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ANALYSIS OF THE TRANSITIONAL REINSURANCE PROGRAM AND IMPLICATIONS FOR EMPLOYER PLAN SPONSORS

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Earlier this year, the Department of Health and Human Services (“HHS”) 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 (PPACA). 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 such as 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. Also, a state can establish a reinsurance program even if it does not establish a health insurance exchange.

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 and to stabilize premiums 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. This is intended to reduce risk by partially offsetting risk for high cost enrollees.

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 became 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 (although states are not prohibited from continuing a reinsurance program after the end of such three-year period). With respect to self-insured plans administered by a third party administrator, neither the statute nor the Final Regulations provide absolute clarity with regard to whether the third party administrator or the plan is ultimately liable for the reinsurance contribution. However, as discussed below, it is our understanding that the plan itself is ultimately liable for the fee, but that the third party administrator is responsible for remitting the contribution to the responsible agency 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. It is our understanding that HHS’s current view, based on the above-referenced statutory language, is that the third party administrator is responsible for the act of *remitting* the reinsurance contribution, but that the self-funded plan itself is ultimately liable for the *amount* of the reinsurance contribution (and that the third party administrator can request reimbursement from the plan of the amount of the reinsurance contribution, whether directly or through additional administrative fees).

To the extent that third party administrators are liable for collecting and remitting the new fee, it should be expected that such administrators may seek to collect that fee over the course of each plan year in the form of an additional monthly (or other periodic) per capita charge rather than seeking to collect the fee from plan sponsors when the fee is otherwise due to the responsible agencies. Query to what extent third party administrators could be subject to penalties or otherwise held liable by the regulators for the actual fee amount in the event such administrators fail to collect and remit the fee to the responsible agency at the required time.

Comment: As noted above, with respect to self-funded plans, it is our understanding that liability for the new fee will generally belong to self-funded plan sponsors, but that the “third party administrator” will be responsible for collecting and remitting the fee “on behalf of” a self-funded plan. 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. This correlates with our understanding that HHS views the plan as ultimately liable for the amount of the reinsurance contribution.

COVERAGE GIVING RISE TO LIABILITY

The Final Regulations provide that issuers or administrators on behalf of self-insured group health plans (dubbed by the Final Regulations as “contributing entities”) must make reinsurance contributions on behalf of all group health plans and health insurance coverage they represent except those set forth in the Final Regulations. The only type of coverage expressly excluded in the Final Regulations is health coverage consisting solely of HIPAA-excepted benefits under Public Health Service Act (“PHSA”) section 2791(c).

Specifically, the types of coverage described in PHSA section 2791(c)(1) that are excluded from the application of the transitional reinsurance fee are the following:

- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers’ compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

The types of coverage described in PHSA section 2791(c)(2) that are excepted are the following, *provided such coverage is offered separately*:

- Limited scope dental or vision benefits;
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
- Such other similar, limited benefits as are specified in regulations.

Comment: The regulations under PHSA section 2791(c)(2) provide that benefits provided under a health flexible spending arrangement (as defined in Internal Revenue Code section 106(c)(2)) (“Health FSA”) are excepted benefits for this purpose only if they satisfy the following two requirements:

- (i) 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

(ii) 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). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the Health FSA is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the Health FSA).

Based on the foregoing, many employers' Health FSAs would qualify as HIPAA-excepted benefits and thus would not be subject to the transitional reinsurance fee.

The types of coverage described in PHSa section 2791(c)(3) that are excepted are the following, *provided such coverage is offered as independent, noncoordinated benefits*:

- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance.

The types of coverage described in PHSa section 2791(c)(4) that are excepted are the following, *provided such coverage is offered as a separate insurance policy*:

- Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of title 42), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

Comment: There is some overlap between the types of coverage excluded from the transitional reinsurance fee and the types of coverage excluded for purposes of the Patient-Centered Outcomes Research Institute ("PCORI") fee, as set forth in new Internal Revenue Code sections 4375 and 4376, and the new Form W-2 reporting requirements for applicable employer-sponsored plans, as set forth in Internal Revenue Code section 6051(a)(14). However, the exclusions are not identical, so careful attention is required as to the PPACA provisions that may apply to a particular type of coverage.

Per the preamble to the Final Regulations, contributing entities must make reinsurance contributions on behalf of plans in the Federal Employees Health Benefits Program, state and local government employee plans, and grandfathered health plans. The statute requires the contribution amount for an issuer to be based on the issuer's "fully insured commercial book of business for all major medical products." The preamble to the Final Regulations provides that "private" Medicare and Medicaid plans

and federal and certain state high-risk pools are exempt from making reinsurance contributions because they are not commercial books of business. We read the term “private” to mean that Medicare Advantage plans and Medicare Part D coverage (prescription drug coverage) do not give rise to fee liability. Significantly, subject to the discussion below regarding retiree-only coverage, it would appear to be the case that employer-sponsored prescription drug coverage for retirees would give rise to fee liability.

