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HHS Issues Final Rule on Transition Reinsurance Program

Introduction

The transitional reinsurance program was established with the stated intent of stabilizing premiums in the individual market during calendar years 2014 through 2016. The program cannot be extended past 2016 without an act of Congress.

Under the statute, the program will be financed through "contribution funds from contributing entities," which is a round-about way of saying "payments from health insurers and third-party administrators ("TPA"), on behalf of self-funded group health plans," to support reinsurance payments to individual market insurers that cover high-cost individuals. Although the final rule refers to "contributing entities" and "contributions," the payment amounts discussed below are not voluntary.

The goal of the transitional reinsurance program is to reduce the uncertainty of insurance risk in the individual market by partially offsetting risk for high-cost enrollees. By limiting insurer's exposure to high-cost enrollees, it's hoped this program will limit individual market rate increases that might otherwise occur because of the immediate enrollment of individuals with unknown health status. The program is intended to be state-based but if a state chooses not to establish a transitional reinsurance program, the final rule provides that the U.S. Department of Health and Human Services ("HHS") will do so on its behalf. Based on HHS' communications with the states, as of February 25, 2013, Maryland and Connecticut were the only states electing to operate transitional reinsurance programs in 2014.

We have updated this Article since its original publication to incorporate the process for submitting a count and payment to HHS.

What is the estimated reinsurance contribution?

Pursuant to the final rule, the national contribution rate will be $5.25 per covered life, per month in 2014, which is equivalent to an **annual rate of $63 per covered life**. The amount was calculated by summing up the three amounts that HHS is required to collect from contributing entities and then dividing the sum total by the estimated number of enrollees in plans that will be required to make a contribution payment. For 2014, the total amount HHS is required to collect is comprised of the following: $10 billion for the reinsurance pool; $2 billion to be paid to the U.S. Treasury to partially offset the government's cost for the Early Retiree Reinsurance Program ("ERRP"); and $20.3 million for administrative expenses. States that decide to operate their own reinsurance program may elect to collect more than the amount represented by the national contribution rate set by HHS.

For future years, HHS intends to publish an annual notice setting forth the national contribution rate for the upcoming benefit year. HHS anticipates the 2015 benefit year contribution rate will be $44 per covered life. For 2016 the contribution rate is unknown, but we do know that the amount to be collected for the reinsurance pool is scheduled to decline.

Who is required to make a reinsurance contribution payment?

Under the final rule, health insurance issuers and self-insured group health plans are ultimately responsible for making the payment. However, a self-insured group health plan may elect to use a TPA or administrative-service-only contractor to make the payment on its behalf. Self-insured plans using a TPA should discuss with their TPA whether they will be submitting to HHS on their behalf. Also, using a TPA to submit does not shift liability of the fee or missed deadlines away from the self-insured plan. A self-insured, self-administered group health plan without a TPA or administrative-services-only contractor would make its reinsurance contributions directly. For benefit years 2015 and 2016, self-insured, self-administered plans are not required to make reinsurance contributions.

What coverage is affected?

In general, a contributing entity is required to make reinsurance contributions on behalf of major medical coverage, but is not required to make payments on behalf of coverage that is not major medical coverage or which is considered excepted benefits. Therefore, health savings accounts ("HSA"), as well as health reimbursement arrangements ("HRA") that are integrated with a group health plan, would not be subject to the assessment. However, assessments would be required for the group health plan providing major medical coverage that is typically associated with an HSA or HRA. In addition, no contributions would be required from (1) flexible spending accounts, (2) employee assistance plans, wellness programs, and disease management programs (to the extent they do not provide major medical coverage), (3) self-insured group health plans or health insurance coverage that consists solely of excepted benefits, such as stand-alone dental or vision, (4) Private Medicare (Medicare plans such as Medicare Advantage and Part D drug plans that are provided by insurance issuers), Medicaid, CHIP, state high-risk pools, and basic health plans described in section 1331 of PPACA[1], (5) stop-loss and indemnity reinsurance policies, (6) military benefits under TRICARE, (7) expatriate health coverage, and (8) coverage limited to prescription drug benefits.

The final rule also provides useful insight on a number of special situations. When an individual has both Medicare coverage and employer-sponsored group health coverage, Medicare Secondary Payer ("MSP") rules would apply and the employer-sponsored group health coverage would be considered major medical only if the group health coverage is the primary payer of medical expense under the MSP rules. The employer-sponsored plan would not be responsible for making reinsurance contributions for retirees covered under an employer plan where Medicare is the primary plan and the employer plan is secondary.

With respect to Tribal coverage, the final rule excludes such coverage when offered by a Tribe to Tribal members, their spouses and dependents in their capacity as members of the Tribe. However, a plan offered by a Tribe to employees (or retirees and dependents) because of a current or former employment relationship would be required to make a reinsurance contribution payment for that coverage.

