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ALERT: HEALTH CARE REFORM BILL

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HHS ISSUES ADDITIONAL GUIDANCE ON TRANSITIONAL REINSURANCE PROGRAM

Section 1341 of the Patient Protection and Affordable Care Act (PPACA) requires that standards be implemented enabling states to establish and maintain a transitional reinsurance program. The purpose of the program is to help stabilize premiums for coverage in the individual health insurance market.

PPACA provides for three risk-spreading mechanisms to mitigate the potential impact of adverse selection and to stabilize premiums: a risk corridor, a risk adjustment program and the transitional reinsurance program. Only the reinsurance program is discussed in this *Alert*, as it is the program of particular interest to plan sponsors of group health plans.

On March 23, 2012 the Department of Health and Human Services (HHS), issued a final regulation implementing the premium stabilization rules. However, those regulations did not provide the most important information for employers that sponsor group health plans: the amount that will have to be paid. The Willis *Alert* addressing those earlier regulations can be found **here.**

On December 7, 2012 HHS published proposed regulations that expand and revise some of the prior guidance, such as addressing the reinsurance amount and other structural changes to the program to provide uniformity from state to state. The proposed regulations can be found **here.**

BACKGROUND

Starting in 2014, due to insurance reform under PPACA, health coverage will be available to anyone, regardless of health status, either in the individual market or through the small group market. This unfettered availability may result in adverse selection (i.e., the tendency for high-risk individuals to buy health insurance and low-risk individuals to defer purchase of health insurance) which in turn would result in fewer healthy enrollees. Such adverse selection may ultimately cause premiums to increase in any market, but especially in the individual and small group markets.

In order to stabilize these increasing premiums, especially in the first three years (2014-2016) of operation of state insurance exchanges, PPACA provides for the implementation of a transitional reinsurance program. Reinsurance is basically buying protection against the possibility that some rare set of circumstances (such as high claim cost) might produce losses that an insurer is unable to fund on its own. Thus, the reinsurance program under PPACA is designed to reduce the uncertainty of insurance risks in the individual market by making payments for high-cost claims. 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."

The reinsurance program will be funded with payments to an "applicable reinsurance entity" from health insurance issuers and certain plan administrators on behalf of group health plans. Although the regulations provide for states to establish a reinsurance program, even if not establishing a health insurance exchange, states are ***not required*** to establish such a program. If a state chooses not to establish a reinsurance program, then HHS will establish it for the state. The program is scheduled to run for a three-year period beginning January 1, 2014.

AMOUNT OF RESINSURANCE CONTRIBUTIONS AND REIMBURSEMENTS

In order to fund the transitional reinsurance program, PPACA provides for aggregate contributions in the amount of $12 billion for plan years beginning in 2014, $8 billion for plan years beginning in 2015 and $5 billion for plan years beginning in 2016. The contributions consist of three components: a basic contribution rate, a contribution to the U.S. Treasury, and an amount to cover administrative costs. It is noted in the guidance that the $5 billion payable to the Treasury is the same amount appropriated for the Early Retiree Reinsurance Program (ERRP). Reinsurance contributions are calculated by adding the basic contribution rate, the U.S Treasury contribution and administrative costs and then dividing by the estimated number of enrollees in plans that must make reinsurance contributions.

$$\text{National Per Capita Contribution Rate} = \frac{\text{Basic contribution rate + U.S. Treasury contribution + Administrative cost}}{\text{Estimate of enrollees in plans subject to contributions}}$$

HHS determines the national per capita contribution rate for a benefit year (defined to be a calendar year). Based on the required 2014 amounts, HHS has estimated the per capita amount as $5.25 a month, or $63 a year. The per capita contribution will be applied to all "reinsurance contribution enrollees" who are defined as individuals covered by a plan for which reinsurance contributions must be made pursuant to the final regulations. Since the regulations reference individuals covered by a plan, this means that "reinsurance contribution enrollees" are employees, spouses and dependents, and the fee will be applicable to all of these.

HHS is responsible for allocating reinsurance payments to appropriate insurance issuers in a 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 or $32,000 ($100,000 - $60,000 attachment point = $40,000 X 80%).

Additionally, the proposed regulations provide that a state may elect to collect additional reinsurance contributions for administrative expenses or reinsurance payments. However, due to the federal preemption of state laws that relate to an ERISA-covered plan, a state cannot collect an additional reinsurance contribution from an ERISA self-insured plan.

AFFECTED PLANS AND EXCEPTIONS

Health insurance issuers and third-party administrators (TPAs) on behalf of group health plans, referred to as "contributing entities," are generally required to make contributions to the transitional reinsurance program. The guidance clarifies that the ultimate liability for the reinsurance fee rests with the self-insured plan, but that a TPA can remit the fee on behalf of the plan. Presumably, insurance issuers will pass the fee directly on to the plan sponsor of the group health plan by way of premiums. Thus, the plan sponsor (generally the employer) should be prepared to fund this contribution, regardless of being fully insured or self-insured. Furthermore, a self-insured plan that is self-administered is expected to make the reinsurance payments directly. Neither the statute nor the regulations provide exceptions for governmental or church plans that are self-insured.

