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For your information

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Reinsurance and other fees could impact employer health care costs

To help offset the cost of coverage expansion and other provisions, the Patient Protection and Affordable Care Act (ACA) imposes a number of broad-based fees and taxes on entities associated with providing health care coverage. Among them are fees pertaining to reinsurance, risk corridors, and risk adjustment programs that are related to funding and stabilizing premiums in the individual market and the health insurance Exchanges. Pharmaceutical and medical device manufacturers, health insurance issuers, third party administrators, manufacturers and importers of prescription drugs are also subject to fees and excise taxes. Most of the fees do not apply until 2014; however, some do apply sooner, and could lead to increases in an employer's cost of providing health coverage. To avoid unwelcome surprises, it is important for employers to consider many of these fees and taxes now, before full implementation takes place.

Background

The ACA requires that public health insurance Exchanges be available in every state by January 1, 2014. Exchanges are state and/or federal-based competitive health insurance marketplaces through which individuals and small businesses can purchase private health insurance (considered qualified health plans). The federal government will run Exchanges in states that chose not to set up an Exchange. The ACA includes provisions relating to reinsurance, risk corridors, and risk adjustment that are meant to mitigate the impact of adverse selection and stabilize premiums in the individual and small-group market as insurance reforms and the Exchanges are implemented.

The transitional reinsurance program is designed to help stabilize premiums in the individual market during the first three years Exchanges are operational (2014-2016). It is funded by contributions from health insurance issuers and third-party administrators (TPAs) on behalf of self-insured plans. Under the regulations, states that establish an Exchange are not required to also establish a reinsurance program. If a state chooses not to establish a program, the Department of Health and Human Services (HHS) will establish the program and perform the functions for that state. Unlike reinsurance, the risk-adjustment program is a permanent program, intended to provide payments to health insurance issuers to attract higher-risk populations by transferring funds from plans that enroll the lowest-risk individuals to plans that enroll the highest-risk individuals. This program is designed to reduce or eliminate premium differences among plans based solely on favorable or unfavorable risk selection in the

individual and small-group markets. The temporary risk corridor program provides additional protection for issuers of qualified health plans in Exchanges.

Additional fees and excise taxes include those related to the Patient-Centered Outcomes Research Institute,as well as to health insurers, certain branded prescription drugs, medical devices, and high-cost plans.

Transitional Reinsurance Program

The transitional reinsurance program is meant to stabilize premiums for coverage in the individual market during the first three years Exchanges are operational (2014-2016). All health insurers and TPAs, on behalf of self-insured group health plans, must make contributions to support this transitional reinsurance program. The funding for this program could have a significant impact on employer group health plans.

Contributing Entity. Regulations related to this program indicate that a "contributing entity" must make reinsurance contributions. The regulations define a contributing entity as "a health insurance issuer or a third party administrator on behalf of a self-funded plan." In the case of a self-funded group health plan, although the preamble to the regulations suggests that the plan could be liable for the contribution, the regulations themselves provide only that the TPA make the reinsurance contribution "on behalf of a group health plan." Presumably some of the cost of this contribution would be passed along to the self-insured plan (subject to contract negotiation between the employer and the TPA).

The final regulations do not specifically address self-insured plans that are self-administered. The preamble refers to collecting funds from self-insured plans and TPAs; however, the actual definition of a contributing entity in the final regulations does not include a self-administered, self-funded plan. Likely, the plan in this instance would be responsible for making the reinsurance contribution to HHS, but HHS will need to issue clarifying guidance (regarding this and other matters).

Coverage Subject to Fee. Generally, the contribution applies to coverage from all health insurance issuers and TPAs on behalf of self-insured group health plan coverage, including state and local governmental plans. Contributions are not required for plans or coverage that consists solely of HIPAA excepted benefits, such as stand-alone, limited scope dental and vision plans; most health FSAs; certain long-term care plans; accident or disability plans; liability insurance; workers compensation; coverage for on-site clinics that offer a *de minimis* amount of medical care; and specified disease, hospital indemnity, or fixed indemnity and supplemental benefit plans (provided under a separate contract, policy, or certificate of insurance), such as Medicare or TRICARE supplemental plans. The regulations also provide that insurers of plans that are not "commercial books of business" or "major medical" products are excluded from making reinsurance contributions. Thus, private Medicare and Medicaid plans are exempt from making reinsurance contributions because they are not "commercial books of business." It is unclear whether the reinsurance fee would apply to retiree-only plans. Some argue that it would, but further guidance is needed.

