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For your information

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Transitional reinsurance program results in significant new costs for group health plans

The Department of Health and Human Services (HHS) has issued additional guidance on the three-year transitional reinsurance program that is established under health reform to help stabilize premiums in the individual health insurance market from 2014 to 2016. This program is funded by contributions from insurers in the individual, small group and large group markets, as well as by self-insured group health plans. HHS has estimated an annual per capita rate of $63 for 2014, and payment will likely be due in early January 2015. The fee applies to all participants in group health plans providing major medical coverage, including dependents, and will result in significant new costs for group health plans.

Background

The individual and small group market changes, effective in 2014, will significantly alter the health insurance marketplace and create market and pricing uncertainties for insurers. The Patient Protection and Affordable Care Act (ACA) included the following “premium stabilization programs” to provide insurers with greater payment stability and to protect against adverse selection as insurance market reforms are implemented:

- Transitional Reinsurance Program – This is a temporary program, in place from 2014 to 2016, that will provide funding to insurers that incur high claim costs for enrollees in the individual market, both inside and outside the Exchanges. States have the option to establish the program, but HHS will establish a program if a state does not. The program is funded by insurers in the individual, small group and large group markets, as well as by self-insured plans.
- Temporary Risk Corridors Program – Similar to the reinsurance program, this temporary program will be in place from 2014 to 2016. This federal program only applies to individual and small group market plans offered inside the Exchanges. The program protects against inaccurate insurer rate-setting by sharing gains and losses among the health plans. Effectively the program helps limit insurer gains and losses. The program is funded by the insurers.
- Risk Adjustment Program – This is a permanent program that applies to individual and small group market plans offered inside and outside the Exchanges. The program will provide payments to insurers who disproportionately attract higher-risk populations. The program is funded by

transferring funds from insurers with relatively low risk enrollees to the insurers with higher risk enrollees.

Final regulations on these premium stabilization programs were published on March 23, 2012. (See our October 23, 2012 *For Your Information*.) HHS has now released proposed regulations that expand and revise some of the prior guidance, as well as proposing payment parameters for these programs. This guidance is scheduled to be published on December 7, 2012, and comments are due 30 days after publication.

This *For Your Information* focuses on the transitional reinsurance program, which will have the most direct impact on large group health plans and their sponsors.

Overview of transitional reinsurance program

The primary purpose of the transitional reinsurance program is to help stabilize premiums in the individual health insurance market from 2014 to 2016. According to the HHS guidance, the "reinsurance program is designed to protect against insurers' potential perceived need to raise premiums due to the implementation of the 2014 market reform rules, specifically guaranteed availability." Each state may establish a reinsurance program. If a state decides not to implement a program, HHS will do so for that state.

In 2014, insurers will receive a reimbursement of 80% of the individual claims that exceed an attachment point of $60,000 up to a national reinsurance cap of $250,000. For example, for an individual claim of $100,000, the insurer will receive 80% of $40,000 (the excess of $100,000 over the $60,000 attachment point), or $32,000.

The total amount to be collected under the reinsurance program from insurers and self-insured group health plans is $25 billion over three years. $20 billion of the amount collected will fund the reinsurance pool, while the remaining $5 billion will be paid to the U.S. Treasury.

Year	Reinsurance Pool	U.S. Treasury	Total
2014	$10 billion	$2 billion	$12 billion
2015	$6 billion	$2 billion	$8 billion
2016	$4 billion	$1 billion	$5 billion
Total	$20 billion	$5 billion	$25 billion

The guidance notes that the $5 billion payable to the U.S. Treasury is the same amount appropriated for the Early Retiree Reinsurance Program (ERRP).

States can also establish a supplemental reinsurance program, in addition to the federal reinsurance program, and charge additional fees to health plans. However, the guidance confirms that neither ACA nor the proposed guidance gives a state the authority to collect contributions from self-insured plans.

Contributing entities

ACA Section 1341 states that health insurance issuers are responsible for making reinsurance contributions with respect to insured coverage and that third-party administrators (TPAs) are responsible for making contributions on behalf of self-insured group health plans. However, the guidance clarifies that the self-insured plan is the entity liable for the payment, although it may utilize a TPA or administrative services only contractor to transfer the contributions on its behalf. The guidance also confirms that a self-insured, self-administered plan, without a third-party administrator, would make its reinsurance payment directly.

