

# TRANSITIONAL REINSURANCE FEE COUNTS DUE BY NOVEMBER 17

The transitional reinsurance fee is one of several established by the Patient Protection and Affordable Care Act (PPACA). The enrollment count for 2014, used to calculate the reinsurance fee, is officially due by November 15, 2014, although, because that day is a Saturday, the Department of Health and Human Services (HHS) will accept submissions through November 17, 2014. Employers with self-insured plans will need to submit the required information and make the required payments by the applicable deadlines.

## BACKGROUND

Due to insurance reform under PPACA, health coverage is now 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.

To stabilize these increasing premiums, 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 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. The program will collect contributions from group health plans to fund reinsurance payments to insurers in the individual and small group markets, administrative costs of the reinsurance program and the General Fund of the U.S. Treasury. This is a three-year program that runs from 2014 to 2016.

The reinsurance contribution rate for 2014 is \$63 (\$5.25/month) per enrolled individual, including dependents. For 2015, the rate will decrease to \$44 per covered life.



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## WHO IS RESPONSIBLE FOR MAKING REINSURANCE CONTRIBUTIONS?

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. Health insurance issuers and third-party administrators (TPAs) on behalf of group health plans, referred to as “contributing entities,” are 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.

For 2015 and 2016 (the change does not apply to the 2014 benefit/calendar year), self-insured group health plans that do not use a TPA for claim payment, claim adjudication or enrollment (referred to as “self-insured, self-administered plans”) would not be treated as contributing entities and would be exempt from reinsurance contributions. A self-insured plan can qualify for this exemption, even if it outsources some plan administrative functions, provided it outsources the function to an unrelated third party and meets one or more of the following criteria:

- Outsourcing is limited to pharmacy benefits or excepted benefits (like dental or vision)
- Only a de minimis amount of core administrative services for benefits other than pharmacy or excepted benefits is outsourced (a de minimis amount is up to 5% of either the amount or value of the enrollment or claim processing transactions for the outsourced benefits)
- The plan “leases” a network and obtains provider network development, claim repricing and similar services

## WHAT BENEFITS ARE SUBJECT TO THE REINSURANCE CONTRIBUTION REQUIREMENT?

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 interpreted as requiring reinsurance contributions only for “major medical coverage” which the final regulations define as a catastrophic plan, an individual or a small group market plan (subject to actuarial value requirements) or health coverage for a broad range of services and treatments in various settings that provides minimum value (having a 60% actuarial value).

The following types of plans and coverage are 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
- Coverage that does not provide minimum value (having a 60% actuarial value)
- 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 status 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

## WHAT COUNTING METHODS ARE AVAILABLE FOR SELF-INSURED CONTRIBUTING ENTITIES?

The reinsurance contribution is applicable for a group health plan based on the average number of lives (employees and dependents) covered under the plan. The annual enrollment count for the contribution is based on a calendar year. The available counting methods calculate covered lives based on enrollment in the first nine months of a calendar year. Self-insured plans can use one of four methods to determine the average number of covered lives.

- **Actual count method** – Add the number of lives covered for each day of the first nine months of the calendar year and divide that total by the number of days in those nine months.
- **Snapshot count method** – Add the number of lives covered on a date (or more dates if an equal number of dates are used for each quarter) during the corresponding month in each of the first three quarters of the benefit year (provided that the dates used for the second and third quarters are within the same week of the quarter as the date used for the first quarter) and divide that total by the number of dates on which a count was made. The same month must be used for each quarter (for example, January, April and July).
- **Snapshot factor method** – Add the number of lives covered on any date (or more dates if an equal number of dates are used for each quarter) during the corresponding month in each quarter; divide that total by the number of dates on which a count was made. For this method, however, calculate the total lives covered on a date 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 on the date multiplied by 2.35. Use the same months for each quarter (e.g., January, April and July). As with the snapshot count method, the dates used for the second and third quarters must be within the same week of the quarter as the date used for the first quarter.
- **Form 5500 method** – Calculate the total lives covered for a plan that offers only self-only coverage by adding the number of participants covered at the beginning and the end of the benefit year (as reported on the Form 5500) and divide by two. For a self-insured group plan that offers self-only coverage and coverage other than self-only coverage, add the total participants covered at the beginning and the end of the benefit year, as reported on the Form 5500. A non-calendar-year plan may use the Form 5500 method. Such a plan would calculate the number of covered lives using the number of participants covered at the beginning and end of the most current plan year, as reported on Form 5500.

Each of the above methods is explained in more detail here: [https://www.regtap.info/uploads/library/RL\\_CountMethodEx\\_5CR\\_072114.pdf](https://www.regtap.info/uploads/library/RL_CountMethodEx_5CR_072114.pdf).

## WHAT IS THE CONTRIBUTION PROCESS?

Reinsurance contributions can only be made through Pay.gov. If an entity does not have a Pay.gov account, it must create one to complete the reinsurance contribution submission filing.