PPACA provides that contribution amounts for the reinsurance program are to reflect an insurer's "commercial book of business for all major medical products." Thus, the statute is being interpreted to require reinsurance contributions only for "major medical coverage" which the proposed regulations define as "health coverage which may be subject to reasonable enrolled 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." The proposed regulations provide that the following types of plans and coverage would be excluded from reinsurance contributions.

- Medicare, Medicaid, CHIP or state high-risk pools, because they are not part of an insurer's commercial book of business; likewise, Medicare Part C or Part D programs are part of a "governmental book of business" and excluded from the reinsurance contribution
- Coverage that is not issued on a form filed and approved by a state insurance department (expatriate coverage may fall within this category)
- Coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance
- Stand-alone dental or vision plans
- Liability insurance, including general liability and automobile
- Workers' compensation
- Credit-only insurance
- Long-term care
- Health flexible spending accounts (FSAs) that meet the definition of an excepted benefit
- Employee assistance programs, disease management or wellness program as long as the program does not provide for major medical coverage
- Stop-loss coverage
- Health savings accounts (HSAs) (although reinsurance contributions are required for the high deductible health plan)
- Health reimbursement arrangements (HRAs) integrated with a group health plan (although reinsurance contributions are required for the group health plan)
- Tribal coverage offered to tribal members, their spouses and dependents, in their capacity as tribal members and not in their capacity as current or former employees of the tribe or their dependents, as this would not be a commercial book of business

Although there is not a per se exemption for retiree plans, the proposed regulations clarify that when an individual has both Medicare and employer-provided coverage, the group health plan will only be considered major medical coverage when the group health plan is primary to Medicare. So for example, a working 68-year-old covered under the employer's group health plan and enrolled in Medicare (with the group health plan as primary) would be counted for purpose of the reinsurance contribution. A 68-year-old retiree who is enrolled in the group health plan (with Medicare as primary) would not be counted for the reinsurance contribution. This is the same application that would be used for a group health plan covering pre-Medicare retirees, disabled employees where Medicare is not primary and COBRA beneficiaries.

CALCULATING REINSURANCE CONTRIBUTIONS

The reinsurance contribution is applicable for a group health plan based on the average number of lives (employees and dependents) covered under the plan. Although the contribution is required for insurers and the administrators of self-insured plans, this *Alert* is only addressing the calculation method for a self-insured plan, as insurers are responsible for the contribution for a fully insured plan. The guidance provides a number of methods for calculating the average number of lives for a self-insured group health plan. To be consistent, a plan sponsor must use the same method for the duration of a calendar year; however, a different method may be used from one calendar year to the next. These methods are similar to those provided for determining the Patient Centered Outcomes Research Institute (PCORI) fee (also referred to in previous communications as the Comparative Effectiveness Research fee). Contributions can be calculated using a different method for the reinsurance fee than for the PCORI fee. Note again that the PCORI fee is based on a plan year, while the reinsurance contribution is based on a benefit year, defined by HHS as a calendar year.

At the same time HHS issued the proposed regulations, the Internal Revenue Service (IRS) issued a Transitional Reinsurance Program FAQ, which provides that health insurance issuers and a sponsor of a self-insured group health plan may treat the reinsurance program contributions as ordinary and necessary expenses paid or incurred in carrying on a trade or business, subject to any applicable disallowances. Furthermore, a footnote contained in the preamble to the new proposed regulations states, "[t]he Department of Labor has reviewed this proposed rule and has advised that paying required 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 the Affordable Care Act as interpreted in this proposed rule." Accordingly, it appears that plan sponsors may elect to reimburse the cost of the annual fee from the respective plan, as permitted by ERISA and DOL regulations and guidance issued thereunder. If electing to reimburse this cost from the plan, plan sponsors should ensure that the plan document properly reflects this provision.

ACTUAL COUNT METHOD

The average number of lives covered under the plan for the plan year can be determined by adding the total number of lives covered for *each day of the first nine months of the calendar year* and d*ividing that total by the number of days in those nine months.*

> **EXAMPLE:** Employer is the plan sponsor of a self-insured health plan. Employer determines the sum of the lives covered for each day of the first nine months in the applicable calendar year as 2,463,750. The average number of lives covered under the plan will be determined by dividing 2,463,750 by 273 days (the number of days in the first nine months of a normal calendar year, i.e., not considering a leap year): 9,024.

SNAPSHOT FACTOR METHOD

Add 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 divide that total by the number of dates on which a count was made. 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 multiplied by 2,35. *This counting method is only used over the first three quarters of the calendar year.* The date or dates for each quarter generally must be the same, except that the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter.