Interesting questions have arisen as to whether certain types of benefits, such as retiree-only coverage and wellness plans, are subject to the reinsurance contributions. Given the language in the Final Regulations, which states that only HIPAA-excepted benefits are not subject to the reinsurance contributions, it seems that all other types of coverage (including retiree-only coverage and wellness plans) would be subject to the reinsurance contribution to the extent they constitute group health plans and do not qualify as any of the HIPAA-excepted benefits listed above. Whether a type of coverage constitutes a group health plan generally would require a determination of whether such coverage provides benefits consisting of “medical care” within the meaning of Internal Revenue Code section 213. Additionally, with respect to insured coverage, consideration should be given as to whether such coverage is a commercial book of business, as described in the preceding paragraph. No guidance has been provided regarding when coverage is considered a commercial book of business.

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 will be used to determine fee liability.

The flat per capita amount referenced in the preceding paragraph will be applied to all “reinsurance contribution enrollees” of such contributing entities. A “reinsurance contribution enrollee” is defined to mean an individual covered by a plan for which reinsurance contributions must be made pursuant to the Final Regulations. For purposes of employer-sponsored plans, this appears to mean that a plan’s total reinsurance contribution is based on the number of enrollees covered under the plan for the relevant period, including non-employee beneficiaries such as spouses and dependents. In other words, the per capita fee does not apply solely to the employee participant, but it also applies to all other individuals covered under the plan.

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.

Comment: HHS has yet to confirm the amount of the per capita fee that will apply for each reinsurance contribution enrollee (which, as noted above, is defined to include each covered life under the plan, including spouses, dependents, and other beneficiaries, and is not limited to the employee participant in the context of employer-sponsored group health plans). *It is our understanding that some have estimated the fee could range from \$61 per reinsurance contribution enrollee to as high as \$105 per reinsurance contribution enrollee.* To the extent this is the case, the

transitional reinsurance fee will result in significantly greater fee liability on a plan-by-plan basis than the PCORI fee (defined above), which is limited to \$1 times the average number of covered lives in the first year of the PCORI fee, and \$2 times the average number of covered lives in later years of the PCORI fee. The relative cost of the transitional reinsurance fee is likely to be magnified to the extent that HHS fails to adopt certain rules proposed by the Department of the Treasury (“Treasury”) in connection with the PCORI fee intended to reduce the extent to which plan sponsors would be subject to PCORI fee liability for a given enrollee covered under multiple plans where such plans are all self-funded and share the same plan year (see below for further discussion).

Comment: Treasury recently issued proposed regulations regarding how the PCORI fee is determined based on a per capita basis. The proposed regulations provided a series of helpful methods that could be used to determine the number of covered lives in a plan, including a rule that allows employers to count a covered life only once for purposes of determining fee liability to the extent that all of the plans at issue (i) are self-funded, and (ii) share the same plan year, *e.g.*, they are all calendar year plans. Although these rules may be very helpful to certain plan sponsors of self-funded plans in reducing their PCORI fee liability, it is unclear the extent to which similar rules will apply for purposes of the transitional reinsurance fee. This is because the transitional reinsurance program is under the purview of HHS rather than Treasury, and, thus, it is unclear whether HHS will adopt similar rules.

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. (States that elect to collect contributions may set their own timeframes for collection, but, in the preamble to the Final Regulations, HHS encourages states to adopt timeframes similar to the one adopted by HHS to minimize the burden on issuers in multiple states.)

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.

PENALTIES FOR FAILURE TO PAY TRANSITIONAL REINSURANCE CONTRIBUTIONS

The transitional reinsurance fee was enacted as a stand-alone provision of the PPACA, and is not expressly included in the PHSA, despite the fact that HHS has authority to issue regulations with respect to the fee. Pursuant to PPACA section 1321, which indicates that the enforcement provisions of the PHSA will apply for purposes of the transitional reinsurance fee, it appears that the typical PHSA enforcement mechanisms and penalties will apply to a health insurance issuer or a group health plan that does not remit the required transitional reinsurance contributions to the state or HHS, as appropriate. In general, the maximum monetary penalty that may be imposed appears to be \$100 per day per affected individual. Exactly how this penalty will apply in the context of the transitional reinsurance fee (*e.g.*, whether a third party administrator on behalf of a self-insured group health plan will be liable, or how the number of "affected individuals" would be counted) remains unclear at present.

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