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Employee Benefits | Life Insurance | Risk Management

TO: Clients of Sitzmann Morris & Lavis Insurance Agency

RE: Transitional Reinsurance Program Proposed Rules

On December 7th a proposed rule by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) is expected to be published in the Federal Register. The proposed rule addresses a number of provisions designed to stabilize premiums including: risk adjustment, reinsurance and risk corridors. It also addresses provisions designed to increase the number of individuals with health insurance including: cost-sharing reductions, advance payments of the premium tax credit, and insurance market reforms. This memo will focus on the transitional reinsurance program.

Background: The Affordable Care Act (ACA) directs a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. This program will shift some of the risk from the insurer to a reinsurer for insuring high-cost individuals, such as those with pre-existing conditions. HHS estimates that the reinsurance program will reduce premiums for individual insurance by 10-15%. Health insurers and third-party administrators on behalf of self-insured group health plans are required to make contributions. The first payment will be due in January 2015. Although insurers are required to make the payment on fully-insured policies, it is expected that the cost will be passed directly on to the plan in the rates beginning in 2014.

Key Provisions:

The proposed rules include the following changes to policies in the premium stabilization rule:

- Uniform reinsurance payment parameters to be used by all States;
- Established uniform reinsurance contribution collection and payment calendar;

- A one-time annual reinsurance contribution collection, instead of quarterly collections in a benefit year;
- Collection of reinsurance contributions by HHS under the national contribution rate from both health insurance issuers and self-insured group health plans;
- A limitation on the States' ability to change reinsurance payment parameters from those that HHS establishes in the annual HHS notice of benefit and payment parameters – a State may only propose supplemental reinsurance payment parameters if the State elects to collect additional funds for reinsurance payments or use additional State funds for reinsurance payments; and
- A limitation on States that seek additional reinsurance funds for administrative expenses, such that the State must have its applicable reinsurance entity collect those additional funds.

Contribution Amount: The HHS has established the per capita rate of $5.25 per month for benefit year 2014. This totals $63 per participant per year. The fee applies to all participants in group health plans providing major medical coverage, including dependents. The rate is determined using the total amounts required for the reinsurance pool, the U.S. Treasury and administrative costs for collecting the contributions and administering the reinsurance pool. This total is divided by the estimated number of enrollees in plans required to make payments. Since those costs decline in 2015 and 2016, the per capita rate is estimated to decrease to $42/yr and $26.25/yr respectively.

Major Medical Coverage: This fee only applies to" major medical coverage". This term is not defined in ACA. In these proposed rules HHS states major medical coverage is health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings, including inpatient, outpatient, and emergency room settings.

Coverage that is limited in scope (for example, dread disease coverage, hospital indemnity, stand-alone dental and vision) would not be major medical coverage. A health reimbursement arrangement (HRA) which is integrated with a group health plan is excluded, as are all health

savings accounts (HSAs) and health flexible spending arrangements (FSAs). Employee assistance plans, disease management programs and wellness programs do not constitute major medical coverage. When an individual has both Medicare and employer-provided group coverage, only when the group is primary is the coverage considered major medical. Group coverage for employees substantially all of whom work outside the U.S. (expatriate coverage) which is not written on a form filed and approved by a State would also be excluded.

Collection of Contributions: No later than November 15th of each benefit year (2014 – 2016), a contributing entity must submit to HHS an annual enrollment count of the average number of covered lives. Within 15 days of submission or by December 15th, whichever is later, HHS will notify each contributing entity of the amount to be paid. Payment must be remitted to HHS within 30 days after the date of the notification of contributions due. Health insurance issuers are responsible for making contributions for fully-insured plans. Third-party administrators (TPAs) are responsible for making contributions on behalf of self-insured group health plans. The sponsors of self-insured plans are still liable for the payment although they can utilize a TPA or administrative services only contractor to transfer the contributions on its behalf. A self-insured, self-administered plan would make its payment directly.

Counting Methods: HHS has proposed using the same methods permitted under the Comparative Effective Research (CER) fee provision, modified to allow for an annual count determined in the fourth quarter. The sponsor of a self-insured plan is allowed to use a different counting method for purposes of the reinsurance contribution from that used for purposes of the CER fee. Under each of these methods the number of covered lives will be determined based on the first nine months of the benefit year. The following methods can be used for self-insured group health plans:

Actual Count Method (insurers and self-insured plans): Calculate the sum of the lives covered for each day of the first nine months of the plan year and divide that sum by the number of days in those nine months.

Snapshot Count Method (insurers and self-insured plans): 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 three quarters of the benefit year. The dates used for the

second and third quarters must be within the same week of the quarter as the date used for the first quarter. Divide the total by the number of dates on which a count was made.

Snapshot Factor Method (self-insured plans): Add the total lives covered on any 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 three quarters of the benefit year, and divide that total by the number of dates on which a count was made. The number of lives is calculated by adding the number of participants with self-only coverage to the product of the number of participants with coverage other than self-only and a factor of 2.35. Self-only coverage + (other than self-only x 2.35) = total number of covered lives.

Form 5500 Method (insurers and self-insured plans): For a plan that offers self-only coverage and coverage other than self-only coverage, add the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500 for the last applicable plan year.

If an employer sponsors both self-insured and insured options, then only the actual count or snapshot count methods may be used.

Frequently Asked Questions: At the same time HHS released these proposed rules, the Internal Revenue Service published a set of FAQ. In it the IRS states that sponsors of self-insured plans can treat these reinsurance contributions as ordinary and necessary business expenses.

What's Next:

Plan sponsors may want to begin estimating the amount of reinsurance contributions that will be required. Comments on the proposed regulations are due 30 days after publication. We will provide you with more detail as it becomes available. As always, contact your SML Account team if you have any questions.