Advisory

Employee Benefits

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HHS Issues Proposed Regulations Implementing Reinsurance Fees Paid by Carriers and Group Health Plans Under the Affordable Care Act

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The Patient Protection and Affordable Care Act (Act) fundamentally changes the way that health insurance is regulated in the United States. These changes are part of an ambitious statutory scheme that comprehensively reforms insurance underwriting practices. Reforms include new guaranteed issue, availability, and renewability standards, along with modified community rating requirements.

Congress was justifiably concerned that the Act's changes to insurance underwriting practices, particularly as they apply in the individual and small group markets, could destabilize these markets and invite adverse selection. The Act therefore tries to address these concerns by, among other things, directing the Department of Health and Human Services (HHS) to develop a series of "premium stabilization" programs, the collective purpose of which is to address these concerns. One of these programs—the transitional reinsurance program—is funded by contributions from health insurance issuers and self-funded group health plans. The transitional reinsurance program is financed with payments made to programs established state by state. If a state declines to establish such a program, then HHS will do so. The transitional reinsurance collection program requirement spans three years – 2014, 2015, and 2016 – but states are free to continue it thereafter.

On March 23, 2012, HHS issued a final regulation implementing the premium stabilization rules. While this regulation is of particular interest to health insurance issuers in the individual and group markets, it did not address the one question of particular interest to employers that sponsor group health plans: how much are we going to have to pay? In proposed regulations published December 7, 2012 (the "proposed regulations"), HHS answered this question—tentatively. At the same time, HHS proposed substantial changes to the basic structure of the transitional reinsurance program that would require greater program uniformity from state to state.

This advisory focuses on and explains how transitional reinsurance program fees will be determined and collected from health insurance issuers and plan sponsors of self-funded group health plans in 2014 and beyond.

Background

The Act prescribes both the amount and sources of the funds needed to fund the temporary reinsurance program, but leaves it to HHS to develop the collection mechanism and to establish an "all-in" per capita contribution rate. The per capita contribution rate has three components: a basic contribution rate, an additional contribution to the U.S. Treasury, and an amount to cover administrative costs:

- For 2014, the basic contribution rate is $10 billion. (For 2015, this amount is $6 billion and for 2016, $4 billion).[1] Under the proposed regulations, the basic contribution rate relies on "national payment parameters," which include (1) an attachment point of $60,000, when reinsurance payments would begin, (2) a national reinsurance cap of $250,000, when the reinsurance program stops paying claims for a high-cost individual, and (3) a uniform

coinsurance rate of 80%.

> **Example:** A $100,000 claim would trigger a $40,000 excess loss (i.e., $100,000 minus the $60,000 attachment point). The insurer would be reimbursed $32,000 (i.e., 80% of $40,000).

- The Act separately calls for the collection of funds for contribution of $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016 to be deposited with the U.S. Treasury (which as the proposed regulations indicate is the same amount that was used to fund the Act's Early Retiree Reinsurance Program).
- The final component of the per capita contribution rate is an amount for administrative costs, which HHS estimates at about $20 million.

Each year, the national per capita contribution rate is calculated by dividing the sum of these three amounts (the basic reinsurance rate, the U.S. Treasury contribution, and administrative costs) by the estimated number of enrollees in plans that must make reinsurance contributions.

Under the proposed regulations, amounts would be paid out to help offset potential increases in the cost of individual coverage (including that offered through the public insurance exchanges) as the country implements the Act's insurance market reforms, particularly in the first few years when the risk of adverse selection against the individual market as a whole is perceived as greatest.

Imposition of Reinsurance Fees

Under the proposed regulations, the reinsurance contribution of a "contributing entity" is calculated by multiplying the "average number of covered lives" of reinsurance contribution enrollees during the "benefit year" (i.e., the calendar years 2014, 2015, or 2016) for all of the contributing entity's plans and coverage subject to the rule, by the "national contribution rate" for the year.