> **EXAMPLE:** Employer has a self-insured health plan providing coverage for employee, employee plus one and family. Employer designates the first day of each quarter for determining covered lives. On January 1 there is employee-only coverage for 600 participants, and 800 for other than employee-only coverage. On April 1 there is employee-only coverage for 608 lives and 800 for other than employee-only coverage. On July 1 the plan provides employee-only coverage for 610 lives and for other than employee-only coverage 809 lives. The average number of lives covered under the plan for the plan year is 2,493. [((600 + (2.35 X 800) + ((608 + (2.35 x 800) + ((610 + (2.35 x 809) + ((610 + 2.35 x 809)) divided by three]

FORM 5500 METHOD

The average number of lives is determined on the basis of information in the ERISA Form 5500 filings for the last applicable plan year. The guidelines provide that a self-insured group health plan may rely upon such data, even though the data may reflect enrollment in a previous benefit year. Plans providing self-only coverage calculate the number of lives by adding the number of Form 5500 at the beginning and end of the plan year, divided by two. For plans providing coverage to employees and dependents, the number of lives is the sum of the number of participants of Form 5500 at the beginning and end of the plan year.

> **EXAMPLE:** Employer has a self-insured health plan with a plan year of August 1, 2012 through July 31, 2013 offering employee-only coverage. On Form 5500 the employer reports 4,000 participants on the first day of the plan year and 4,200 participants on the last day of the plan year. The plan sponsor determines the average number of lives covered by adding 4,000 and 4, 200 (8,200) divided by two (4,100).

> **EXAMPLE:** Employer has a self-insured health plan with a plan year of August 1, 2012 through July 31, 2013 offering employee, employee plus one and family coverage. On Form 5500 the employer reports 4,000 participants on the first day of the plan year and 4,200 participants on the last day of the plan year. The plan sponsor determines the average number of lives covered by adding 4,000 and 4,200 (8,200).

Procedures for counting covered lives for group health plans with a self-insured coverage option and an insured coverage option.

When determining the number of covered lives for reinsurance contributions for a group health plan that has insured and self-insured options, the plan must use either the Actual Count Method or the Snapshot Factor Method.

MULTIPLE PLANS

For the purpose of the reinsurance contribution, a plan sponsor has multiple plans when it maintains two or more group health plans (or a group health plan with both insured and self-insured components) that collectively provide major medical coverage for the same covered lives. These types of multiple plans are aggregated and treated as a single self-insured group health plan when calculating any reinsurance contribution amount. This aggregation prevents double counting of lives across multiple plans.

There are two exceptions to this aggregation rule provided in the proposed regulations. Aggregation is not required with respect to a group health plan that only provides:

- Coverage for excepted benefits, such as stand-alone dental or stand-alone vision

OR

- Prescription drug coverage

PLAN SPONSOR – PLAN DOCUMENT

Because the plan sponsor is responsible for payment of the contribution, it is important to know how "plan sponsor" is defined. The proposed regulations define "plan sponsor" as the employer in the case of a single employer, the employee organization, the

board of trustees for a multiemployer plan, the committee for a multiple employer welfare arrangement (MEWA), the cooperative or association for rural elective cooperatives and the trustee for a plan maintained by a voluntary employees' beneficiary association (VEBA).

Generally, when a self-insured plan covers employees of more than one related employer, they are deemed to be under common control of one employer and one plan sponsor. However, the proposed regulations for the reinsurance contribution do not contain rules that would treat related entities as a single employer. Thus, in this situation, the regulations provide that the plan sponsor (and entity responsible for the contribution) will be the person identified in the terms of the plan document that governs the plan. In addition to being named in the plan document as the plan sponsor, the entity must also consent to the designation by no later than the date by which the count of covered lives for that benefit year (calendar year) is required to be provided.

If a plan sponsor is not designated in the terms of the plan document then the plan sponsor is each employer which has employees covered under the plan. Thus, each employer would be responsible for making any applicable reinsurance contribution for the employees it has covered under the plan. This provision again emphasizes the importance of an employer ensuring its plan is established and governed by a plan document (and that such document properly designates the plan sponsor).

REMITTING REINSURANCE CONTRIBUTIONS

In order to simplify the collection of the reinsurance contributions for insurers and self-insured group health plans, HHS will be the only collecting entity and will collect contributions on an annual basis for all states. Initially it was proposed that the states would establish their own collections on a quarterly basis. (However, if a state decides to operate its own reinsurance program, then this would be a separate fee and would not be collected by HHS.) The guideline for paying payments will be as follows:

- By November 15 of each benefit year (2014, 2015, and 2016) the contributing entity submits to HHS an enrollment count of the average number of covered lives subject to the reinsurance contribution.
- HHS will notify the contributing entity within 15 days of submission of the annual enrollment count or by December 15, whichever is later, of the reinsurance contribution amount to be paid.
- Contributions by the contributing entity are required to be remitted within 30 days after HHS' notification of contributions.

CONCLUSION

The transitional reinsurance program is to assist in stabilizing premiums for the individual and small group market in 2014. It is likely to result in additional costs for employer-plan sponsors. Plan sponsors of both fully and self- insured plans need to begin to consider the additional costs the plan may incur. Also, plan sponsors of self-insured plans will need to work with their TPAs to determine how they intend to administer the contribution.

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