Amount and Collection of Fee. Rates under this program have not been set, leaving unclear the financial impact of this program on group health plans for 2014 and beyond. The regulations provide that the reinsurance contributions will be based on a national per capita contribution rate, which HHS will announce in its annual notice of benefit and payment parameters. The regulations provide that the reinsurance assessment applies on a per-covered-life basis. Although HHS has not yet issued this announcement, estimates are that the assessment could be between $60 and $100 per covered life. Although it was anticipated rates would be announced this month, it is more likely that rates will be announced after the November elections.

The regulations state that reinsurance contributions will be collected quarterly beginning January 15, 2014. Self-insured plans and TPAs on their behalf will make contributions directly to HHS, but the payment process is not yet clear. Further guidance is anticipated.

Recordkeeping Requirements. The regulations indicate that each contributing entity will have to keep data to substantiate the contribution amounts for the contributing entity. However, the regulations do not spell out exactly what data is required. Instead, the regulations provide that the contributing entity will have to collect this data "in the manner and timeframe specified by the State or HHS."

INSIGHT

Although the reinsurance program has received little attention, some large employers are concerned that the fee associated with this program could be unduly burdensome on self-insured plans, particularly those with a large number of covered lives, multiple plans, or that use multiple TPAs. Informally, the White House and HHS have been soliciting comments from the employer community regarding the burden imposed by the reinsurance program.

Risk Adjustment Program

The primary goal of the risk adjustment program is to better spread the financial risk carried by health insurance issuers. This permanent program is intended to provide payments to health insurance issuers that attract higher risk populations by transferring funds from plans that enroll the lowest-risk individuals to plans that enroll the highest risk individuals. The program likely will not have an impact on large-employer group health plans.

Contributing Entity. All non-grandfathered plans (inside and outside the Exchange) in the individual and small group markets will either pay into the risk adjustment program or receive a payment from it.

Coverage Subject to the Fee. The program applies to coverage other than HIPAA excepted benefits, as defined above. In addition, the regulations provide that HHS may exempt other plans.

Amount and Fee Collection. A risk adjustment methodology will be proposed in the annual HHS notice of benefit and payment parameters. Regulations pertaining to the program provide that states

certified to operate an Exchange have the option to establish a risk adjustment program, but do not have to do so. The regulations make clear that if a state chooses not to establish a risk adjustment program, HHS will establish a program and perform the risk adjustment functions for the state. States operating their own risk adjustment programs may propose an alternative methodology for approval by HHS.

Recordkeeping Requirements. The final regulations state that a plan must submit or make accessible all required risk adjustment data for the plan as established by HHS. However, the regulations do not say how this is to be done. Presumably, the annual notice of benefit and payment parameters will spell this out.

Risk Corridor Program

The risk corridor program is a temporary program (2014-2016) designed to protect against uncertainty in setting rates for qualified health plans (QHPs) by limiting the extent of insurer losses (and gains) by shifting costs between the federal government and QHPs. The program should not have an impact on large employer group health plans.

Contributing Entity. QHPs that have allowable costs that are less than the target amount (namely, the total premiums minus the QHP's administrative cost) must make a payment to HHS.

Coverage Subject to the Fee and Reimbursement. Both individual and small group QHPs are subject to the fee and eligible for reimbursement.

Amount and Collection of Fee and Reimbursement. QHPs whose costs are at least 3% below the plans' cost projections will remit charges for a percentage of those savings to HHS, while qualified health plans whose costs are at least 3% above cost projections will receive payments from HHS to offset a percentage of their losses.

Recordkeeping Requirements. The regulations provide that issuers will be required to submit premium and allowable cost data to HHS. The annual HHS notice of benefit and payment parameters will provide guidance on how this data should be submitted.