Contributing Entities and Excluded Entities

The Act imposes the obligation to pay reinsurance fees on "health insurance issuers, and third party administrators on behalf of group health plans,"[2] which the proposed regulation refers to as "contributing entities." Under the proposed regulations, with respect to insured coverage, the issuer is liable. With respect to self-insured group health plans, the *plan* is liable, although the plan may contract with a third-party administrator to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion. This is both a welcome clarification and the correct result, since third-party administrators are mere service providers to plans.

In the case of issuers, the method for establishing the amount of the reinsurance fee must reflect, in part, an issuer's fully insured commercial book of business for all major medical products. The preamble to the proposed regulation interprets this to mean that an issuer will not be required to make reinsurance contributions for coverage that is non-commercial, or that is not "major medical coverage." The proposed regulation defines the term "major medical coverage" to mean—

> "[H]ealth 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 settings."[3]

The proposed regulations therefore require employer-sponsored group health plans, whether fully insured or self-funded, that offer broad-based, comprehensive coverage, including health care continuation (i.e., COBRA) coverage, to make reinsurance contributions. But plans that do not provide major medical coverage are not liable. These include plans with benefits that are limited in scope (e.g., dread disease coverage, hospital indemnity coverage, stand-alone vision coverage, or stand-alone dental coverage) or extent (e.g., Health Savings Accounts, Health Reimbursement Accounts that are integrated with group health plans, and medical Flexible Spending Accounts). Also excluded are programs that provide ancillary benefits such as wellness programs, disease management programs, and employee assistance plans.

Nor would the reinsurance fee be levied with respect to retirees enrolled in Medicare who receive supplemental

coverage from their former employers, but it would be assessed on retired employees not yet eligible for Medicare and receiving health care coverage from their former employers. The exception differs from the carve-out for retirement benefits provided in the preamble to the grandfather interim final rule, which exempts retiree-only plans from the reach of the Act's insurance market reforms. Instead, HHS has chosen to draw the line based on whether Medicare is the primary payer (in which case no reinsurance fee is imposed) or the secondary payer (in which case a reinsurance fee is imposed). For example, a working 68-year-old employee enrolled in a group health plan who, under the Medicare Secondary Payer rules, is a beneficiary for whom Medicare is the secondary payer would be counted for purposes of reinsurance contributions. However, a 68-year-old retiree enrolled in a group health plan who, under the Medicare Secondary Payer rules, is a beneficiary for whom Medicare is the primary payer would not be. In addition, private Medicare and Medicaid plans are excluded from reinsurance contributions because they are not part of a commercial book of business.

Counting Covered Lives

The proposed regulations offer rules for counting the number of covered lives. The proposals build on the methods permitted for purposes of the fee to fund the Patient-Centered Outcomes Research Trust Fund. Under each method, the number of covered lives is based on the first nine months of each benefit year.

For insured plans, counting methods include an "actual count method," a "snapshot method" and a "member months/state form method." As their names suggest, the "actual count" and "snapshot" rely on, respectively, an average of daily data or a uniform date or dates with each quarter. Under the member months/state form method, the carrier uses data from its annual NAIC Supplemental Health Exhibit or similar data from other state forms, but with modifications to adjust for the fact that the raw data may be out of date.

For self-funded plans, counting methods include an actual count method and a snapshot count method. There is also a proposed modified snapshot method, called a "snapshot factor method" that adds the totals of lives covered on snapshot dates but multiplies the number of individuals with other than self-only coverage by a factor of 2.35. Lastly, self-funded plans may apply the "Form 5500 method," which uses data from the Form 5500 for the last applicable plan year. The number of lives under this method is calculated based on the average number of lives during the year but double-counts individuals with other than self-only coverage.

National Reinsurance Contribution Rate

Under the proposed regulation, the amount of reinsurance contributions is determined based on a uniform national per capita contribution rate taking into account the items outlined above multiplied by the number of plan participants, *not* the number of covered employees. Thus, for example, an employee with family coverage for himself or herself, a spouse and two dependents would count as four participants or members. The reinsurance contribution required from a contributing entity for a year is a product of the average number of covered lives of reinsurance contribution enrollees during the first nine months of a benefit year and the contribution rate for the year.

