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American Benefits Council

Preparing for PPACA Webinar

Transitional Reinsurance Program & Fee Assessed on Insured and Self-Insured Plans

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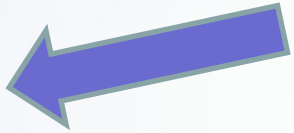
Overview of Discussion

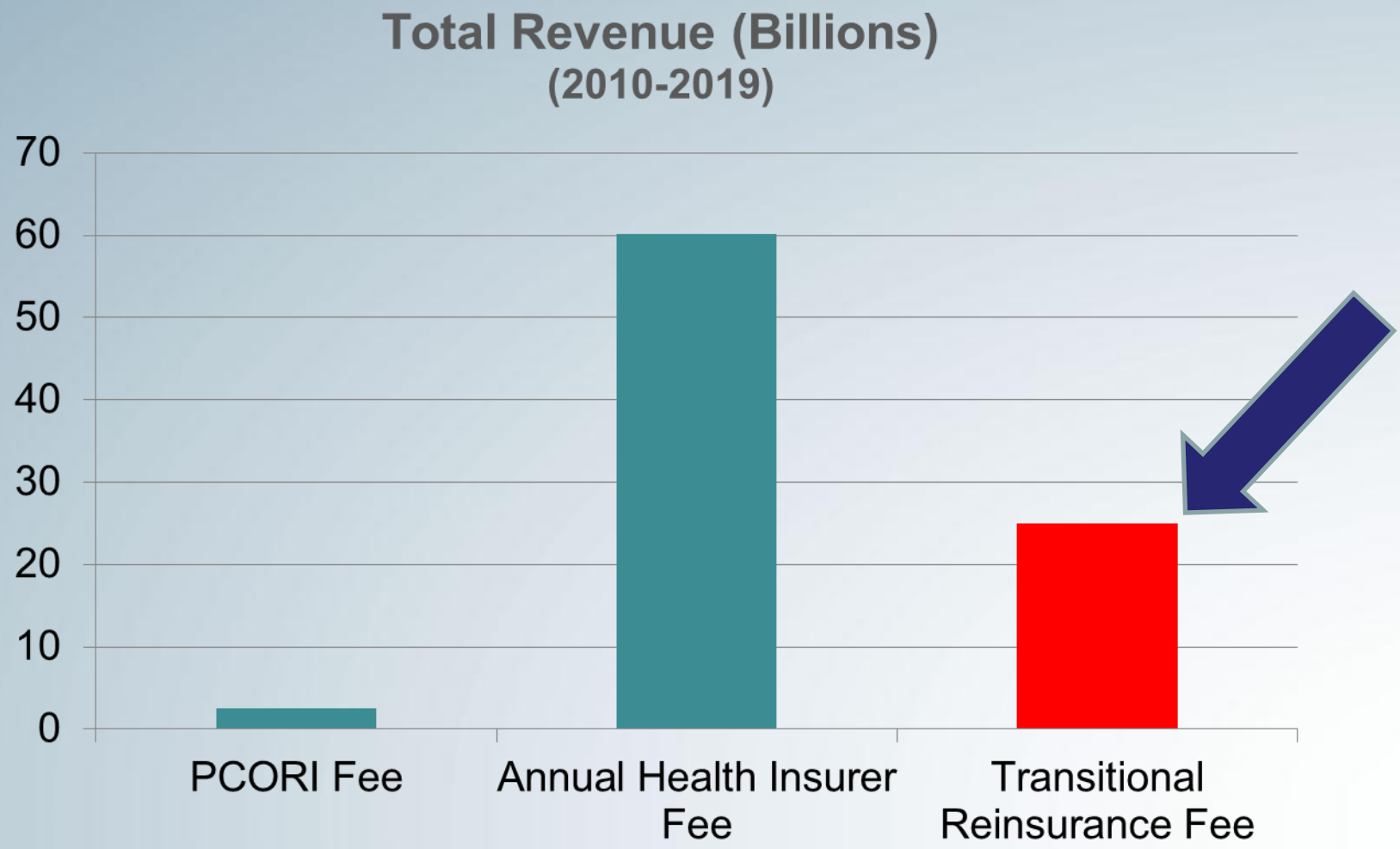
- Background on the new program and related fee
- Who is liable for the fee?
- What is the amount of the fee?
- What plans give rise to fee liability?
- When will the fee be due and how will it be collected?
- What penalties apply for noncompliance?