> Buck Comment: While insurers are required to make the payment, in most cases the insurer will pass the cost directly on to the plan sponsor of a group health plan. Although the payment won't be required until the end of each year (see **Payment of reinsurance contributions** below), the insurer may want to the collect amounts during the year. For example, an insurer might build the fee into the 2014 insurance rates.

Concurrent with the release of this HHS proposed regulations, the Internal Revenue Service (IRS) also issued guidance in the form of Frequently Asked Questions that confirms sponsors of self-insured plans and health insurance issuers can treat these reinsurance contributions as ordinary and necessary business expenses.

Coverage subject to reinsurance contributions

ACA requires that the reinsurance contribution amounts reflect, in part, an issuer's "fully insured commercial book of business for all major medical products." The proposed regulations interpret this statutory language as requiring reinsurance contributions only with respect to "major medical coverage," which it defines as "health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings, including inpatient, outpatient, and emergency room setting." They further state that the following types of coverage will not be subject to the reinsurance contribution because they are limited in scope and do not provide major medical coverage:

- Stand-alone vision and dental plans
- Health savings accounts (HSAs) (However, reinsurance contributions would generally be required for the group health plan.)
- Health reimbursement arrangements (HRAs) integrated with a group health plan (However, reinsurance contributions would generally be required for the group health plan.)

- Health flexible spending accounts (FSAs)
- Employee assistance plans, disease management programs, and wellness programs (The programs must provide ancillary benefits that do not constitute major medical coverage.)
- Hospital indemnity coverage
- Dread disease coverage
- Stop-loss insurance
- Other excepted benefits

The guidance also states that employer-sponsored coverage will be considered major medical coverage only when it pays primary to Medicare. If Medicare pays primary with respect to an individual, such as when an individual has retiree coverage, that individual is not counted for purposes of calculating the reinsurance contributions.

> Buck comment: Thus, employer-sponsored retiree medical plans that supplement Medicare will not be subject to the reinsurance contribution. However, the reinsurance contribution will be required for pre-Medicare retirees, disabled employees where Medicare coverage is not primary and COBRA beneficiaries. There does not appear to be a "retiree only" plan exception to the reinsurance contribution requirements.

As discussed above, ACA defines the reinsurance contribution amounts to reflect an issuer's "fully insured commercial book of business for all major medical products." The guidance defines "commercial book of business" to include individual, small group and large group market polices. Products offered by an insurer under Medicare Part C or D would be part of a "governmental book of business" and therefore not subject to the reinsurance contribution.

> Buck comment: This is welcome news for employers who have implemented employer group waiver plans (commonly called EGWPs) for providing prescription drug coverage or medical coverage for Medicare retirees.

National contribution rate

To simplify the collection and administration of the reinsurance program, a uniform national per capita contribution rate will be used. The rate will be determined using the total of the amounts required for the reinsurance pool, the U.S. Treasury, and administrative costs for collecting the contributions and administering the reinsurance pool. This total would be divided by the estimated number of enrollees in plans required to make reinsurance payments:

$$\text{National Per Capita Contribution Rate} = \frac{\text{Reinsurance pool + U.S. Treasury + Administration}}{\text{Estimate of enrollees in plans subject to contributions}}$$

Based on the 2014 amounts of $10 billion for the reinsurance pool, $2 billion for the U.S. Treasury and HHS's estimate of $20.3 million for administration, the estimated per capita amount for 2014 is $5.25 a month, or $63 a year. As discussed further below, the rate applies to all participants, including dependents.

> Buck comment: The 2014 rate will be finalized by HHS, probably late in 2014, when they can better estimate 2014 enrollee numbers. Using similar assumptions for 2015 and 2016 results in estimated annual per capita rates of $42 and $26.25 respectively.
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> For an employer with 20,000 enrollees (employees and dependents) in medical coverage, the 2014 contribution will be approximately $1.3 million. Over the three-year transitional reinsurance program, the total amount of this employer's contributions will be approximately twice that amount, or $2.6 million.

