Legislative Brief

Health Care Reform - Reinsurance Fees

June 26, 2014

Reinsurance Fee Annual Enrollment Count Due November 15, 2014

Beginning in 2014, the Affordable Care Act (ACA) establishes the following three risk-spreading programs to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk carried by issuers: a transitional reinsurance program, a temporary risk corridor program and a permanent risk adjustment program.

The **transitional reinsurance program** is intended to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014 through 2016) when individuals with higher-cost medical needs gain insurance coverage. **This program will impose a fee on health insurance issuers and self-insured group health plans.**

The Department of Health and Human Services (HHS) issued **regulations** on March 23, 2012, governing certain aspects of the reinsurance payments. Further regulations were issued later to expand on these requirements, provide additional details, and set the contribution rate for **2014** and **2015**. The most recent final rule which contains the 2015 contribution rate, includes an exception for certain self-insured, self-administered plans and implements a two-installment collection schedule for the reinsurance fees.

WHO MUST PAY THE FEES?

The ACA requires "contributing entities" to pay fees to support the reinsurance program. A contributing entity is defined as a health insurance issuer or a third-party administrator on behalf of a self-insured group health plan. As described below, certain types of coverage are excluded from paying fees to the reinsurance program.

Fully-insured Group Health Plans

For insured health plans, the **issuer of the health insurance policy** is required to pay fees to the reinsurance program. Although sponsors of fully-insured plans are not responsible for paying the reinsurance fees, issuers will likely shift the cost of the fees to sponsors through premium increases.

Self-insured Group Health Plans

With respect to self-insured group health plans, the **plan** is liable for paying the reinsurance fees, although a third-party administrator (TPA) or administrative-services-only (ASO) contractor may make the fee payment at the plan's direction. **Reinsurance fees may be paid from plan assets because the payment is required by the plan under the ACA.** (Note: This differs from PCORI fees which may not be paid from plan assets because PCORI fees are imposed on plan sponsors.)

Exception for Self-insured, Self-administered Group Health Plans

HHS modified the definition of "contributing entity" for the 2015 and 2016 benefit years to **exempt certain self-insured, self-administered group health plans** from the reinsurance contribution requirement. This exemption is exclusive to plans that do not use third party administrators (TPAs) for core administrative functions of claim processing, adjudication and enrollment (*i.e.*, a TPA may be used for obtaining provider network and beneficial pricing, and core administrative functions relating only to pharmacy or excepted benefits, but a TPA cannot provide 5% or more of a plan's core administrative functions). HHS expects few plans to qualify for the exemption; most self-insured health plans rely extensively on a TPA and will not be eligible.

Special Rules for Coverage that is Partially Insured and Self-Insured, and Fully Insured Coverage Provided by Multiple Insurers

- Plans partially insured and partially self-insured: If medical benefits are provided under a self-insured arrangement but prescription drug benefits are provided under an insured arrangement, the prescription drug insurer is not responsible for payment of the reinsurance fee. However, an insurer that offers major medical coverage is responsible for the reinsurance fee payment because the insured component of the plan is major medical coverage.

- Fully Insured Coverage Provided by Multiple Insurers: In situations where fully insured coverage is provided by multiple insurers, the insurer that provides the greatest portion of inpatient hospitalization coverage is responsible for reinsurance fee.

COVERAGE SUBJECT TO REINSURANCE FEE	PARTY RESPONSIBLE FOR PAYING FEE
Major Medical Coverage (includes health coverage for a broad range of services and treatments - including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings (in-patient, out-patient, ER) - but excludes coverage that does not provide minimum value) Note: Applies to catastrophic plans and individual and small group plans subject to actuarial value requirements	The issuer if insured; the plan if self-insured
Retiree-Only Coverage (to the extent it qualifies as major medical and no other exception applies) • Reinsurance fee is required for individuals with Medicare coverage when the employer-provided group health coverage is primary and Medicare is the secondary payer • Retiree-Only HRA is exempt from reinsurance fee (CMS does not consider plans with a dollar limit on benefits to be providing major medical)	The issuer if insured; the plan if self-insured
COBRA Coverage (to the extent it qualifies as major medical and no other exception applies) Note: HHS has clarified that COBRA (or other continued coverage) is a form of employment-based group health coverage paid for by the former employee	The issuer if insured; the plan if self-insured (note: since it is a permissible plan expense under ERISA, employee contributions can be used toward payment of fee)