Background

- One of three significant fees that applies to issuers and/or self-funded plan sponsors
  - Annual Health Insurer Fee
    - ONLY applies to issuers of certain types of "health insurance" for any "United States health risk", although this fee will likely be passed on to plan sponsors of insured plans in whole or in part
  - PCORI Fee
    - Applies to issuers of certain types of individual and group health insurance as well as plan sponsors of self-funded group health plans
  - Transitional Reinsurance Assessment
    - This is the fee we are talking about today



Background


Total Revenue (Billions)
(2010-2019)
70
60
50
40
30
20
10
0
PCORI Fee
Annual Health Insurer Fee
Transitional Reinsurance Fee

Background

- Section 1341 of the ACA requires the HHS Secretary, in consultation with the National Association of Insurance Commissioners ("NAIC"), to implement standards enabling states to establish and maintain a 3-year transitional reinsurance program ("Transitional Reinsurance Program") during the implementation of health reform

- Each state's Transitional Reinsurance Program is intended to assist issuers who provide individual insurance market coverage to high-cost enrollees during the implementation of health reform both inside and outside the exchange

Background

"The reinsurance program, which is a State-based program, will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk for high-cost enrollees. By limiting issuers' exposure to high-cost enrollees, this program will attenuate individual market rate increases that might otherwise occur because of the immediate enrollment of individuals with unknown health status."

HHS Final Regulations, 77 Fed. Reg. 17,220, 17,221 (Mar. 23, 2012)

Background

- Section 1341 requires health insurance issuers, as well as certain plan administrators on behalf of self-insured group health plans, to make contributions to raise revenue to pay for –
  - the Transitional Reinsurance Program for a three-year period beginning January 1, 2014 ($20 billion)
    - 2014 - $10 billion
    - 2015 - $6 billion
    - 2016 - $4 billion
  - Early Retiree Reinsurance Program ("ERRP") ($5 billion)
- Earlier this year, HHS issued final regulations ("Final Regulations") regarding the Transitional Reinsurance Program
- The Final Regulations provide very helpful guidance, but many questions remain

Background

- Things to keep in mind
  - This fee is NOT the PCORI fee or the annual health insurer fee
  - The fee applies for a 3-year period – from 2014 to 2016
  - The fee applies to certain insured and self-funded plans
  - HHS has authority over this fee, not Treasury, which has authority regarding the PCORI and annual health insurer fees
    - Thus, different rules may apply

What is the amount of the fee?

- Proposed regulations indicated that the fee could be allocated to plans and coverage based on market share
  - Somewhat incongruous in connection with self-funded plans
  - Additionally, would have posed difficulties for employers from perspectives of financial planning and accounting

What is the amount of the fee?

- Final Regulations make clear that the fee will be a per capita fee
  - The Final Regulations give no further insight into the amount of the per capita fee; however, **some estimate that the fee could be anywhere from $61 per person to as high as $105 per person for 2014**
    - This is a much higher per capita fee than the PCORI fee (which is $1 per capita for 2013 (collected in 2014) and $2 per capita through 2019)
  - States have the right to charge additional fees with respect to individual, small and large group *insured* coverage
    - Thus sponsors of insured small and large group plans could see additional fee liability imposed by states
    - ERISA preemption precludes states from seeking to recover additional fees from self-funded plans

What is the amount of the fee?

- The per capita fee applies to each “reinsurance contribution enrollee” under the plan
  - Effectively, encompasses each covered life under the plan
    - Includes employees, spouses, dependents, and any other individuals receiving coverage under the plan at issue
  - Issue of “double counting”
    - Treasury/IRS has proposed a rule to reduce double counting of individuals with respect to the PCORI fee
    - It is unclear whether a similar rule might apply here

Who is liable for the fee?

- Depends on whether the plan is insured or self-funded
  - **If insured, then liability runs to the issuer** 
    - Note: It should be expected that the fee will be passed on to plan sponsors in the form of increased premiums. This is due, in part, to the fact that such amounts do not adversely affect the issuer for MLR purposes (but could give rise to increased scrutiny by state or federal regulators as part of rate review)

Who is liable for the fee?

