

HHS Releases Final Rules Regarding Transitional Reinsurance Program

By Seth Perretta and Allison Ullman of Crowell & Moring LLP

The Department of Health and Human Services (“HHS”) recently issued final regulations (“Final Regulations”) regarding the standards related to reinsurance, risk corridors and risk adjustment consistent with sections 1341, 1342 and 1343 of the Patient Protection and Affordable Care Act, as amended (the “Affordable Care Act”). Of particular interest to plan sponsors is the transitional reinsurance program established under section 1341, which will require health insurance issuers, as well as certain plan administrators on behalf of self-insured group health plans, to make contributions to a transitional reinsurance program for the three-year period beginning January 1, 2014. This memorandum discusses section 1341 and the Final Regulations, with an eye toward how the transitional reinsurance program may affect plan sponsors. As discussed in more detail below, section 1341 is likely to result in additional costs for employer plan sponsors and, depending on whether the plan at issue is self-administered, certain additional reporting obligations.

Background

Section 1341 requires the HHS Secretary, in consultation with the National Association of Insurance Commissioners (“NAIC”), to implement standards enabling states to establish and maintain a transitional reinsurance program pursuant to which health insurance issuers (with limited exception for certain types of insurance, including HIPAA-excepted benefits and stand-alone dental and vision coverage), and certain plan administrators on behalf of group health plans, are required to make payments to an “applicable reinsurance entity” – a not-for-profit organization that carries out reinsurance functions under section 1341 – for the three-year period beginning January 1, 2014. States are not required to establish a reinsurance program; if a state chooses not to establish a reinsurance program, then HHS will establish a reinsurance program for such state.

Reinsurance contributions will be used to make reinsurance payments to health insurance issuers that cover high risk individuals in the individual market (excluding grandfathered health plans) for the three-year period beginning January 1, 2014. The transitional reinsurance program is intended to reduce the uncertainty of insurance risk in the individual market during the first three years of operation of the state health insurance exchanges, i.e., 2014 through 2016, by making payments toward high cost cases as a result of adverse selection.

Section 1341 itself does not provide much detail as to the method for determining the required contribution of each affected health insurance issuer, or an administrator with respect to a self-funded group health plan; rather, Congress delegated broad regulatory authority to HHS to shape the contours of the transitional reinsurance program. Proposed regulations (“Proposed Regulations”) published in the July 15, 2011 Federal Register left many questions unanswered. The Final Regulations are very helpful in terms of providing additional clarifying guidance to states and issuers, as well as to administrators of self-funded group health plans, regarding the implementation and operation of the transitional reinsurance program.

The Final Regulations were made available by HHS for public inspection on March 16, 2012, and were published in the March 23, 2012 Federal Register. The Final Regulations will become effective on May 22, 2012.

Liability for Transitional Reinsurance Contributions

As noted above, and per the express language of section 1341 and the Final Regulations, health insurance issuers and third party administrators on behalf of group health plans will generally be required to make contributions to the transitional reinsurance program for the three-year period beginning January 1, 2014. With respect to self-insured plans administered by a third party administrator, neither the statute nor the Final Regulations provide much guidance with regard to whether the third party administrator or the plan is ultimately liable for the reinsurance contribution, although it is clear that the third party administrator may make such contribution on behalf of the plan.

Comment: The Final Regulations reiterate the express statutory language as well as the statements in the Proposed Regulations that the third party administrator is making the reinsurance contribution “on behalf of” a group health plan. The Final Regulations themselves do not appear to address whether a third party administrator or the plan is in fact liable for the reinsurance contribution. The Final Regulations merely set forth those plans that do not give rise to a reinsurance contribution in the first instance – such as a plan providing only HIPAA-excepted benefits.

Although not entirely clear, based on our reading of the regulations (as well as policy arguments indicating that it may be easier for HHS to collect the reinsurance contribution from third party administrators rather than individual plans), it appears that HHS is of the view that the third party administrator is responsible for the payment of the reinsurance contribution, but that the reinsurance contribution can nonetheless be passed on to the plan in the form of additional administrative fees.

Comment: As noted above, with respect to self-funded plans, the Final Regulations indicate that the liability for the reinsurance assessment runs to the “third party administrator.” Notably, the use of the term “third party administrator” seems a bit incongruous based on common parlance when applied to self-funded plans that are self-administered by the plan sponsor, which is the claims administrator for a self-insured group health plan. Although a case could be made that such plans are not required to make contributions to the transitional reinsurance program, it appears to us that the more likely interpretation by the regulators is that the plan sponsor itself, as the claims processing entity (and as a third party to the plan), will be responsible for remitting the reinsurance contribution to the applicable reinsurance entity. This reading is reinforced by the preamble to the Final Regulations, which states that HHS will collect contribution funds “from self-insured plans *and third-party administrators on their behalf*,” implying that, where a plan is self-administered, HHS will look to the plan itself for payment of the reinsurance contribution.