TYPES OF COVERAGE NOT SUBJECT TO REINSURANCE FEE

- Health reimbursement arrangements (HRAs) that are integrated with major medical coverage (although reinsurance fees will be required for the group health plan providing major medical coverage)
- Health savings accounts (HSAs) (although reinsurance fees will be required for an employer-sponsored high-deductible health plan)
- Health FSAs (not considered major medical coverage due to ACA's $2,500 annual limit on salary deferrals to a health FSA)
- Employee assistance plans, wellness programs and disease management plans that provide ancillary benefits and not major medical coverage
- Coverage consisting solely of HIPAA excepted benefits is not subject to the reinsurance program (e.g., stand-alone dental and vision plans, accident-only coverage, disability income coverage, liability insurance, workers' compensation coverage, credit-only insurance or coverage for on-site medical clinics)
- Expatriate health coverage (as defined by HHS)
- A self-insured group health plan or health insurance coverage that consists solely of benefits for prescription drugs
- Stop-loss and indemnity reinsurance policies
- Coverage offered by an insurer under contract to provide Medicare, Medicaid or CHIP benefits
- TRICARE or other military helath benefits
- Certain plans or coverage provided by an Indian Tribe to Tribal members and dependents
- Self-insured group health plan or insurance coverage that consists solely of benefits for prescription drugs
- Products offered by an insurer under Medicare Parts C or D (because these are governmental, not commercial, books of business; regulations provide that for insured benefits, the policy must be provided as part of a commercial book of business)

HOW MUCH ARE THE FEES?

The reinsurance program's fees are based on a national contribution rate, which HHS announces annually.

- For 2014, HHS announced a national contribution rate of **$63** per covered life (about $5.25 per month).
- For 2015, the annual contribution rate will be **$44** per covered life (about $3.67 per month).
- For 2016, HHS plans to establish the uniform reinsurance contribution rate for the 2016 benefit year in the HHS notice of benefit and payment parameters for 2016.

The national contribution rate is calculated by dividing the sum of three statutory components (the reinsurance payment pool, the U.S. Treasury contribution and administrative costs) by the estimated number of enrollees in plans that must make reinsurance contributions.

HOW WILL THE FEES BE DETERMINED AND COLLECTED?

An issuer's or plan sponsor's reinsurance fee will be calculated by multiplying the number of covered lives (active employees and their dependents) during the benefit year for all of the entity's plans and coverage that must pay contributions, by the national contribution rate for the benefit year. Thus, the annual contribution in 2014 for a group health plan with 150 covered lives would be $9,450 per year (150 x $63 = $9,450).

COBRA: Individuals who are receiving continuation coverage (such as COBRA coverage) are included in the number of covered lives under the plan.

Situations in which lives are covered in multiple arrangements:

No reinsurance fee is required in the case of employer-provided group health coverage where:

- coverage applies to individuals who are also enrolled in individual market health insurance coverage for which reinsurance contributions are required; or
- such coverage is supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives.

Note: Most employers will not determine whether coverage is supplemental or secondary because the administrative burden associated with this task will likely outweigh the reinsurance fee savings.

Methods for Calculating Lives

The regulations provide a variety of methods for counting lives similar to the regulations governing PCORI fees. Insured plans may use the actual count method, snapshot method or member months method. Self-insured plans may use the actual count method, snapshot method or Form 5500 method. For the Form 5500 method, the benefit year is the plan year (benefit year is otherwise generally defined as a calendar year for which a health plan provides coverage for health benefits).

A plan does not have to use the same counting method for the reinsurance fee that is used for purposes of the PCORI fee.

1. ***Actual Count Method.*** Sum of lives covered for each day of the applicable period and divide that sum by the number of days in the period. (The applicable period for PCORI and reinsurance fee differ—PCORI fee period is the plan year, reinsurance fee period is Jan—Sept for the applicable year.)
2. ***Snapshot Method.*** Average the number of lives covered under the plan for the applicable period by adding total lives covered on a date during each quarter (or, alternatively, an equal number of dates each quarter), and dividing the total by the number of dates which a count is made. While using a specific date for each quarter is not required, the date must be consistent each quarter. The applicable fee for PCORI and reinsurance fee differ—PCORI fee period is 1 day each year, reinsurance fee period is typically one day each quarter.
3. ***Form 5500 Method***. The average number of lives covered under the plan for the plan year is calculated by simply adding the total participant counts at the beginning and end of the plan year reported on the most recently filed Form 5500 (for plans only offering single coverage this number is then divided by 2). The Form 5500 method may be used if the Form 5500 is filed no later than the due date for the fee imposed for that plan year. The Form 5500 method is only method that solely counts the principal insured (i.e., employee, retirees and COBRA qualified beneficiary are counted, but not spouses and dependents).