Lastly, COBRA and other continuation coverage is subject to a reinsurance contribution payment to the extent that the coverage provided qualifies as major medical coverage.

[1] Section 1331 of PPACA gives states the flexibility to establish a basic health insurance program for low-income individuals not eligible for Medicaid.

How are covered lives calculated?

The ultimate reinsurance contribution payment will be the product of the national contribution rate and the number of covered lives for each affected plan (major medical coverage). For example, for 2014, a self-insured plan with 1,000 covered lives (pursuant to major medical coverage) would be liable for a reinsurance contribution payment of $63,000.

The final rule provides a number of different methods that can be used to calculate covered lives. These methods build upon the methods permitted for calculating covered lives for purposes of calculating the Patient-Centered Outcomes Research ("PCOR") fee. A description of the various counting methods follows:

Actual Count Method: A health insurance issuer and self-insured group health plan would add the total number of lives covered for each day of the first nine months of the benefit year[2] and divide that total by the number of days in those nine months. The calculations are based on the first nine months of a calendar year, since contributing entities will have to provide a report to HHS setting forth the annual enrollment count of the number of covered lives for purposes of the reinsurance contribution for that year (see below).

Snapshot Count Method: A health insurance issuer and self-insured group health plan would add the totals of lives covered on a date (or more dates if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year, (provided that the dates used for the second and third quarters must be within the same week of the quarter as the date used for the first quarter), and divide that total by the number of dates on which a count was made. For this purpose, the same months must be used for each quarter (for example, January, April and July).

Snapshot Factor Method: A self-insured group health plan can use this method by adding the totals of lives covered on any date (or more dates if an equal number of dates are used for each quarter) during the same corresponding month in each quarter, and dividing that total by the number of dates on which a count was made. However, for this method, the number of lives covered on a date is calculated by adding the number of participants with self-only coverage on the date to the product of the number of participants with coverage other than self-only coverage on the date multiplied by 2.35. For example, a plan with 30 individuals with self-only coverage and 20 individuals with other than self-only coverage on each counting date will have a total of 77 covered lives (30 + (20*2.35)). For this purpose, the same months must be used for each quarter (for example, January, April, July). Moreover, as with the snapshot count method, the dates used for the second and third quarters must be within the same week of the quarter as the date used for the first quarter.

Form 5500 Method: A self-insured group health plan may calculate the number of lives covered for a plan that offers only self-only coverage by adding the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500, and dividing by two. Additionally, a self-insured group plan that offers self-only coverage and coverage other than self-only coverage may calculate the number of lives covered by adding the total participants covered at the beginning and the end of the benefit year, as reported on the Form 5500.

Member Months Method or State Form Method: Health insurance issuers using this method multiply the average number of policies for the first nine months of the applicable benefit year by the ratio of covered lives per policy calculated from the NAIC Supplemental Health Care Exhibit (or from a form filed with the issuer's state of domicile for the most recent time period). Issuers would count the number of policies in

[2] Benefit year is defined as the calendar year for the purpose of the transitional reinsurance program.

the first nine months of the applicable benefit year by adding the total number of policies on one date in each quarter, or an equal number of dates for each quarter (or all dates for each quarter), and dividing the total by the number of dates on which a count was made.

For example, if a health insurance issuer indicated on the NAIC form for the most recent time period that it had 2,000 policies covering 4,500 covered lives, it would apply the ratio of 4,500 divided by 2,000, equaling 2.25 to the number of policies it had over the first three quarters of the applicable benefit year. If the issuer had an average of 2,300 policies in the three quarters of the applicable benefit year, it would report 2.25 multiplied by 2,300 as the number of covered lives for the purposes of reinsurance contributions.

The final rule provides additional insight with respect to which methods can, or cannot be used, under special circumstances. For plans that offer one or more coverage options that are self-insured and one or more other options that are insured, then the actual count method or the snapshot count method must be used. For multiple self-insured group health plans, the rule provides that the Form 5500 method is prohibited, since that method would not easily permit aggregate counting due to the fact that the identities of the covered lives are not available on that form. If a plan sponsor maintains two or more group health insurance plans (or a group health insurance plan with both insured and self-insured components) that collectively provide major medical coverage for the same covered lives, then these multiple plans must be treated as a single self-insured group health plan.

While the aforementioned methods are based on those established for the PCOR fee, contributing entities are allowed to use a different counting method for the annual enrollment count of covered lives for purposes of the reinsurance contribution payment and a different method to calculate the PCOR fee.

Compliance Pointer: Employers cannot simply rely upon the count they used to pay the PCOR fee. Although the same methods are used, the reinsurance contribution is based on the first nine months of enrollment during a calendar year. (i.e., January through September). Although fluctuations may occur in the fourth quarter of a benefit year, those fluctuations are ignored when counting covered lives.