> For 2014, the estimated per member/per year reinsurance contribution rate is $63.00 (or $5.25 per member/per month).

In an earlier document describing the regulatory impact of the reinsurance program, HHS indicated that the cost of transitional reinsurance program fees would result in premium increases of about one percent of premiums in the group market, while at the same time anticipating that reinsurance payments would relative to what would otherwise occur "result in premium decreases in the individual market of between 10 and 15 percent.[4]

Multiple Plans

If a plan sponsor maintains two or more group health plans that collectively provide major medical coverage for the same covered lives (called "multiple plans"), the plans are aggregated and treated as a single self-insured group health plan for purposes of calculating any reinsurance contribution amounts. (According to the preamble to the proposed regulation, "[t]his approach would prevent the double counting of a covered life for major medical coverage offered across multiple plans, and prohibit plan sponsors that provide such major medical coverage from

splitting the coverage into separate arrangements to avoid reinsurance contributions on the grounds that it does not offer major medical coverage.")

To this general rule, HHS proposes two exceptions:

- If the benefits provided by any health insurance or self-insured group health plans are limited to "excepted benefits" (e.g., such as stand-alone dental or vision benefits), the excepted benefits coverage need not be aggregated with other plans for purposes of this section.
- If benefits provided by any health insurance or self-insured group health plan are limited to prescription drug coverage, that prescription drug coverage need not be aggregated so as to reduce the burden on sponsors who have chosen to structure their coverage in that manner. (Under the proposed rule, coverage that consists solely of prescription drug benefits is not major medical coverage.)

Aggregation is unnecessary in these instances since, if enrollees have major medical coverage and excepted benefits or carve-out prescription drug benefits, reinsurance contributions only would be required with respect to the major medical coverage.

The plan sponsor of a multiple plan is responsible for paying the applicable fee. The proposed regulation defines the term "plan sponsor" to mean:

- The employer, in the case of a plan established or maintained by a single employer;
- The employee organization, in the case of a plan established or maintained by an employee organization;
- The joint board of trustees, in the case of a multi-employer plan;
- The committee, in the case of a multiple employer welfare arrangement;
- The cooperative or association that establishes or maintains a plan established or maintained by a rural electric cooperative or rural cooperative association;
- The trustee, in the case of a voluntary employees' beneficiary association (VEBA); and
- In the case of a plan not described above, the person identified or designated by the terms of the document under which the plan is operated as the plan sponsor.

Special rules limit the reporting options under multiple plans. Plans with both self-funded and fully insured options must use either the actual count method or snapshot method. Multiple plans with no insured options may use the actual count method, the snapshot count method, or the snapshot factor method but not the Form 5500 method.

Remitting Reinsurance Contributions

Contributing entities are required by November 15 of the 2014 benefit year to submit an enrollment count of the average number of covered lives of reinsurance contribution enrollees for the applicable benefit year (details on how HHS proposes this count be performed are provided above). Within 15 days of the submission of the count, or by December 15 (whichever is later), HHS will notify the contributing entity of the reinsurance contribution amount it owes. Payment of the reinsurance contribution amounts is due to HHS within 30 days after the date of the notification.

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Endnotes

[1] Act § 1341(b)(3)(B)(iii).

[2] Act §§ 1341(b)(3)(B).

[3] Prop. Reg. 45 C.F.R. § 153.400; *see also*, 77 Fed. Reg., p. 73,152 (Dec. 7, 2012) (explaining, in the preamble to the proposed regulation, HHS's reasoning for limiting the reinsurance fees to plans offering major medical converge).

[4] CCIIO Regulatory Impact Analysis: Establishment of Exchanges and Qualified Health Plans and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (March 16, 2012), p.42.

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