The method used to calculate lives may impact the reinsurance fee to be paid. It may be beneficial for plans to calculate the reinsurance fee under each method and utilize the most financially advantageous method. Groups with high average members per contract may benefit from the Form 5500 method if available (a plan must file Form 5500 to utilize this method). Groups that experience a short period of high employment may benefit from the snapshot method.

States operating reinsurance programs may elect to collect additional contributions on top of the federal contribution rate to cover administrative expenses or additional reinsurance payments. The 2013 final rule notes that neither ACA nor the regulations give a state the authority to collect additional contributions from self-insured plans covered by ERISA. HHS will collect the reinsurance fees from issuers and plan sponsors in all states, including states that elect to operate their own reinsurance programs. These collections by HHS will be made based on a national, uniform calendar. If a state imposes an additional contribution on top of the federal contribution rate, issuers would be required to make those payments in a manner specified by the state.

Two Installment Collection Schedule

In the 2015 Notice of Benefit and Payment Parameters Final Rule, HHS modified the collection schedule for the reinsurance program so that the annual fee can be paid in two installments—one at the beginning of the calendar year following the applicable benefit year, and one at the end of that calendar year. This two-installment policy is designed to alleviate the upfront burden of the reinsurance contribution, allowing contributing entities additional time to make the payment. A contributing entity may pay the total reinsurance fee in the first installment.

The reinsurance contribution amounts for reinsurance payments and for administrative expenses will be collected earlier in the calendar year following the applicable benefit year, while the reinsurance contribution amounts for payments to the U.S. Treasury will be collected in the last quarter of the calendar year following the applicable benefit year.

On May 22, 2014, CMS issued guidance explaining the streamline process by which a contributing entity will actually pay reinsurance fees it owes. HHS will use www.Pay.gov. A contributing entity can complete all required steps for the reinsurance fee on Pay.gov, including registration, submission of annual enrollment count, and remittance of contributions. A form will be available on Pay.gov where a contributing entity will provide basic company and contact information and the annual enrollment count for the applicable benefit year no later than Nov. 15, 2014. The form will auto-calculate the reinsurance fee. To complete the submission, entities will also submit payment information and schedule a payment date for remittance of the reinsurance fee (first installment to occur no later than Jan. 15, 2015). Pay.gov provides a “one-stop” approach to complete the reinsurance fee process.

Pay.gov Date	Activity	Amount
November 15, 2014	Submit 2014 annual enrollment count, submit payment information and schedule future payment date(s) for remittance	
January 15, 2015	Remit first installment for 2014	$52.50 per covered life (allocated toward reinsurance payments and administrative expenses)
4th Quarter 2015	Remit second installment for 2014	$10.50 per covered life (allocated toward U.S. Treasury)
November 15, 2015	Submit 2015 annual enrollment count, submit payment information and schedule future payment date(s) for remittance	
January 15, 2016	Remit first installment for 2015	$33 per covered life (allocated toward reinsurance payments
4th Quarter 2016	Remit second installment for 2015	$11 per covered life (allocated toward U.S. Treasury)

ARE THE FEES DEDUCTIBLE?

The Internal Revenue Service (IRS) issued a set of **FAQs** to address the tax treatment of the ACA’s reinsurance fees. Taxpayers generally may deduct ordinary and necessary business expenses, including most fees and taxes paid to the government. However, under the rules of the Internal Revenue Code (Code), deductions for ordinary and necessary business expenses may be disallowed, limited or deferred in some circumstances.

According to the FAQs, a sponsor of a self-insured group health plan that pays reinsurance fees may treat the fees as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Code. This tax treatment applies whether the contributions are made directly by the plan sponsor or through a TPA or ASO contractor.

Recordkeeping Requirements

HHS requires that a contributing entity maintain documents and records sufficient to substantiate the enrollment count submitted for at least ten years (may be retained in any media form), and make that evidence available upon request for verification of reinsurance fees.

The health care reform law—the Affordable Care Act (ACA)—has many complex requirements for employers and health plans. Please contact Kapnick Insurance Group with any questions about how you can prepare for any of the health care reform requirements. This Kapnick Insurance Group Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal or tax advice. The information contained in this communication is intended to provide general information regarding health care reform and related topics, and is based on general information available at the time it was prepared. Readers should contact their tax and/or legal counsel for advice that is appropriate to their specific circumstances. This information cannot be used by any taxpayer to avoid tax penalties.

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