or divorced spouses, and short service older employees who leave before eligibility for post-retirement medical benefits. The company has a generous continuation of coverage for families of deceased employees and post-retirement medical coverage for employees over age 55 with 10 years of service. Because of the circumstances of the group which already includes early retirees not eligible for medicare and some survivors, the extra morbidity is assumed to be 25% of the morbidity level for the non-COBRA insureds with similar demographic characteristics. The enrollment exposure during the next year of COBRA continuees is assumed to be 2% of total exposure so that the monthly benefit cost is .5% higher than without such continuees.

Finally, for a pool of groups with a standard premium rate basis the assumption of extra morbidity is 50% and the enrollment exposure is assumed to be 4%, making the extra cost of allowing such continuees 2% of the standard rate basis.

In summary, the premiums for insured groups and the funding of self-insured groups will have to anticipate the extra benefit costs associated with COBRA and this cost cannot be charged directly to the continuees. The cost is likely to vary dramatically by group and wherever it is possible the special circumstances of each group should be considered. Within a relatively short time, such as two years, the aggregate extra morbidity and the relative exposures will be known. Each company should maintain the statistics to validate its assumptions and to determine future factors, because it will be vital when situations such as described for company ABC develop. □

DEVELOPMENT OF NEW VALUATION LAW FOR LIFE INSURERS

By Walter S. Rugland

At the Florida winter meeting of the NAIC's Life and Health Actuarial Task Force (LHATF), agreement was reached on an approach to be taken to reconstitute the Standard Valuation Law (SVL) applicable to life insurers.

John Montgomery, chairperson of LHATF, expects the results of the work to be approved in 1989 or 1990.

At the June NAIC meeting LHATF had been given authority to initiate a study of reconstitution of the SVL and the coordination of the project was assigned to the Standing Technical Advisory Committee (STAC), chaired by Charles Greeley.

STAC presented a proposed approach to reconstruction of SVL at LHATF's October meeting. The approach suggested the ultimate goal is an actuary's opinion as to the adequacy of the company's assets to support current and anticipated business plans. This opinion would be separate from considerations for earnings reports, currently legal solvency and tax payable calculations. STAC said the ultimate goal is not attainable within the forseeable future.

As an interim goal STAC suggested pursuit of a reconstituted SVL which focuses on the actuary's opinion as to adequacy of assets supporting the reported reserves on in force business, together with development of a minimum reserve approach which reflects the risk position of the company. This latter feature has been labeled "dynamic solvency testing".

The interim proposal is an all-encompassing revision of the Standard Valuation Law which emphasizes an actuary's opinion. Conceptually, the opinion would include all of the current reported actuarial liabilities of the company. The actuary's opinion would be based on cash flow analysis if appropriate for the company product structure and risk profile.

As a result of the work done in support of the opinion, and the opinion itself, actual reserves could be materially different from company to company, and for those companies managing risk in a manner which justifies it, materially

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