December 5, 2012

Guidance Issued for 2014 Transitional Reinsurance Program

The Department of Health and Human Services (HHS) has issued eagerly awaited new proposed rules implementing the three-year Transitional Reinsurance Program under the Affordable Care Act (the "Act"). These proposed regulations provide much-needed guidance for determining self-insured plans' and insurers' contributions to this program. HHS is seeking comments on the proposed rules and may make modifications in final regulations.

Background. Under the Act, each state may establish a Transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the first three years that the state health insurance exchanges are operational (2014 through 2016). If a state chooses not to establish a reinsurance program, HHS will do so for the state. Under the Transitional Reinsurance Program, over 3 years (2014 – 2016), HHS will collect contributions ($25 billion total) from self-insured group health plans and insurers and allocate those funds among insurers that cover high-cost individuals, with the goal of minimizing premium increases associated with covering those individuals. Final regulations issued earlier this year addressed the timing, method and other aspects of the contributions as they apply to these plans. The final regulations also clarified that the contributions are based on the number of enrollees covered by the plan, including employees and non-employee beneficiaries such as spouses and dependents. See Our Conner Strong & Buckelew Update on these earlier regulations for more background information.

Contribution Rate. HHS has proposed a national contribution rate of $5.25 per covered life, per month for 2014, equivalent to $63 per covered life for the year, which is at the lower end of projections previously made by benefit experts. Comments are requested on this calculation, as well as whether HHS has the authority to defer until 2016 a portion of the reinsurance payments that are to be paid to the US Treasury to partially offset the government's cost for the Early Retiree Reinsurance Program (ERRP). If this amount is deferred, it is estimated that the 2014 contribution rate would be $52.54 per covered life for the year. HHS will set contribution rates for 2015 and 2016, which are to be lower than the 2014 rate. If states establish their own reinsurance programs, they have the option of requiring additional reinsurance contributions, although those additional contributions will apply to insurers only and not to self-insured plans.

Contribution for Major Medical Only. A contributing entity is required to make contributions on behalf of "major medical coverage" and is not required to make payments on behalf of coverage that is not major medical coverage or which is "excepted benefits" under HIPAA (such as stand-alone dental and vision coverage). Therefore, plans do not have to count covered lives in the

following types of coverage:

- health savings accounts (HSAs)
- health reimbursement arrangements (HRAs) that are integrated with a group health plan
- flexible spending accounts (FSAs)
- employee assistance plans
- wellness programs
- disease management programs (to the extent they do not provide major medical coverage)
- stop-loss or indemnity reinsurance policies
- coverage provided by Indian Tribes to Tribal members and their dependents
- Indian Health Service health programs

Medicare Coverage. If an individual has both Medicare and employer-sponsored coverage, the employer plan would only be required to make Transitional Reinsurance Program contributions when the employer plan is the primary payer under Medicare Secondary Payer rules. Therefore, for example, when an individual is still actively employed, covered under an employer plan and also covered under Medicare, the employer plan is considered primary and it would be subject to the reinsurance contribution for these individuals. The employer plan would not be responsible for making reinsurance contributions for retirees covered under an employer plan and Medicare where Medicare is the primary plan and the employer plan is secondary.

Expatriate Coverage. With respect to group coverage designed primarily for employees who work outside the U.S., HHS proposes that the coverage will be subject to reinsurance contributions only if the coverage is through a policy filed and approved by a state department of insurance. HHS will treat coverage for overseas travel similarly.

Annual Contributions. Self-insured group health plans and insurers must make reinsurance payments annually on a calendar year (rather than plan year) basis. Plan administrators will be required to send plan enrollment counts to HHS by November 15, 2014. HHS will then send out bills by December 15, 2014 (or within 15 days of submission of annual enrollment count, whichever is later). Within 30 days of notification, the self-insured plan must remit reinsurance contributions to HHS. Originally, HHS had proposed that the first-year payment be made by January 15, 2014, and that the payments be made quarterly rather than annually. HHS (rather than states) will collect reinsurance contributions and disburse reinsurance payments based on states' needs for reinsurance payments. This is intended to help streamline the collection process so that insurers and self-insured plans are not responsible for making payments to each individual state. Issuers are liable for making reinsurance contributions for insured coverage. For self-insured group health plans, the plan is liable, although the plans can (but are not required to) have third-party administrators make reinsurance contributions to HHS on their behalf.

Counting Lives. Contributing entities are permitted to use several different methods for determining enrollment. The rules provide 4 alternative methods for determining the average number of covered lives for a given year under a self-insured plan (there are 3 alternative methods for determining the average number of covered lives for a given year for insurers):

- **Actual Count Method:** Add the total number of covered lives for each day of the first 9 months of the calendar year and divide that total by the number of days in those 9 months.
- **Snapshot Count Method:** Add the totals of lives covered on a date (or more dates if an equal number of dates are used for each quarter) during the same corresponding month in

each of the first 3 quarters of the year (e.g., January, April, July) and divide that total by the number of dates on which a count was made.

- **Snapshot Factor Method:** Add the totals of lives covered on one date in each quarter, or an equal number of dates for each quarter, and divide the total by the number of dates on which a count was made. The number of lives covered on a date is the sum of (1) the number of participants with self-only coverage on that date, plus (2) the product of the number of participants with coverage other than self-only coverage on the date and 2.35. The plan must use the same months for each quarter (e.g., January, April, July, October).
- **Form 5500 Method:** For a plan only providing only self-only coverage, treat the average number of covered lives under the plan for a plan year as the sum of the total participants at the beginning and the end of the plan year, as reported on the plan's Form 5500, divided by 2. For plans providing coverage that is not limited to the self-only coverage, add the number of participants reported for the beginning of the plan year to the number reported for the end of the plan year, as reported on the plan's Form 5500.

If an employer sponsors a group health plan that offers one or more coverage options that are self-insured and one or more other coverage options that are insured, the plan sponsor can use the actual count method or snapshot count method. If a plan sponsor maintains 2 or more self-insured or insured 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, the plan sponsor should treat these plans as a single self-insured group health plan for purposes of calculating reinsurance contributions.

- If at least one of the plans is insured, the plan sponsor must determine the average number of covered lives using the actual count method or snapshot count method.
- If all of the plans are self-insured, the plan sponsor must determine the average number of covered lives using the actual count method, snapshot count method, or snapshot factor method described above, applied across the multiple plans as a whole.

For each of the above methods, the plan sponsor must determine and report to HHS: (a) the average number of covered lives calculated, (b) the counting method used, and (c) the names of the multiple plans being treated as a single group health plan. If any of multiple plans are limited to excepted benefits under HIPAA (such as stand-alone dental and vision benefits) or prescription drug coverage, those benefits do not need to be aggregated with major medical coverage for purposes of determining reinsurance contributions.

Deductible Contributions. The Internal Revenue Service (IRS) issued Frequently Asked Questions addressing the tax deductibility of these contributions. Health insurance issuers will be able to treat the contributions as tax-deductible as an ordinary and necessary business expense. Self-insured plans may also treat the contributions as (1) tax deductible for this purpose, and (2) a plan expense under Title I of ERISA.

This fee will result in additional costs for employer plan sponsors and, depending on whether the plan at issue is self-administered, certain additional reporting obligations. We are hopeful that future guidance will provide other means for mitigating the cost impact and minimizing the administrative burden for employers. Should you have questions about this or any aspect of healthcare reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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