Using Pay.gov, the contributing entity (or TPA on its behalf) will access the “ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form” to enter the annual enrollment count. The form will auto-calculate the annual contribution amount based on the annual enrollment count; the contributing entity will then schedule payment for the calculated reinsurance contributions on the payment page.

HHS has published an Annual Enrollment and Contributions Submission Form Manual to assist plans in making their reinsurance contribution submission, available here: [Annual Enrollment and Contributions Submission Form Manual 1.0](#).

A self-insured group health plan that has not already done so should immediately inquire whether the TPA will submit the filing on its behalf. If not, then the employer should set up a Pay.gov account and work with its TPA to collect the information needed to complete the form.

HHS offers contributing entities the option to pay: (1) the entire 2014 benefit year contribution in one payment no later than January 15, 2015 reflecting \$63.00 per covered life; or (2) in two separate payments for the 2014 benefit year, with the first remittance due by January 15, 2015 reflecting \$52.50 per covered life, and the second remittance due by November 15, 2015 reflecting \$10.50 per covered life.

HHS recommends that contributing entities schedule their contribution payments at least 30 days after the day the enrollment and contributions form is submitted, but before the applicable regulatory deadlines to allow for validation and correction of the payment if necessary.

Contributing entities should register with **REGTAP (The Registration for Technical Assistance Portal)**. REGTAP provides information about the transitional reinsurance fee and allow registrants to submit questions.

## WHAT IS THE PENALTY FOR LATE PAYMENT OF THE TRANSITIONAL REINSURANCE FEE?

An employer's obligation to pay the reinsurance fee is considered a federal debt, subject to federal debt collection rules. Failure to pay the fee on time could result in interest and penalties accruing on the amount of the fee owed.

## NEXT STEPS

The contributing entity must complete the following steps by November 17, 2014:

- **Set up an account in Pay.gov.** Create a user profile that includes user and company information here: <https://pay.gov/public/registration>.
- **Complete the contribution form.** Requires a billing contact, billing address, and the names and contact information for three submitter contacts who can discuss information submitted on the form and supporting documentation. The form also requires the annual enrollment count, determined using one of the approved counting methods discussed above, and whether the form is being submitted for the first installment payment, the second installment payment or the combined payment. If the contribution will be made in two installments, the form and supporting documentation must be submitted twice (once for each payment). The entity submitting the form must also confirm that the annual enrollment count matches the enrollment count in the supporting documentation. Finally, an authorizing official for the entity submitting the form must certify that the data submitted is true, correct and complete.

The contribution form is available here: <https://www.pay.gov/public/form/start/64510311>.

- **Upload supporting documentation.** Consists of a comma-separated value (CSV) file with one row for each contributing entity. Find details about the supporting documentation file layout requirements at: [https://www.regtap.info/uploads/library/RIC\\_FileLayoutJobAid\\_081114\\_v2\\_5CR\\_081314.pdf](https://www.regtap.info/uploads/library/RIC_FileLayoutJobAid_081114_v2_5CR_081314.pdf).

The Transitional Reinsurance Program Job Aid was created to support contributing entities in the creation of the supporting documentation.

- The Job Aid is an MS Excel workbook that allows users to enter, validate and convert contributing entity information into a CSV file format, which can be accessed here: **Supporting Documentation: Job Aid**.
- HHS has created a Supporting Documentation Job Aid Manual, which is available here: **Supporting Documentation: Job Aid Manual 1.0**.
- Additional information about the Job Aid can be found at: [https://www.regtap.info/uploads/library/RL\\_JobAidReview\\_091714\\_091914\\_092414\\_v1\\_5CR\\_091714.pdf](https://www.regtap.info/uploads/library/RL_JobAidReview_091714_091914_092414_v1_5CR_091714.pdf).

- **Enter payment information** (e.g. payment date and banking information). Payment may only be made on Pay.gov using an ACH payment (payments cannot be made via check or credit card). Only one bank account may be entered on a form. If the entity submitting the form is submitting contributions on behalf of several contributing entities with different bank accounts, a separate form is required for each. The payment must be scheduled for a date on or before the applicable reinsurance contribution deadline. Since automatic debits to a business account may be blocked by the bank, self-funded clients should contact their banks to have the ALC+2 value added to allow for automatic debits. For the reinsurance contribution process the **ALC+2 is: 7505008015**.

## CONCLUSION

A significant amount of time, work and expense is involved in complying with the transitional reinsurance fee process by the November 17, 2014 deadline. Employers with self-insured plans should promptly begin gathering the required enrollment information, register with Pay.gov, submit the required enrollment and contributions form, and prepare to make the ACH payment transfer. They should also register with REGTAP so that they will have access to all of the resources HHS has made available.

The following link to the HHS website provides an overview of the reinsurance contribution process and links to various forms and resources: **[Transitional Reinsurance Program: Overview and Procedures for Reinsurance Contributions](#)**.



# KEY CONTACTS

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