Determination and Amount of Transitional Reinsurance Contributions

As noted above, section 1341 requires all health insurance issuers, and third party administrators on behalf of self-insured group health plans, to make contributions to support the transitional reinsurance program. The statute provides that, from 2014 through 2016, the aggregate contributions to be collected for and/or by all states will equal \$10 billion for 2014, \$6 billion for 2015, and \$4 billion for 2016, with such amounts solely to be used in paying claims under the transitional reinsurance program. An additional amount equal, on a national basis, to \$2 billion in 2014, \$2 billion in 2015 and \$1 billion in 2016 will be collected for deposit into the general fund of the U.S. Treasury.

One issue that arose in connection with the Proposed Regulations is whether the contribution amounts attributable to each state would be set based on a national, rather than a state-level, contribution basis. The Final Regulations provide that the contribution amounts will be set based on a national contribution rate. Each “benefit year,” which is defined to be a calendar year, HHS will set the national contribution rate in an annual HHS notice of benefit and payment parameters along with the proportion of the national contribution rate that will be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses of the applicable reinsurance entity for the state or HHS when carrying out the transitional reinsurance program.

Comment: The Final Regulations clarify that the reinsurance contribution is determined on a national basis (versus state-level) and that the reinsurance contribution is determined and announced by HHS for each given “benefit year.” The statute and the Proposed Regulations were less than clear as to whether reinsurance contributions would be measured and paid on a calendar or plan year basis. The Final Regulations appear to resolve this issue by defining a “benefit year” to be a calendar year.

Rather than using a “percent of premium” approach to determine the amount that a contributing entity (i.e., an issuer or an administrator on behalf of a group health plan) must contribute in a year, the Final Regulations provide that a flat per capita amount is determined based on all covered enrollees of such contributing entities.

Comment: The Proposed Regulations were unclear as to how the reinsurance contribution would be collected. More specifically, the Proposed Regulations left unanswered whether the reinsurance contribution payable by a subject issuer or third party administrator would be measured as a percent of premium (or deemed premium in the case of self-funded plans) or on a per-covered life basis. The Final Regulations answer this question by making clear that reinsurance contributions are based on a per-covered life basis. The regulators believe this approach will allow for easier administration of the transitional reinsurance program and enable compliance by entities required to make reinsurance contributions.

The Final Regulations permit a state to collect more than the amounts specified by the statute, if the state believes that such amounts are not sufficient to cover its transition reinsurance

payments or to cover its administrative costs.

Collection of Transitional Reinsurance Contributions

The Final Regulations make clear that the reinsurance contributions are to be collected on a quarterly basis beginning on January 15, 2014.

With respect to issuers in the fully insured market, a state that establishes a reinsurance program would have the option, but would not be obligated, to collect contributions from issuers in the fully insured market. If a state does not elect to collect from the fully insured market, HHS would collect contributions from issuers.

With respect to self-insured plans, in response to public concerns that states may lack authority/ability to collect contributions therefrom, the Final Regulations provide that HHS will collect contribution funds from self-insured plans and third party administrators on their behalf, whether or not a state elects to establish a reinsurance program.

Comment: The provision in the Final Regulations providing for collection by HHS of reinsurance contributions with respect to self-insured plans is consistent with traditional federal oversight of self-insured plans, given that states typically do not have any authority/reach with regard to self-insured plans.

HHS will distribute the reinsurance contributions collected to the applicable reinsurance entity for a state, net of the state's share of the U.S. Treasury contribution and administrative expenses incurred when performing reinsurance functions.

If a state establishes a reinsurance program and elects to collect more than the amounts that would be collected based on the national contribution rate for administrative expenses, then the state must notify HHS within 30 days after publication of the proposed annual HHS notice of benefit and payment parameters of the additional contribution rate that it elects to collect for administrative expenses. Further, the state must ensure that the state's applicable reinsurance entity collects any additional amount for administrative expenses, or accepts additional amounts from HHS. For reinsurance payments, the state must ensure that the state's applicable reinsurance entity collects all additional reinsurance contributions from contributing entities for the purpose of reinsurance payments. In sum, HHS will only collect additional amounts for administrative expenses for a state and will not collect additional amounts for reinsurance payments for a state.

For more information, please call us at (202) 624-2500.