HHS ISSUES FINAL REGULATIONS ON REINSURANCE PROGRAM

Section 1341 of the Patient Protection Affordable Care Act (PPACA) requires that standards be implemented enabling states to establish and maintain a transitional reinsurance program. The purpose of the program is to help stabilize premiums for coverage in the individual health insurance market.

PPACA provides for three risk-spreading mechanisms to mitigate the potential impact of adverse selection and stabilize premiums: a risk corridor, a risk adjustment program and the transitional reinsurance program. Only the reinsurance program is discussed in this Alert as it is the program of particular interest to plan sponsors of group health plans.

BACKGROUND

Starting in 2014, due to insurance reform under PPACA, health coverage will be available to anyone, regardless of health status, either in the individual market or through the small group market. This unfettered availability will result in adverse selection, that is, the tendency for high-risk individuals to buy health insurance and low-risk individuals to defer purchase of health insurance resulting in an inability to attract healthy enrollees. Such adverse selection ultimately causes premiums to increase in any market, but especially in the individual and small group markets.

In order to stabilize these increasing premiums, especially in the first three years of operation of state insurance exchanges, 2014-2016, PPACA provides for the implementation of a transitional reinsurance program. Reinsurance is basically buying protection against the possibility that some rare set of circumstances (such as high claims cost) might produce losses that an insurer is unable to fund on its own. Thus, the reinsurance program under PPACA is designed to reduce the uncertainty of insurance risks in the individual market by making payments for high-cost claims.

The reinsurance program will be funded with payments to an “applicable reinsurance entity” from health insurance issuers and certain plan administrators on behalf of group health plans. Although the regulations provide for states to establish a reinsurance program, even if not establishing a health insurance exchange, states are not required to establish such a program. If a state chooses not to establish a reinsurance program, then the Department of Health and Human Services (HHS) will establish it for the state. The program is scheduled to run for a three-year period beginning January 1, 2014. However, a state is permitted to continue a reinsurance program after the end of the three-year period. The final regulations can be found at www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf.
AFFECTED PLANS AND EXCEPTIONS

Health insurance issuers and third-party administrators (TPAs) on behalf of group health plans are generally required to make contributions to the transitional reinsurance program. Currently, it is unclear whether the TPA or the actual plan is liable for the reinsurance contribution. It is presumed the plan is ultimately responsible for the fee, but that the TPA bears the responsibility for remitting the fee on behalf of the plan. Presumably, insurance issuers will have a way to pass this fee onto employers, and administrators of self-insured plans will more than likely seek reimbursement over the course of the plan year. Thus, the plan sponsor, i.e., generally the employer, should be prepared to fund this contribution, regardless of being fully insured or self-insured. It also appears that a self-insured plan that is self-administered will also be expected to cover this fee. Neither the statute nor the regulations provide exceptions for governmental or church plans that are self-insured.

Contributions to the reinsurance program are required for group health plans. Thus, plans that consist solely of excepted benefits as provided under section 2971(c) of the Public Health Service Act are expressly excluded from this fee. Specifically, the types of coverage that are excluded from application of the transitional reinsurance fee are the following:

- Limited-scope dental and vision plans, accident-only or disability-only plans, and on-site clinics. A dental or vision plan will be deemed to be excepted if provided under a separate policy, certificate, or contract of insurance or if participants may decline coverage and participants must pay an additional contribution to elect the coverage.
- Coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance provided coverage is offered as independent noncoordinated benefits
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability and automobile
- Workers’ Compensation
- Credit-only insurance
- Long-term care
- Health flexible spending accounts (FSA) that meet the definition of an excepted benefit. The fee will apply to a health FSA if (i) no other conventional group health plan coverage is offered in addition to the health FSA, and (ii) the health FSA is designed so that the maximum benefit potentially payable to any participant for a year could not exceed the greater of two times the participant’s salary reduction election or $500 plus the participant’s salary reduction election.
- Employee Assistance Programs, disease management or wellness program as long as the program does not provide for significant medical care or treatment.
- Medicare and Medicaid programs are exempt from the fee.

