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Reinsurance Fees—Exemption for Certain Self-insured Plans

The Affordable Care Act (ACA) creates a transitional reinsurance program to help stabilize premiums in the individual market for the first three years of Exchange operation (2014-2016) when individuals with higher-cost medical needs gain insurance coverage. The program imposes a fee on health insurance issuers and self-funded group health plans.

On March 11, 2014, HHS published its **2015 Notice of Benefit and Payment Parameters Final Rule**, which addresses key changes to the transitional reinsurance program for 2015. The final rule:

- Exempts certain self-insured, self-administered plans from the reinsurance fees for 2015 and 2016; and
- Modifies the collection deadlines for the fees to reduce the upfront burden to plans and issuers.

REINSURANCE FEES

Contributions to the reinsurance program are required for health plans (fully insured and self-insured) that provide major medical coverage. Certain types of plans are exempt from the requirement to pay reinsurance fees, such as health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) that are integrated with major medical coverage, health savings accounts (HSAs) and coverage that consists solely of excepted benefits under HIPAA (for example, limited-scope dental and vision plans).

For insured health plans, the issuer of the health insurance policy is required to pay the reinsurance fees. For self-insured health plans, the plan sponsor is liable for paying the reinsurance fees, although a third-party administrator (TPA) or administrative-services only (ASO) contractor may be used to make the fee payment at the plan's direction.

The reinsurance program's fees are based on a national contribution rate. The national contribution rate is calculated by dividing the sum of three statutory components (the reinsurance payment pool, the U.S. Treasury contribution and administrative costs) by the estimated number of enrollees in plans that must make reinsurance contributions.

For 2014, the national contribution rate is **$5.25 per month ($63 per year)**. For 2015, the contribution rate will be about **$3.67 per month ($44 per year)**. The reinsurance fee is calculated by multiplying the number of covered lives (employees and their dependents) during the benefit year for all of the entity's plans and coverage that must pay contributions, by the national contribution rate for the benefit year.

EXEMPTION FOR SELF-INSURED, SELF-ADMINISTERED GROUP HEALTH PLANS

In the 2015 Notice of Benefit and Payment Parameters Final Rule, HHS modified the definition of "contributing entity" for the 2015 and 2016 benefit years to **exempt certain self-insured, self-administered group health plans** from the reinsurance contribution requirement.

For 2015 and 2016, the term "contributing entity" excludes self-insured group health plans that do not use a third party administrator in connection with the core administrative functions of claims processing or adjudication (including the management of appeals) or plan enrollment.

The final rule clarifies that a self-insured plan will not lose self-administered status because it uses an unrelated third party to obtain provider network and related claim repricing services. Also, a self-insured plan will not lose self-administered status because it outsources:

- Core administrative functions (claims processing, claims adjudication and enrollment services) to an unrelated third party, such as a pharmacy benefits manager (PBM), provided that the underlying benefits are **pharmacy benefits or excepted benefits**; or
- A **small amount** (up to 5 percent) of core administrative services for benefits other than excepted benefits or pharmacy benefits to an unrelated third party. The five percent limit is measured based on either the number of transactions processed by the third party or the volume of claims processing and adjudication and plan enrollment services provided by the third party.

Thus, for the 2015 and 2016 benefit years, a "contributing entity" means a health insurance issuer or a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third party administrator in connection with claims processing or adjudication (including the management of appeals) or plan enrollment.

The modified definition of "contributing entity" will be effective only for the 2015 and 2016 benefit years. To avoid disruption for plans and issuers, the final rule does not change the definition of a "contributing entity" for the 2014 benefit year. For 2014, a contributing entity means:

- A health insurance issuer; or
- A self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage), **regardless of whether the plan uses a third party administrator**.

CHANGES TO THE FEE COLLECTION SCHEDULE

HHS acknowledged that the process for reinsurance collections outlined in the 2013 final rule would result in substantial upfront payments from contributing entities for the reinsurance program. Therefore, the 2015 Notice of Benefit and Payment Parameters Final Rule modifies the collection schedule for the program so that reinsurance contributions will be made in two installments—one at the beginning of the calendar year following the applicable benefit year, and one at the end of that calendar year.

For example, the $63 per capita reinsurance contribution for 2014 would be collected in two installments: $52.50 in January 2015 and $10.50 late in the fourth quarter of 2015.

The reinsurance contribution amounts for reinsurance payments and for administrative expenses would be collected earlier in the calendar year and the reinsurance contribution amounts for payments to the U.S. Treasury would be collected in the last quarter of the calendar year.

For the 2015 benefit year, the final rule requires the $44 annual per capita contribution rate to be allocated as follows:

- $33 towards reinsurance payments and administrative expenses, payable in January 2016; and
- $11 towards payments to the U.S. Treasury, payable late in the fourth quarter of 2016.

According to HHS, the two-installment payment policy is designed to alleviate the upfront burden of the reinsurance contribution, allowing contributing entities additional time to make the payment.

The change in the collection schedule will not affect the amount of funds collected for reinsurance payments. In addition, the contributing entity will be required to submit an annual enrollment count only once for each benefit year, by Nov. 15 of the benefit year.

For the first installment, if the enrollment count is submitted by Nov. 15 of the benefit year, HHS will notify a contributing entity in December of the benefit year of the reinsurance contribution amount allocated to reinsurance

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payments and administrative expenses to be paid for the applicable benefit year. The contributing entity must remit this amount within 30 days after the date of the first notification.

For the second installment, in the fourth quarter of the calendar year following the applicable benefit year, HHS will notify the contributing entity of the portion of the reinsurance contribution amount allocated for payments to the U.S. Treasury for the applicable benefit year. A contributing entity must remit this amount within 30 days after the date of this second notification.

MORE INFORMATION

Contact Clarke & Company Benefits, LLC for more information on the ACA's reinsurance fees.

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