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Reinsurance Fees Will Cost Group Health Plans

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**.

On March 23, 2012, the Department of Health and Human Services (HHS) issued a **final rule** to implement the ACA's standards for reinsurance, risk corridors and risk adjustment programs. On March 1, 2013, HHS released a second **final rule** to expand upon these standards and provide additional guidance on the operation of these programs.

On March 11, 2014, HHS published its **2015 Notice of Benefit and Payment Parameters Final Rule**, which includes standards relating to the ACA's risk-spreading programs. The final rule contains the 2015 reinsurance 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

The 2013 final rule clarifies that, for self-insured group health plans, the **plan sponsor** 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. For a plan maintained by a single employer, the employer would be the plan sponsor.

In addition, the Department of Labor (DOL) has advised that paying reinsurance fees constitutes a permissible expense of the plan under ERISA because the payment is required by the plan under the ACA.

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

In the 2015 Notice of Benefit and Payment Parameters Final Rule, 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.

> For 2015 and 2016, the term "contributing entity" excludes self-insured group health plans that do not use a third party administrator in connection with the core administrative functions of claims processing or adjudication (including the management of appeals) or plan enrollment.

The final rule clarifies that a self-insured plan will not lose self-administered status because it uses an unrelated third party to obtain provider network and related claim repricing services. Also, a self-insured plan will not lose self-administered status because it outsources:

- Core administrative functions (claims processing, claims adjudication and enrollment services) to an unrelated third party, such as a pharmacy benefits manager (PBM), provided that the underlying benefits are **pharmacy benefits or excepted benefits**; or
- A **small amount** (up to 5 percent) of core administrative services for benefits other than excepted benefits or pharmacy benefits to an unrelated third party. The five percent limit is measured based on either the number of transactions processed by the third party or the volume of claims processing and adjudication and plan enrollment services provided by the third party.

Thus, for the 2015 and 2016 benefit years, a "contributing entity" means a health insurance issuer or a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third party administrator in connection with claims processing or adjudication (including the management of appeals) or plan enrollment.

The modified definition of "contributing entity" will be effective only for the 2015 and 2016 benefit years. To avoid disruption for plans and issuers, the final rule does not change the definition of a "contributing entity" for the 2014 benefit year. For 2014, a contributing entity means:

- A health insurance issuer; or
- A self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage), **regardless of whether the plan uses a third party administrator**.

WHAT TYPES OF COVERAGE ARE EXCLUDED?

Contributions to the reinsurance program are only required for plans that provide **major medical coverage**. According to the 2013 final rule, health flexible spending account (FSA) coverage is not major medical coverage due to the ACA's $2,500 annual limit on salary deferrals to a health FSA.

Coverage that consists solely of excepted benefits under HIPAA is not subject to the reinsurance program. This includes, for example, 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. Thus, issuers and plan sponsors will not be required to pay fees for these types of plans.

In addition, the following plans and coverage are excluded from reinsurance fees under the 2013 final rule:

- 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);

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- Health savings accounts (HSAs) (although reinsurance fees will be required for an employer-sponsored high-deductible health plan);
- Health FSAs;
- Employee assistance plans, wellness programs and disease management plans that provide ancillary benefits and not major medical coverage;
- Expatriate health coverage (as defined by HHS in future guidance);
- A self-insured group health plan or health insurance coverage that consists solely of benefits for prescription drugs; and
- Stop-loss and indemnity reinsurance policies.

Also, under the 2013 final rule, fees are only required for individuals with Medicare coverage when the employer-provided group health coverage is the primary payer and Medicare is the secondary payer. If the group health plan is the secondary payer, individuals with Medicare coverage will not be counted for the reinsurance fees. For example, 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 will not be counted for purposes of reinsurance contributions.

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 $5.25 per month ($63 per year).
- For 2015, the annual contribution rate will be $44 per enrollee per year, about $3.67 per month.

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.

An issuer's or plan sponsor's reinsurance fee will be calculated by multiplying the number of covered lives (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).

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

The 2013 final rule includes a variety of methods for issuers and plan sponsors to determine the average number of covered lives under a health plan. These methods include:

- A snapshot method;
- An actual count method; and
- A method based on using data from insurance forms or the Form 5500.

In the 2015 Notice of Benefit and Payment Parameters Final Rule, HHS clarifies the Form 5500 counting method by changing the references from "benefit year" to "plan year" to clarify that a self-insured group health plan may use the enrollment set forth in the Form 5500 even if the group health plan is based on a plan year other than the benefit year (defined as a calendar year for which a health plan provides coverage for health benefits).

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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.

HOW WILL THE FEES BE DETERMINED AND COLLECTED?

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.

In the 2015 Notice of Benefit and Payment Parameters Final Rule, HHS modified the collection schedule for the reinsurance program so that the fees will 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.

According to HHS, this two-installment policy was designed to alleviate the upfront burden of the reinsurance contribution, allowing contributing entities additional time to make the payment.

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.

- ***First installment***—A contributing entity must submit its annual enrollment count to HHS by Nov. 15 of the benefit year. If the enrollment count is timely submitted, HHS will notify the contributing entity in December of the benefit year of the reinsurance contribution amount allocated to reinsurance payments and administrative expenses to be paid for the applicable benefit year. The contributing entity must remit this amount within 30 days after the date of the first notification.

- ***Second installment—***In the fourth quarter of the calendar year following the applicable benefit year, HHS will notify the contributing entity of the portion of the reinsurance contribution amount allocated for payments to the U.S. Treasury for the applicable benefit year. A contributing entity must remit this amount within 30 days after the date of this second notification.

For the 2014 benefit year, of the $63 annual per capita contribution rate, $52.50 will be allocated towards reinsurance payments and administrative expenses, and $10.50 towards payments to the U.S. Treasury. Therefore, if a contributing entity submits its enrollment count by Nov. 15, 2014:

- A reinsurance contribution payment of $52.50 per covered life will be invoiced in December 2014, and payable in January 2015; and

- Another reinsurance contribution payment of $10.50 per covered life will be invoiced in the fourth quarter of 2015, and payable late in the fourth quarter of 2015.

For the 2015 benefit year, the $44 annual per capita contribution rate will be allocated $33 towards reinsurance payments and administrative expenses, and $11 towards payments to the U.S. Treasury. These amounts will similarly be payable in January 2016 and late in the fourth quarter of 2016, respectively.

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

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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.

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