Whether retiree-only coverage and wellness plans are subject to the reinsurance contributions remains unclear. To the extent they constitute group health plans and do not qualify as any of the excepted benefits listed above, it seems these coverages would be subject to the contribution. Furthermore, as it relates to insured coverage, the regulations provide that contribution amounts are based on the issuer’s “fully insured commercial book of business”. However, guidance has not been provided as to exactly when coverage is considered a commercial book of business.
AMOUNT OF RESURANCE CONTRIBUTION

In order to fund the transitional reinsurance program, PPACA provides for aggregate contributions in the amount of $12 billion for plan years beginning in 2014, $8 billion for plan years beginning in 2015 and $5 billion for plan years beginning in 2016. This amount includes an aggregate amount of $5 billion which is to be collected for deposit into the U.S. Treasury as general revenue.

Reinsurance contributions will be based on a national per capita contribution rate to be determined by HHS for a benefit year (defined to be a calendar year). HHS will announce the contribution rate in an annual notice of benefit and payment parameters. The per capita contribution will be applied to all “reinsurance contribution enrollees” who are defined as individuals covered by a plan for which reinsurance contributions must be made pursuant to the final regulations. Since the regulations reference individuals covered by a plan, this apparently means that “reinsurance contribution enrollees” are employees, spouses and dependents and the fee will be applicable to all of these.

As this regulation recently became effective and fees are not due until January 2014, HHS has yet to communicate the amount of the per capita fee for each reinsurance contribution enrollee. However, it is estimated that the fee could range between $61-$105. This fee is much greater than the Comparative Effectiveness Research Fee (CER) recently discussed in Willis Alert, July 2012, “IRS Issues Proposed Regulations for Comparative Effectiveness Research Fees” ($1 per average covered life increasing to $2 per average covered life).

Additionally with the CER fee, plan sponsors were provided some relief with a rule that lets covered lives participating in multiple self-insured plans which have the same plan year as being only counted once for the purpose of the fee. However, the CER fee is regulated by the Treasury Department and Treasury provided this relief rule. The transitional reinsurance program is regulated by HHS and any such relief does not seem apparent at this time. Of course, further guidance from HHS is expected regarding this program.

HHS is responsible for allocating reinsurance payments to appropriate insurance issuers in a state, the U.S. Treasury, and to the state reinsurance program or HHS for administrative expenses of carrying out the transitional reinsurance program. Additionally, the regulations provide that states are permitted to collect more than the amounts specified by the statute and for a longer amount of time then the three year period provided in the statute, if these amounts are insufficient for covering transition reinsurance payments or administrative cost. (The regulations provide additional guidance for states choosing to collect additional funds such as notice, timing and recordkeeping requirements.)

TIMING

Regulations for the transitional reinsurance fee were effective as of May 22, 2012. Assessments for the fee will be in operation from 2014-2016. Contributions are expected to be collected on a quarterly basis beginning on January 15, 2104. Although states have the option of collecting the fee for the fully insured market, HHS retains responsibility for collecting the fee for self-insured plans. States that will be collecting contributions are permitted to set their own timeframe but are encouraged to adopt similar timeframes to those adopted by HHS.
RECORDKEEPING

Self-insured plans are required to maintain certain records relating to the fee. The transitional reinsurance program requires each self-insured plan to maintain a record of the state of residency of each participant and beneficiary that the plan covers. Thus, plans will need to prepare to gather this information during their 2013 open enrollment period.

PENALTIES

In general, the maximum monetary penalty that may be imposed appears to be $100 per day per affected individual. However, at this time, it is unclear how this penalty will apply as to the transitional reinsurance fee. Issues yet to be resolved include whether the TPA will be liable if the fee is not paid, as well as, how the number of “affected individuals” will be counted.

CONCLUSION

Recently published regulations for a transitional reinsurance program to assist in stabilizing premiums for the individual and small group market in 2014 caught many employee benefit professionals off-guard. The program is likely to result in additional costs for employer plan sponsors, possibly additional recordkeeping and for those who self-administer their plans, additional reporting obligations. Plan sponsors of both fully and self-insured plans need to begin to consider the additional costs the plan may incur (without knowing exact contribution requirements). Also, both types of plans will need to work with either their insurance carriers or TPAs to determine how residency information for all participants will be recorded and maintained.

As further guidance on the transitional reinsurance fee program is expected, Willis will continue to keep you apprised of any information as it develops.