Employee Benefits & Executive Compensation ADVISORY

March 28, 2012

Health Care Reform Update: Final Regulations Impose Reinsurance "Contribution" on Fully Insured and Self-Insured Plans Starting in 2014

The Affordable Care Act (ACA) provides for a State-based transitional reinsurance program to help stabilize premiums for coverage in the individual health insurance market during the first three years of operation of the Exchanges (2014-2016). The program is designed primarily to transfer risk from the group market to the individual market. The program is funded through "contributions" from fully insured and self-insured plans. The statute sets forth the aggregate amount to be collected—$12 billion in 2014, $8 billion in 2015 and $5 billion in 2015. The aggregate amount is divided among plans subject to the fee as provided by the Department of Health and Human Services (HHS).

On March 16, 2012, HHS issued final regulations regarding the reinsurance program (the "Final Regulations").[1] Among other provisions, the Final Regulations provide that the contribution requirement will be imposed on a per capita basis based on the number of enrollees and that the contribution is payable to HHS by health insurance issuers and third-party administrators on behalf of self-insured plans (called "contributing entities" in the Final Regulations). The per capita amount, as well as other details relating to the program, will be set forth in future guidance that is scheduled to be issued by HHS no later than October of this year in the form of federal "benefit and payment parameters."

This advisory focuses on the contribution requirement, particularly as applied to self-insured group health plans.

Background—The Reinsurance Program

The transitional reinsurance program is one of three risk-spreading mechanisms that are provided under the ACA that together are designed to mitigate the potential impact of adverse selection and provide stability for health insurers that issue individual and small group health insurance policies. Adverse selection occurs when each new health insurance purchaser understands his or her own potential health risks better than health insurance issuers do, and health insurance issuers are therefore less able to accurately price their products. As described by the HHS, the reinsurance program is designed to reduce the uncertainty of insurance risk in the individual market by making payments to insurers for high-cost enrollees in the individual market. Theoretically, this will reduce individual market rate increases that might otherwise occur because of the immediate enrollment of individuals with unknown health status, potentially including those currently in State high-risk pools.

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1 The final regulations were published in 77 Fed Reg17220 (March 2, 2012) and may be found at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf.

Payments under the reinsurance program are funded by contributions payable by health insurance issuers and third-party administrators on behalf of self-insured group health plans. Under the statute, a total of $25 billion will be collected for the three-year period 2014-2016, $20 billion of which will be used to fund the reinsurance program and $5 billion of which will be paid into the general funds of the U.S. Treasury.[2] In addition to these statutory amounts, States may impose additional contribution requirements to fund administrative expenses associated with the reinsurance program and/or to provide for additional reinsurance payments.

Each State decides whether to establish a reinsurance program or whether to have HHS administer the reinsurance program for the State. If a State establishes a reinsurance program, the program must be operated through a reinsurance entity that meets certain requirements.

Application of the Contribution Requirement to Group Health Plans

Contribution amount

Under the Final Regulations, the contribution requirement will apply on a per capita basis with respect to each individual covered by a plan subject to the contribution requirement (such individuals are referred to in the Final Regulations as a "reinsurance contribution enrollee"). As noted above, the amount of the per capita contribution, as well as other details, will be set forth in future guidance to be issued by HHS in the form of "benefit and payment parameters." The HHS benefit and payment parameters are expected to be issued by October 2012.

Plans subject to the contribution requirement

The contribution requirement is imposed on health insurance issuers in the case of fully insured individual and group health plan coverage and on third-party administrators on behalf of self-insured plans, including governmental plans. The contribution requirement does not apply with respect to plans that provide coverage solely of "excepted benefits" as defined under HIPAA (e.g., coverage for a specified disease or stand-alone vision or dental coverage). The per capita requirement will impose an especially onerous administrative and financial burden on plans such as employee assistance programs (EAPs) and health reimbursement arrangements (HRAs) that do not qualify as excepted benefits if the program or arrangement does not currently keep track of covered dependents and/or provides limited reimbursement benefits. There is no exception to the contribution requirement for grandfathered plans.

Payment process and timing

In the case of self-insured plans, the third-party administrator is responsible for paying the contribution on behalf of the group health plan. When an insurer is acting as a third-party administrator under an ASO contract, the insurer should be responsible for payment of the contribution as a third-party administrator on behalf of the plan, not as an insurer.

The proposed regulations defined "third-party administrator" to mean the claims processing entity for a self-insured group health plan. The preamble to the proposed regulations provided that, if a self-insured group health plan processes its own claims, the self-insured plan will be considered a third-party administrator for

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2 During Congressional consideration of the ACA, the Congressional Budget Office (CBO) allocated the $5 billion payable to the U.S. Treasury as a revenue offset for the Early Retiree Reinsurance Program (ERRP) established under ACA. However, there is no direct link between the $5 billion and funding of the ERRP. Further information on the ERRP may be found at www.ERRP.gov.

purposes of the reinsurance program. The final regulations do not define the term "third-party administrator," leaving this to future guidance.

The final regulations provide that the required contribution is to be paid as follows:

- Contributions on behalf of self-insured plans are paid by the third-party administrator directly to HHS.
- If a State does not establish a reinsurance program (so that the reinsurance program is run by HHS), all contributions (including by insurers for fully insured plans) are paid directly to HHS.
- If a State establishes a reinsurance program, then the State determines how contributions with respect to fully insured plans will be collected—i.e., the State can provide that contributions with respect to fully insured plans will be paid by the insurer to the reinsurance entity that administers the State program or paid to HHS.
- Special rule for additional contributions: The final regulations authorize States to impose additional contributions in excess of those required under the statute either for administrative costs or for additional reinsurance payments. Additional contributions for administrative costs are paid either to HHS or to the applicable State reinsurance entity in the same manner as the contributions specified in the statute. If a State imposes additional contributions to fund additional reinsurance payments, such additional amounts (whether imposed on fully insured or self-insured plans) must be paid to the applicable State reinsurance entity (that is, HHS will not collect any additional contributions to fund additional reinsurance).

The Final Regulations provide that contributions payable to HHS must be paid on a quarterly basis beginning January 15, 2014. States have flexibility to determine the timing of contributions payable to applicable reinsurance entities. Insurers and third-party administrators are required to provide to HHS or to the applicable State reinsurance entity data required to substantiate the contribution amounts in the manner and timeframe specified by the State or HHS.

If contributions are paid to HHS, HHS is responsible for determining the proper amount to apply to reinsurance payments for a State, the amount to be transferred to the U.S. Treasury and the amount, if any, to be used by a State for administrative expenses of the reinsurance program. If contributions are paid to a State reinsurance entity, the reinsurance entity is responsible for making these determinations.

Enforcement of the contribution requirement

The proposed regulations provided that all contributions, including those on behalf of self-insured plans, would be paid to the applicable State reinsurance agency. The preamble to the Final Regulations indicates that the final rule requires payments on behalf of self-insured plans directly to HHS due to concerns regarding the States' lack of authority and oversight over self-insured plans. The Final Regulations do not address enforcement mechanisms that HHS may use with respect to self-insured plans. For example, it is not clear what action HHS may take regarding a third-party administrator that does not collect a contribution from a self-insured plan or a self-insured plan that does not pay the contribution to the third-party administrator for remitting to HHS.

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