COBBS ALLEN

legal alert

Reinsurance Fees

The Affordable Care Act (ACA) established three risk-spreading programs to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk carried by issuers:

- A transitional reinsurance program;
- A temporary risk corridor program; and
- A permanent risk adjustment program.

The **transitional reinsurance program** is intended to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014, 2015 and 2016) when individuals with higher-cost medical needs gain coverage. This program **imposes a fee on health insurance issuers and self-insured group health plans**.

LINKS AND RESOURCES

- The Department of Health and Human Services (HHS) issued two separate final rules implementing the ACA's standards for reinsurance, risk corridors and risk adjustment programs, on March 23, 2012, and March 11, 2013.
- HHS' 2015 Notice of Benefit and Payment Parameters (NBPP) contained the 2015 reinsurance contribution rate, included an exception for certain self-insured plans and implemented a two-installment collection schedule.
- HHS' 2016 NBPP updates the reinsurance program for 2016.

HIGHLIGHTS

Contributing Entities

The ACA requires "contributing entities" to pay reinsurance fees. Contributing entities include:

- Health insurance issuers; and
- Self-insured group health plan sponsors.

Certain self-insured, self-administered group health plans are exempt.

Amount of the FEe

Reinsurance fees are based on a national contribution rate announced by HHS annually. The annual contribution rate is:

- $63 per enrollee per year ($5.25 per month) for 2014;
- $44 per enrollee per year (about $3.67 per month) for 2015; and
- $27 per enrollee per year ($2.25 per month) for 2016.

WHO MUST PAY THE FEES?

The ACA requires "contributing entities" to pay fees to support the reinsurance program. A contributing entity is defined as a health insurance issuer or a self-insured group health plan sponsor. As described below, certain types of coverage are excluded from paying fees to the reinsurance program.

- ***Fully-insured Group Health Plans***: For insured health plans, the **issuer of the health insurance policy** is required to pay reinsurance fees. Although sponsors of fully-insured plans are not responsible for paying the reinsurance fees, issuers will likely shift the cost of the fees to sponsors through premium increases.
- ***Self-insured Group Health Plans***: For self-insured plans, the **plan sponsor** is liable for paying reinsurance fees, although a third-party administrator (TPA) or administrative-services-only (ASO) contractor may pay the fee at the plan's direction. For a plan maintained by a single employer, the employer is the plan sponsor. The Department of Labor (DOL) has advised that **paying reinsurance fees constitutes a permissible expense of the plan under ERISA** because the payment is required by the plan under the ACA.

According to an FAQ issued by HHS, a third party (such as a TPA, ASO contractor, broker, agent or attorney) may submit reinsurance contributions on behalf of a contributing entity. However, the responsibility to make reinsurance contributions remains with the contributing entity, and the decision to delegate the reinsurance contribution submission function resides with the contributing entity. HHS does not regulate who may submit the reinsurance contributions on behalf of the contributing entity.

Exception for Self-insured, Self-administered Group Health Plans

In the 2015 NBPP, HHS modified the definition of "contributing entity" for the 2015 and 2016 benefit years to **exempt certain self-insured, self-administered group health plans**.

> For 2015 and 2016, the term "contributing entity" excludes self-insured group health plans that do not use a TPA 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 5 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 partially self-insured/partially insured group health plan, where the health insurance coverage does not constitute major medical coverage) that uses a TPA in connection with claims processing or adjudication (including appeals management) or plan enrollment.

The modified definition of "contributing entity" is effective only for the 2015 and 2016 benefit years. To avoid disruption for plans and issuers, the final rule did not change the definition of a "contributing entity" for the 2014 benefit year. Thus, for 2014, a contributing entity was:

1. A health insurance issuer; or
2. A self-insured group health plan (including a partially self-insured/partially insured group health plan, where the health insurance coverage does not constitute major medical coverage), **regardless of whether the plan uses a TPA**.

WHAT TYPES OF COVERAGE ARE EXCLUDED?

Reinsurance contributions are only required for plans that provide **major medical coverage**. Health flexible spending account (FSA) coverage is not major medical coverage due to the ACA's $2,500 annual limit on salary deferrals to a health FSA.

Also, coverage that consists solely of excepted benefits under HIPAA is not subject to the reinsurance program (such as stand-alone dental and vision plans, accident-only coverage, disability income coverage, liability insurance, workers' compensation coverage, credit-only insurance or coverage for on-site medical clinics). Thus, issuers and plan sponsors will not be required to pay fees for these plans.

