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CLIENT BULLETIN

HHS Publishes Proposed Regulations on Reinsurance Fee Self-Insured, Self-Administered Health Plans Included

In *Benefit News Brief 2012-45* we reported on the *Premium Stabilization Rule* which implemented various standards for health insurance issuers and third party administrators of self-insured group health plans. Part of the *Premium Stabilization Rule* related to reinsurance fees that HHS will collect from health insurance issuers and from third party administers (TPAs) on behalf of their client *self-insured plans* from 2014-2016. The reinsurance fee would have to be paid by multiemployer group health plans, including ones that are self-insured and self-administered.

The Department of Health and Human Services (HHS) just released a proposed regulation modifying the *Premium Stabilization Rule* that clarifies several matters of interest to multiemployer insured and self-insured group health plans. The proposed regulation is available by "*clicking here*." A discussion of matters of interest to self-insured multiemployer plans is discussed below.

Are Self-Insured, Self-Administered Group Health Plans Required to Pay?

The first bit of news is that self-insured, self-administered group health plans would be liable to make reinsurance contributions. This includes *self-insured, self-administered* multiemployer health plans. The previous regulation left this unclear.

The *Preamble* to the proposed regulation states:

> Section 1341 of the Affordable Care Act provides that health insurance issuers and third party administrators on behalf of group health plans must make payments to an applicable reinsurance entity. Thus, with respect to insured coverage, issuers are liable for making reinsurance contributions. With respect to self-insured group health plans, the plan is liable, although a third-party administrator or administrative-services-only contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion. *A self-insured, self-administered group health plan without a third-party administrator or administrative-services-only contractor would make its reinsurance contributions directly. (emphasis added)*
> 77 FR 73118, 73152

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Who is Liable to Pay the Fee – The Plan or the Plan Sponsor?

Generally, for an insured plan, the health insurance issuer pays the fee. For a self-insured plan, the plan is liable for the reinsurance fee, not the plan sponsor. This means the plan itself can pay the expense from plan assets, unlike the "effectiveness fee" under the *Patient-Centered Outcomes Research Trust Fund* (PCORTF) *Rule*, which must be paid by the plan sponsor.

The *Preamble* to the proposed regulation notes this view that the plan can pay the fee is "sanctioned" by the DOL:

> The Department of Labor has reviewed this proposed rule and advised that paying required reinsurance contributions would constitute a permissible expense of the plan for purposes of Title I of the Employee Retirement Income Security Act (ERISA) because the payment is required by the plan under the Affordable Care Act as interpreted in this proposed rule. (See generally, Advisory Opinion 2001-01A to Mr. Carl Stoney, Jr., available at www.dol.gov/ebsa discussing settlor versus plan expenses.)
> 77 FR 73118, 77198, footnote 56

Estimate Of Reinsurance Contribution Rate

The *Preamble* also contains an estimate of the reinsurance fee cost per enrollee for 2014. The 2014 total to be collected is $12.02 billion. HHS estimates that this would place the contribution rate at **$5.25 per person per month ($63/year)** in benefit year 2014 and less in succeeding years.

Data Submission To HHS And Payment Of Reinsurance Fee

The proposed regulations also state that a contributing entity must submit an annual enrollment to HHS no later than November 15 of benefit year 2014, 2015, and 2016, as applicable. The annual enrollment count should be the average number of covered lives of reinsurance contribution enrollees for each benefit year.

Then, within 15 days of submission of the annual enrollment count or by December 15, whichever is later, HHS will notify each contributing entity of the reinsurance contribution amounts to be paid based on that annual enrollment count.

The contributing entity must remit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year.

Methods of Counting Covered Lives for Calculating Payment of Reinsurance Fee

There are three methods that a self-insured group health plan may use to determine the average number of covered lives for purposes of the annual enrollment count used to calculate the reinsurance fee. Although this is a different and separate fee than the effectiveness fee, the allowed methods mirror the methods permitted to sponsors of self-insured group health plans under the *PCORTF Rule*, modified slightly for timing, so that enrollment counts may be obtained on a more current basis.

The proposed rule clarifies that for individuals with both Medicare coverage and employer-provided group health coverage the reinsurance fee is owed only if the employer coverage is the primary payer of medical expenses under the Medicare Secondary Payer rules.

The three methods are the (1) *Actual Count Method or Snapshot Count Method;* (2) *Snapshot Factor Method;* and (3) *Form 5500 Method*:

(1) Actual Count Method or Snapshot Count Method:
The proposed regulation allows self-insured plans, like health insurance issuers, to use the actual count method or "snapshot" count method. Generally, under the "snapshot count method an issuer would add the totals of lives covered on a date 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.

(2) Snapshot Factor Method:
Under the PCORTF Rule, a plan sponsor generally may use the "*snapshot factor method*" by adding the totals of lives covered on any date during the same corresponding month in each quarter, and dividing that total by the number of dates on which a count was made, except that the number of lives covered on a date is calculated by adding the number of participants with self-only coverage on the date to the product of the number of participants with coverage other than self-only coverage on the date multiplied by 2.35.

(3) Form 5500 Method:
HHS proposes that, for purposes of reinsurance contributions, a self-insured group health plan may also rely upon such Form 5500 enrollment data, even though the data may reflect enrollment in a previous benefit year. (HHS' modeling of the 2014 health insurance marketplace suggests that enrollment in self-insured group health plans is less likely to fluctuate than enrollment in the individual market.)

Thus, a self-insured group plan may calculate the number of lives covered for a plan that offers only self-only coverage by adding the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500, and dividing by two.

Additionally, a self-insured group plan that offers self-only coverage and coverage other than self-only coverage may calculate the number of lives covered by adding the total participants covered at the beginning and the end of the benefit year, as reported on the Form 5500.

Other Major Changes to Premium Stabilization Rule

The *Preamble* sums up the other main changes the proposed regulation makes to the *Premium Stabilization Rule* as:

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

- 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;
- Limitation on States' ability to change reinsurance payment parameters from those that HHS establishes in the annual HHS notice of benefit and payment parameters; and
- Limitation on States that seek additional reinsurance funds for administrative expenses.

Details on the mechanics of how to pay the fee are not yet announced.

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Note: *Tax Treatment Of Reinsurance Fees*

The IRS has released two FAQs on the tax treatment of reinsurance fees at *http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs.* FAQ 2 addresses self-insured plans, including multiemployer plans:

> **Q2:** May a sponsor of a self-insured group health plan treat contributions under the Reinsurance Program as ordinary and necessary business expenses?
>
> **A2:** Yes. A sponsor of a self-insured group health plan that pays Reinsurance Program contributions may treat the contributions as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Code. This treatment applies whether the contributions are made directly or through a third-party administrator or administrative-services-only contractor. If a plan pays Reinsurance Program contributions directly or through a third-party administrator, as may happen, for example, in the case of a multiemployer plan or a plan funded through a voluntary employees' beneficiary association, the employer or employers contributing to the plan would be permitted to deduct their contributions to the plan, subject to any generally applicable disallowances or limitations.