» Depends on whether the plan is insured or self-funded

– **If self-funded, ultimate liability for the fee amount appears to belong to the plan sponsor and not the plan administrator**

- The statute and Final Regulations state that the third party administrator of a self-funded plan will pay the fee "on behalf of" the self-funded plan sponsor

- It is our understanding that HHS' current reading of the statute and regulations is that the third party administrator is liable for collecting and remitting the fee, but is not liable for the amount of the fee itself

Who is liable for the fee?

- Depends on whether the plan is insured or self-funded
  - Interesting questions remain regarding fee liability for self-funded plans
    - Regulations use the term “third party administrator”, which seems somewhat incongruous regarding self-administered plans
    - Plan sponsors should expect administrators to seek to collect the fee through the use of monthly (or other periodic) fees to ensure a pool of money exists for use in remitting the fee at the appropriate time
    - Query to what extent the third party administrator could be liable for penalties, or perhaps the fee itself, if it fails to have collected sufficient amounts over the course of the year

What plans give rise to fee liability?

- The fee generally applies to all “health insurance coverage” and self-funded “group health plans” unless HIPAA-excepted
  - The term “group health plan” is defined by reference to HHS regulations that define a “group health plan” as that which provides “medical care”
  - “Medical care” is, in turn, defined by reference to IRC section 213 “medical care”
  - Application of the fee to plans, such as EAPs, wellness and retiree-only?
  - Possibility for contrary interpretations by plan sponsors of self-funded plans and their third party administrators?

What plans give rise to fee liability?

» The following types of coverage are HIPAA-excepted and are excepted –

– Pursuant to 2791(c)(1) of the PHSA –

- Accident, or disability income insurance, or any combination thereof
- Liability insurance (including general liability insurance and automobile liability insurance)
- Supplemental liability insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics

What plans give rise to fee liability?

- The following types of coverage are excluded, so long as offered separately –
  - Pursuant to 2791(c)(2) of the PHSA –
    - Limited scope dental or vision benefits
    - Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
    - Qualifying health flexible spending arrangement ("health FSA") (see subsequent slide on medical savings accounts)

What plans give rise to fee liability?

- The following types of coverage are excluded, so long as offered as independent, noncoordinated benefits –
  - Pursuant to 2791(c)(3) of the PHSA –
    - Coverage only for a specified disease or illness
    - Hospital indemnity or other fixed indemnity insurance

What plans give rise to fee liability?

- The following types of coverage are excluded, so long as offered as a separate *insurance* policy–
  - Pursuant to 2791(c)(4) of the PHSA –
    - Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of title 42)
    - TRICARE supplemental health insurance
    - Similar supplemental coverage provided to coverage under a group health plan
      - Existing guidance indicates it must be limited to "filling gaps in primary coverage" "such as coinsurance or deductibles". It does not include coverage that is secondary or supplemental by reason of a coordination of benefits provision

What plans give rise to fee liability?

- Regarding medical savings accounts
  - Health flexible spending arrangements ("health FSAs") are excepted to the extent that –
    1. other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and
    2. the health FSA is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election)
  - What about health reimbursement arrangements ("HRAs") and health savings accounts ("HSAs")?
    - Stand-alone or integrated HRAs are subject to the fee
    - HSAs likely are not subject depending on ER endorsement

What plans give rise to fee liability?

- Additionally
  - The fee **applies** to the following:
    - Grandfathered AND nongrandfathered plans
    - FEHB plans
    - State and local governmental plan
  - The fee does **not** apply to the following:
    - Medicaid
    - Medicare Advantage
    - Medicare Part D (Rx coverage)
      - Note: employer-sponsored Rx coverage for post-65 retirees is subject to the fee

When will the fee be due and how will it be collected?

- Due and collected on a quarterly basis beginning January 15, 2014
- If insured, states may collect the fee or may ask HHS to do so on its behalf
- If self-funded, HHS will collect the fee
- Many questions remain –
  - *How* will the fee be remitted?
  - What if HHS over- or underestimates the population of covered lives? For example, will there be a mechanism for reconciliation or true-up?
  - What happens if the TPA fails to remit the fee?

Penalties

- The penalties of section 2723 of the PHSA apply without regard to any limitations regarding group health plans
  - Very generally, $100 per day per affected individual

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