The following plans and coverage are also excluded from reinsurance fees:

- Health reimbursement arrangements (HRAs) that are integrated with major medical coverage (although reinsurance fees will be required for the group health plan providing major medical coverage);
- Health savings accounts (HSAs) (although reinsurance fees will be required for an employer-sponsored high-deductible health plan);
- Health FSAs;
- Employee assistance plans, wellness programs and disease management plans that provide ancillary benefits and not major medical coverage;
- Expatriate insured health coverage (that is, plans that limit enrollment to participants who reside outside of their home country for at least six months of the plan year and any covered dependents);
- Coverage that consists solely of benefits for prescription drugs; and
- Stop-loss and indemnity reinsurance policies.

There is an additional exemption for self-insured expatriate plans, beginning for the 2015 benefit year.

Also, fees are only required for individuals with Medicare coverage when the employer-provided group health coverage is the primary payer and Medicare is the secondary payer. If the group health plan is the secondary payer, individuals with Medicare coverage will not be counted for the reinsurance fees. For example, a 68-year-old retiree enrolled in a group health plan who, under the Medicare Secondary Payer rules, is a beneficiary for whom Medicare is the primary payer will not be counted for purposes of reinsurance contributions.

HOW MUCH ARE THE FEES?

The reinsurance program's fees are based on a national contribution rate, which HHS announces annually. 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 annual contribution rate was **$63 per enrollee** per year, or $5.25 per month.
For 2015, the annual contribution rate is **$44 per enrollee** per year, about $3.67 per month.
For 2016, the annual contribution rate is **$27 per enrollee** per year, or $2.25 per month.

States operating reinsurance programs may collect additional contributions on top of the federal contribution rate to cover administrative expenses or additional reinsurance payments. However, neither the ACA nor the regulations give a state the authority to collect additional contributions from self-insured plans covered by ERISA.

An issuer's or plan sponsor's reinsurance fee will be calculated by multiplying: (1) 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 (2) the national contribution rate for the benefit year. Thus, the annual contribution in 2014 for a group health plan with 150 covered lives would be $9,450 per year (150 x $63 = $9,450).

Contributing entities will use one of the following counting methods to calculate the number of covered lives of reinsurance contribution enrollees for a benefit year:

1	**The Actual Count Method**
2	**The Snapshot Count Method**
3	**The Snapshot Factor Method**
4	**The Member Months or State Form Method**
5	**The Form 5500 Method**

The permitted counting method depends on whether the contributing entity is a health insurance issuer or a self-insured group health plan, and whether, in the case of a group health plan that is a contributing entity, the plan offers more than one coverage option. The following table shows the specific counting methods available for health insurance issuers and self-insured group health plans:

COUNTING METHOD	HEALTH INSURANCE ISSUERS	SELF-INSURED GROUP HEALTH PLANS
Actual Count	✓	✓
Snapshot Count	✓	✓
Snapshot Factor		✓
Member Months or State Form	✓	
Form 5500		✓

Individuals who are receiving **continuation coverage** (such as COBRA coverage) are included in the number of covered lives under the plan. HHS' Center for Medicare & Medicaid Services (CMS) has provided more information on these counting methods, including a presentation and examples. Visit the CMS website for more information.

Actual Count Method

The actual count method may be used by **all contributing entities**. This method involves:

1. Adding the total number of lives covered for the first nine months of the benefit year; and
2. Dividing that total by the number of days in those nine months.

Example: An issuer adds the number of covered lives of reinsurance contribution enrollees for each day of the month for the first nine months of the benefit year (that is, the sum of lives covered for each day of the month for the first nine months of the benefit year). For this issuer, that amount equals 8,195,000 covered lives over the nine months. There are 274 days in the first nine months of the 2016 benefit year. The issuer then divides 8,195,000 covered lives by 275 days to obtain 29,908.75, which is the total number of covered lives of reinsurance contribution enrollees for the 2016 benefit year.

Snapshot Count Method

The snapshot count method may be used by **all contributing entities**. This method involves:

1. Adding the total number of 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 (for example, March, June and September) of the benefit year; and
2. Dividing the total by the number of dates on which a count was made.

The same months must be used for each quarter, and the date used for the second and third quarter must fall within the same week of the quarter as the corresponding date used for the first quarter. According to FAQ 6436, the contributing entity may use last day of each month, regardless of the actual week that the day falls in.

Example: An issuer elects to count the number of covered lives on March 1, 2016, June 1, 2016, and Sept. 1, 2016. The issuer has the following covered lives on each date: 1,600 covered lives on March 1, 2016; 1,650 covered lives on June 1, 2016; and 1,650 covered lives on Sept. 1, 2016. The issuer adds the lives for each date, which equals 4,900. The issuer then divides 4,900 by 3 (the number of dates on which a count was made). Therefore, using the Snapshot Count Method, the issuer's number of covered lives of reinsurance contribution enrollees for the 2016 benefit year equals 1,633.33.