Calculation of Reinsurance Contributions

The national contribution rate applies on a per-covered-life basis, including dependents. The guidance sets out several alternative methods for determining the average number of lives covered during the year for the plan. Under all of the alternatives except the Form 5500 Method, the number of covered lives for the year will be determined based on the first nine months of the applicable calendar year. These alternatives are similar to those provided for determining the Patient-Centered Outcomes Research Institute (PCORI) fee. (See our May 9, 2012 *For Your Information*.) A contributing entity can use a different counting method for purposes of the reinsurance contribution than it uses for the PCORI fee.

> Buck comment: Unlike the PCORI fee, which applies on a plan or policy year basis, the determination of the reinsurance contribution applies on a calendar year basis.

Actual count method (insurers and self-insured plans): The number of lives is determined by taking the sum of the number of lives covered under the plan for each day of the first nine months of the calendar year and then dividing that total by the number of days in those nine months.

Snapshot count method (insurers and self-insured plans): The number of lives is determined by totaling the number of lives covered by the plan on one date during each of the first three quarters of the year and then dividing that sum by three. The same months must be used each quarter. (For example, January, April and July; the first month of each quarter.) The determination can be made on more than one date in each quarter, provided that an equal number of dates are used in each quarter and the dates are within the same week of each quarter. However, in lieu of counting the actual number of covered lives, a self-insured group health plan has the additional option of determining the number of lives in each quarter by adding the number of participants with self-only coverage to 2.35 times the number of participants with coverage other than self-only on the date or dates chosen.

Form 5500 method (self-insured plans only): The number of lives can be based on the information contained in ERISA Form 5500 filings for the last applicable plan year. For plans that only provide self-only coverage, the number of lives is the sum of the number of participants at the beginning and at the end of the plan year, divided by two. For plans that provide self-only and dependent coverage, the number of lives is the sum of the number of participants on the Form 5500 at the beginning and at the end of the plan year.

Member months or state form method (insurers only): A health insurance issuer can use data from the National Association of Insurance Commissioners (NAIC) Supplemental Health Exhibit or similar data from state forms to determine the number of lives. However, adjustments in the data will be required because of the significant enrollment increases expected in the individual market from 2014 through 2016.

For a group health plan that has both self-insured and insured coverage options, either the Actual Count or Snapshot Count Method must be used.

Aggregation of health plans and treatment of carve-out benefits

Some plan sponsors maintain two or more group health plans (whether insured or self-insured) that collectively provide major medical coverage for the same covered lives. For example, some plan sponsors have programs in which physician, hospital or behavioral health services may be provided by different insurers or administrators. For purposes of the reinsurance contributions, these multiple plans will be treated as a single self-insured plan. This prevents double counting of lives across multiple plans. Either the Actual Count or Snapshot Count Method must be used to determine the number of covered lives in these cases.

Aggregation is not required with respect to a group health plan that only provides:

- Coverage of excepted benefits, such as stand-alone dental or vision benefits, or
- Prescription drug coverage

For purposes of this aggregation rule, the term “plan sponsor” has the same meaning as “plan sponsor” for purposes of the PCORI fee. (See our May 9, 2012 *For Your Information*.) Thus, in the case of a plan maintained by a single employer, the employer is the plan sponsor.

Payment of reinsurance contributions

To simplify the administration of the program for insurers and self-insured group health plans, HHS will collect the contributions on an annual basis for all states. (The initial HHS guidance would have required the states that established their own programs to collect quarterly payments.) The timeframe for payments will be as follows:

- By no later than November 15 of each year (2014, 2015 and 2016), the contributing entity is required to submit the annual enrollment count of the number of covered lives subject to the contribution to HHS.
- Within 15 days of submission of the annual enrollment, or by December 15 if later, HHS will notify the contributing entity of the total contribution amount to be paid.
- The contributing entity will be required to submit its payment to HHS within 30 days of notification of the amount due.

Conclusion

While no immediate action needs to be taken by group health plans, plan sponsors may want to begin estimating the amount of reinsurance contributions that will be required and discuss with insurers and third-party administrators how they intend to administer this fee.