Who will collect the reinsurance contribution payment?

HHS will collect the reinsurance contribution payment from both health insurance issuers and self-insured group health plans, even if a state decides to operate its own reinsurance program. Contributing entities must register on Pay.gov, unless they are already registered. This will be the website contributing entities submit their count of covered lives, and pay the fee. This is intended to help streamline the collection process so that health insurance issuers and self-insured group health plans are not responsible for making payments to each individual state. However, if any state decides to operate its own reinsurance program, then HHS would transfer a portion of the administrative fee that is part of the national contribution rate to those states.

Any state that decides to operate its own reinsurance program may elect to collect additional reinsurance amounts beyond the amount represented by the national contribution rate that will be set by HHS. However, the final rule states that “nothing in [PPACA] or this final rule gives a state the authority to

collect any funds – whether under the national contribution rate or under an additional state contribution rate – from self-insured group health plans covered by ERISA."

Any state that chooses to collect additional reinsurance contributions must set forth the amount of any additional contribution that it wishes to collect. Under the final rule, any additional contributions imposed by any given state may only be collected by the state and not by HHS.

What is the tax treatment of the payments?

A sponsor of a self-insured group health plan that pays a reinsurance contribution may treat the contribution as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Internal Revenue Code. This treatment applies whether the contributions are made directly or through a TPA or administrative-services-only contractor.

Moreover, the final rule confirms that paying reinsurance contributions would constitute a permissible expense of the plan for purposes of Title I of ERISA because the payment is required by the plan under PPACA.

What is the process for submitting the count of covered lives to HHS?

Contributing entities will be required to register on Pay.gov and create an account. Contributing entities that already have an account with Pay.gov can use their existing account to submit count and pay the fee. Information provided in the profile will be used to auto-populate certain information on the ***"ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission"*** form. This is the form contributing entities will submit to HHS with the total count of covered lives for the applicable benefit year. The annual enrollment count must be submitted to HHS no later November 15 of the applicable benefit year (i.e., November 15, 2014 for the 2014 benefit year). Contributing entities will select whether they are submitting for first collection, second collection, or combined collection. Next, the gross annual enrollment count (covered lives) is to be entered into the system and the Pay.gov system will auto-calculate the amount of the fee. Once the form has been completed, Supporting Documentation will need to be uploaded to the Pay.gov system. The supporting documentation will assist HHS with verifying the amount of the fee for each contributing entity. All contributing entities are required to provide supporting documentation. It is important the annual enrollment count in the supporting documentation and on the form match, so contributing entities should verify the amounts are correct. Once the form has been completed and the supporting documentation has been uploaded, contributing entities will then enter bank information and schedule payment dates.

The Supporting Documentation requires certain information be included and in a certain format. HHS will be providing sample documentation for contributing entities to use as a guide.

What is the timeframe for collection of the contribution payment?

Once the contributing entity has registered on Pay.gov, filled out the applicable form, and uploaded the supporting documentation, contributing entities must enter checking account information and select a payment date. HHS will do an ACH withdrawal on the date selected. Only one bank account can be used for each form. If a contributing entity chooses to pay the fee in two installments, the contributing entity will have to resubmit the form with the same supporting documentation. The difference being the 'Type of Payment' selection will be 'Second Collection.' Contributing entities have the option to duplicate the form, which is suggested by HHS. The deadline for both submissions is November 15th of the applicable benefit year. A payment date for the second collection will have to be scheduled and paid by the following November 15th. For the 2014 benefit year, if one combined payments is made, payment should be

scheduled within 30 days of submission, but no later than January 15, 2015. If two payments will be made, the first installment should be scheduled within 30 days of submission, but no later than January 15, 2015 and the second installment must be paid by November 15, 2015. However, submission of the form and supporting documentation is still required by November 15, 2014.

Action Steps for Plan Sponsors

1. For insured plans, though the insurer will be responsible for paying the contribution, the assessment could affect the plan's premium. Plan sponsors should discuss the impact with their insurer.

2. For self-funded plans, the plan sponsor should review their TPA administrative services agreement to determine the rights and obligations of each party with respect to counting enrolled lives and remitting the fee and if the TPA will be providing this services what if any additional fee would apply.

3. Register on Pay.gov. Contributing entities will be required to set up a pay.gov account in order to complete the form and pay for the fee. Information provided in the profile will be used to auto-populate the Transitional Reinsurance form, so completing as much as possible will help minimize redundancy.

4. Review the Supporting Documentation content and style requirements to ensure compliance with the Pay.gov website. See the GBS "Getting Ready for the Transitional Reinsurance Fee: Checklist for Self-Insured Plan Sponsors." http://ajg.adobeconnect.com/hcrfees_trexamples/

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.