Snapshot Factor Method

The snapshot factor method may only be used by self-insured group health plans and multiple group health plans maintained by the same plan sponsor that do not include an insured plan. Like the snapshot count method, this method involves:

1. Adding the total number of covered lives of reinsurance contribution enrollees 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
2. Dividing that total by the number of dates on which a count was made.

The same months must be used for each quarter (for example, March, June and September), and the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter. Contributing entities may use last day of each month, regardless of the actual week that the day falls in.

Under this method, the number of lives covered on a date is calculated by adding:

1. The number of participants with self-only coverage on the date; and
2. The product of the number of participants with coverage other than self-only coverage on the date and a factor of 2.35.

In the 2013 Instructions for Form 5500, the DOL clarified that, for this purpose:

- A "participant" does not include covered dependents.
- A self-only policy is major medical coverage offered by a self-insured group health plan that only covers an individual (for example, a participant) but not his or her spouse, dependents or family members.
- An other-than-self-only policy is major medical coverage offered by a self-insured group health plan for an individual (for example, a participant) plus one or more family members.

Example: A self-insured group health plan that elects to use the Snapshot Factor Method counts the number of covered lives of reinsurance contribution enrollees on March 1, 2016, June 1, 2016, and Sept. 1, 2016. The group health plan has the following coverage options that provide major medical coverage in place on each date: 1,000 self-only participants and 800 other than self-only participants on March 1, 2016; 1,100 self-only participants and 895 other than self-only participants on June 1, 2016; and 1,175 self-only participants and 950 other than self-only participants on Sept. 1, 2016.

The group health plan adds the lives for each date, which equals 3,275 participants with self-only coverage and 2,645 participants with other-than-self-only coverage. The group health plan then applies the constant multiplier of 2.35 to the 2,645 participants with other-than-self-only coverage, resulting in 6,215.75 covered lives through other-than-self-only coverage across the dates for the three quarters. Next, the group health plan adds the 3,275 covered lives with self-only coverage and 6,215.75 covered lives with other-than-self-only coverage, resulting in 9,490.75 covered lives across the dates for the three quarters. Then, the group health plan divides 9,490.75 covered lives by 3 (the number of dates on which a count was made), resulting in 3,163.58 covered lives of reinsurance contribution enrollees for the 2016 benefit year.

Member Months or State Form Method

The member months or state form method may only be used by **a health insurance issuer**. This method involves multiplying the average number of policies in effect for the first nine months of the benefit year by the ratio of covered lives per policy in effect, calculated using the prior year's National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit. Issuers that are not required to file an Exhibit may use data from equivalent state insurance filings for the most recent time period.

Example: An issuer has 39,550 policies from their previous year's NAIC Supplemental Health Care Exhibit Part 1 and 98,875 covered lives. In Step 1, the issuer calculates the average number of policies in effect for the first nine months—January through September—of the applicable benefit year. The issuer adds each month's number of policies, resulting in 42,750 policies, and divides by 9. The average number of policies in this example is 4,750. In Step 2, the issuer divides the 98,875 number of covered lives by the 39,550 number of policies, resulting in a ratio of 2.5. In Step 3, the issuer multiplies the 4,750 average number of policies (from Step 1) by the 2.5 ratio of covered lives per policy (from Step 2). The result is 11,875 covered lives of reinsurance contribution enrollees for the 2016 benefit year.

Form 5500 Method

The Form 5500 method may only be used by **self-insured group health plans**. This method requires self-insured group health plan to use the number of covered lives of reinsurance contribution enrollees for the most current plan year, calculated based on the "Annual Return/Report of Employee Benefit Plan" filed with the DOL (**Form 5500**) for the last applicable time period. The IRS understands that, for the 2015 benefit year, self-insured group health plans would use the Form 5500 for 2014 in light of the Form 5500 reporting deadlines.

For purposes of this counting method:

- The number of lives covered for the plan year for a plan offering **only self-only coverage** equals the sum of the total participants covered at the beginning and end of the plan year (as reported on Lines 5 and 6(d) of the Form 5500), divided by 2.
- The number of lives covered for the plan year for a plan offering **self-only coverage and other-than-self-only coverage** equals the sum of the total participants covered at the beginning and the end of the plan year, as reported on Lines 5 and 6(d) of the Form 5500.

In the 2015 NBPP, HHS clarifies the Form 5500 counting method by changing the references from "benefit year" to "plan year" to clarify that a self-insured group health plan may use the enrollment set forth in the Form 5500 even if the group health plan is based on a plan year other than the benefit year (defined as a calendar year for which a health plan provides coverage for health benefits).