Patient-Centered Outcomes Research Institute

The ACA created the Patient-Centered Outcomes Research Institute (PCORI), which is charged with promoting research to evaluate and compare the health outcomes and clinical effectiveness, risks, and benefits of medical treatments, services, procedures, and drugs. The PCORI is funded in part by fees assessed on health insurers and sponsors of self-insured group health plans. The PCORI fee will first be assessed with respect to plan or policy years ending after September 30, 2012 (i.e., ending between October 1, 2012 and September 30, 2013). The fee is $1 times the average number of covered lives (employees and dependents) for the first plan or policy year ending on or after October 1, 2012, increasing to $2 after the first year. The fee is temporary and will not be assessed for plan years ending after September 30, 2019. This program will affect large employer group health plans and, depending

on the size of the plan, could result in a significant payment. (See our May 9, 2012 *For Your Information*.)

Health Insurers

Beginning January 1, 2014, an annual fee applies to any "covered entity" engaged in the business of providing health insurance with respect to health risks in the United States. The amount of the fee is based on the covered entity's annual net health insurance premiums for the calendar year, which must be reported to the Secretary of the Treasury. The fee does not apply to governmental plans, certain nonprofit entities that receive more than 80% of their gross revenue from Medicaid, Medicare, or state children's health insurance programs (SCHIPs), voluntary employee beneficiary associations (VEBAs) that provide health benefits but were not established by an employer, and self-insured group health plans. This fee will affect insured group health plans, and it could indirectly affect the cost of stop-loss insurance.

Prescription Drug Manufacturers

The pharmaceutical industry is subject to an annual fee on certain branded prescription drugs. The fee applies to both domestic and foreign manufacturers and importers of certain branded prescription drugs or biologics offered for sale in the United States. "Branded prescription drug sales" are defined as the sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program. The specified government programs are Medicare Parts B and D, Medicaid, and any program under which branded prescription drugs are procured by the Department of Veterans Affairs, the Department of Defense, or the TRICARE retail pharmacy program.

The fee is allocated among covered entities on the basis of market share in the aggregate for specified government programs (e.g., Medicare). The first annual fee was collected in September 2011. It is possible that overall drugs cost could increase to accommodate this fee, which could have some impact on health plans, including employer group health plans.

Medical Device Manufacturers, Producers, and Importers

The ACA imposes a permanent tax of 2.3% of the sale price on any manufacturer, producer, or importer of medical devices regulated by the FDA and intended for humans, but excluding eyeglasses, contact lenses, hearing aids, and any other medical device HHS determines is generally purchased by the general public at retail for individual use. The proposed regulations contain a list of non-exclusive factors for determining whether a device is for individual use at the retail level. The excise tax applies to sales after December 31, 2012. Although no direct impact on employer group health plans is anticipated, it is possible this tax could initially drive up the cost of medical devices, and that at some point that increase in cost could in turn increase the cost of coverage under employer plans.

High-Cost Health Plans

Beginning in 2018, an excise tax will be imposed on the aggregate value of employer-sponsored health coverage that exceeds certain thresholds. The tax is 40% of the aggregate value in excess of $10,200 for individual coverage and $27,500 for family coverage. In the case of multiemployer plans, all coverage is considered family coverage. The thresholds are higher for certain retiree coverage and coverage of individuals in high-risk professions. All amounts are subject to cost-of-living adjustments. Employers might begin to adjust coverage under the group health plan to avoid the excise tax.

In the case of an insured plan, the tax will be assessed on the insurer providing the coverage. In the case of a self-insured plan, the tax will be assessed on the plan administrator or on the employer if the plan is self-administered.

Conclusion

Employers need to be aware that the fees and taxes described here will likely increase their cost of providing health plan coverage. Although some are temporary, fees and taxes such as those associated with the PCORI, the reinsurance program, and high-cost health plans will have a more immediate and direct impact on employer plans. Fees associated with certain prescription drugs, medical devices, and health insurers are likely to have a less significant impact on employer plans, but they, too, could ultimately increase the cost of coverage.