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Health Reform

Guidance Issued on the Reinsurance Fee

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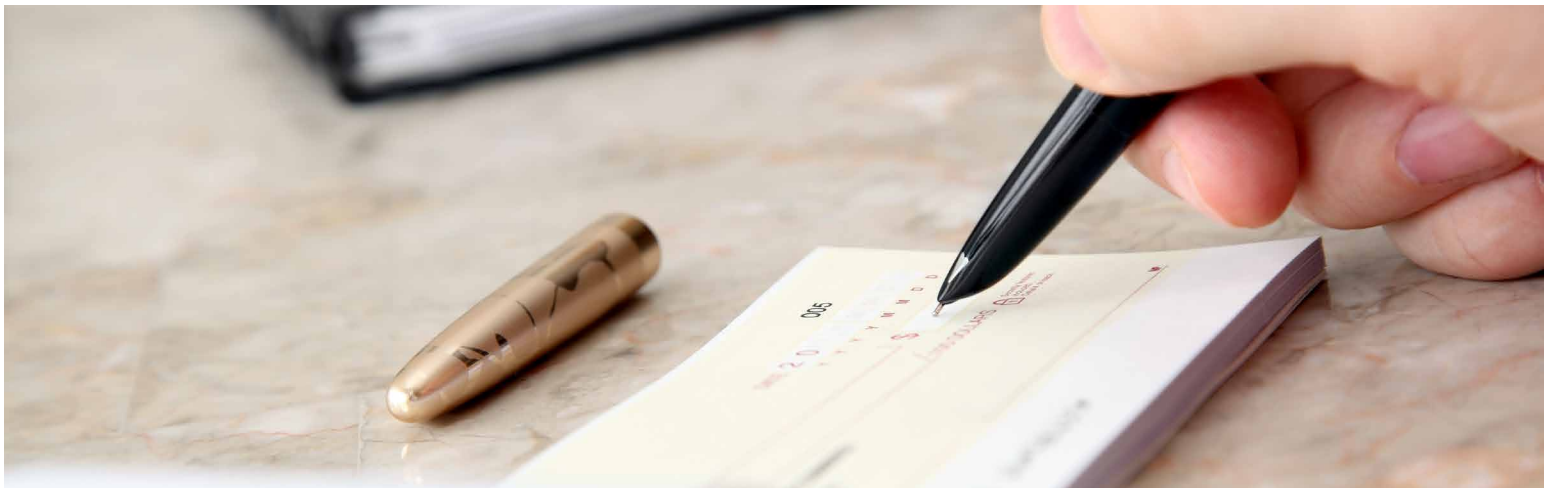

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The Department of Health and Human Services issued a proposed rule providing further detail on the transitional reinsurance program under the Affordable Care Act. It is important to note that this guidance is in proposed format and any final guidance may change from the proposed rule.

Reinsurance Fee

Under the ACA, insurance companies are required to accept all individuals who apply for coverage in the individual market beginning in 2014. The reform establishes a transitional reinsurance program in each state which is designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions. The program, effective from 2014 through 2016, will provide reinsurance payments in an efficient, fair and accurate manner, where they are needed most, to effectively stabilize premiums nationally. Over this three-year period, $25 billion will be collected, $20 billion of which will fund the reinsurance program, while the other $5 billion will be paid to the U.S. Treasury.

Amount of the Fee

For 2014, the proposed annual assessment is $63 per covered life ($5.25/covered life per month). The $25 billion contribution is significantly frontloaded and HHS is seeking comments on whether there can be a delay for part of the fees collected so the contribution rate can be lowered for 2014. In general, for group health plans, the fee is assessed on all lives covered by the plan, not just on the employee.

Who is Subject to the Fee?

The reinsurance fee must be paid by both insured and self-insured group health plans. “Contributing entities” must make the reinsurance contributions except to the extent that the plan or coverage is not major medical coverage, or for insured plans, the coverage is not considered to be part of the carrier’s commercial book of business or is not issued on a form filed and approved by a state insurance department. The guidance provides various exemptions from the reinsurance fee including:

- Limited scope plans and excepted benefits (e.g., dread-disease coverage, hospital indemnity coverage, and stand-alone dental and vision plans)
- HRAs that are integrated with a group health plan
- HSAs and health FSAs
- EAPs, disease management plans, and wellness programs that do not provide major medical coverage
- Stop-loss policies
- Tribal coverage when coverage is offered in the capacity of tribal members and not in the capacity as an employee or former employee (or their dependents).

The proposed rule also states that a group health plan will be considered major medical coverage, and therefore subject to the fee, only if the plan pays primary to Medicare. If a plan is secondary to Medicare with respect to an individual, that individual need not be counted as a covered life for purposes of calculating the reinsurance fee.

Payment of the Fee

The reinsurance assessment will be paid to HHS, even in states that set up their own reinsurance programs. HHS will distribute payments based on the needs of an applicable state. Therefore, the reinsurance funds collected in one state may go to reinsure risk in another state.

Health insurance carriers will pay the fee in the fully insured market. In an important clarification, the regulations state that, for self-insured plans, the plan sponsor is responsible for the fee, but collection may be facilitated through a third-party administrator (TPA).

Subject to various rules, plans will count covered lives using methods similar to counting lives for purposes of the comparative effectiveness research fee under the reform. This includes an actual cost method, a snap-shot method, and utilizing counts reflected on Form 5500, although contributors would not need to use the same counting method for both calculations. A special rule applies to prescription drug coverage. If enrollees have major medical coverage and separate prescription drug coverage, the reinsurance fee would only be required for the major medical coverage. Additionally, special rules may apply when dealing with multiple self-insured plans and combination insured/self-insured coverage that are subject to this requirement.

While states, upon appropriate notification to HHS, may collect additional reinsurance contributions for administrative expenses, in general, they may not collect additional fees from self-insured group health plans subject to ERISA.

Unlike earlier guidance that indicated the fee would be assessed quarterly, HHS proposes annual fee collection with plans reporting enrollment counts by November 15 to HHS and HHS then issuing a payment request to the carrier or plan no later than December 15. Plans will have 30 days from the date of the notice to submit payment.

Tax Implications of the Fee

A sponsor of a self-insured group health plan may treat the reinsurance fees as an ordinary and necessary business expense, subject to any applicable disallowances or limitations under the Internal Revenue Code. This treatment applies whether the contributions are made directly or through a TPA.