In FAQ 6444, CMS clarified that a plan may use the number of lives covered for the most current plan year calculated based upon **the Form 5500 filed for the last applicable time period**. Therefore, if the most current plan year calculated based upon the Form 5500 filed for the last applicable time period represents a period of time during the 2013 calendar year, the plan may use this period in determining the plan's annual enrollment count for the 2014 benefit year for the purpose of reinsurance contributions. For example, a plan that files the 2013 Form 5500 by Oct. 15, 2014, may use those enrollment counts for the **Form 5500 Counting Method** for reinsurance purposes.

*Example for a plan offering **only** self-only coverage*: A group health plan will sum the total participants covered at the beginning and end of the plan year, which is 13,000 (as reported on the Form 5500). The group health plan will divide the 13,000 participants by 2. Therefore, if the plan (as reported on its Form 5500) covers 5,000 participants on Aug. 1, 2015, and 8,000 participants on July 30, 2016, for reinsurance purposes, the result is 6,500 (average) total covered lives of reinsurance contribution enrollees for the 2016 benefit year.

*Example for a plan offering **self-only coverage and other than self-only coverage***: The group health plan will sum the total participants covered at the beginning and the end of the plan year, as reported on the Form 5500. Therefore, if the plan offering both self-only coverage and other than self-only coverage (as reported on its Form 5500) covers 6,000 participants on Aug. 1, 2015, and 9,000 participants on July 30, 2016, for reinsurance purposes, the result is 15,000 total covered lives of reinsurance contribution enrollees for the 2016 benefit year.

HOW WILL THE FEES BE DETERMINED AND COLLECTED?

HHS will collect the reinsurance fees from issuers and plan sponsors in all states, including states that elect to operate their own reinsurance programs. These HHS collections will be made based on a national, uniform calendar. If a state imposes an additional contribution on top of the federal contribution rate, issuers would be required to make those payments in a manner specified by the state.

Two-installment Collection Schedule

Reinsurance fees may be paid 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. According to HHS, this two-installment policy is designed to alleviate the upfront burden of the reinsurance contribution, allowing contributing entities additional time to make the payment. However, **contributing entities may choose to make the full payment at one time**. The reinsurance contributions submission process on Pay.gov has flexibility to allow a combined or two-part payment schedule. FAQ 6441 describes the submission process for each type of payment.

Under the two-installment collection schedule, the reinsurance contribution amounts for **reinsurance payments and for administrative expenses** will be collected earlier in the calendar year following the applicable benefit year, while the reinsurance contribution amounts for **payments to the U.S. Treasury** will be collected in the last quarter of the calendar year following the applicable benefit year. This two-installment schedule is as follows:

- *First installment*—A contributing entity generally must submit its contribution form and supporting documentation to HHS by November 15 of each benefit year, via www.pay.gov.

  HHS requests that the contributing entity schedule its contribution payment date for 30 days after it submits this information—but before the regulatory deadline—to allow time for validation and correction, if necessary.

- *Second installment*—Covered entities that use the two-installment collection schedule must duplicate the contribution form and submit the same supporting documentation to schedule the second payment date.

The annual per capita contribution rate is allocated as follows:

2014 BENEFIT YEAR	2015 BENEFIT YEAR	2016 BENEFIT YEAR
The $63 annual per capita contribution rate was allocated: • $52.50 towards reinsurance payments and administrative expenses (payable by **Jan. 15, 2015**); and • $10.50 towards payments to the U.S. Treasury, (payable by **Nov. 15, 2015**).	The $44 annual per capita contribution rate was allocated: • $33 towards reinsurance payments and administrative expenses (payable by **Jan. 15, 2016**); and • $11 towards payments to the U.S. Treasury, (payable by **Nov. 15, 2016**).	The $27 annual per capita contribution rate is allocated: • $21.60 towards reinsurance payments and administrative expenses (payable by **Jan. 17, 2017**); and • $5.40 towards payments to the U.S. Treasury (payable by **Nov. 15, 2017**).

Key deadlines for the **2016 benefit year** are as follows:

TO MAKE A TWO-PART CONTRIBUTION (FIRST AND SECOND COLLECTION):		
DATE	**ACTIVITY**	**CONTRIBUTION AMOUNT**
No later than Nov. 15, 2016	Submit the contribution form and **schedule payment** of the first collection, then duplicate the form ***and*** **schedule payment** of the second collection	
No later than Jan. 17, 2017	Remit first contribution amount	$21.60 per covered life
No later than Nov. 15, 2017	Remit second contribution amount	$5.40 per covered life
	Total:	**$27.00 per covered life**

Optional Combined Collection

According to HHS, contributing entities may elect to make a **combined collection** (first installment plus second installment), instead of using the two-installment collection schedule. If an issuer or plan sponsor chooses to make a combined collection for the 2016 benefit year, the deadline to submit the contribution is Jan. 17, 2017. Key deadlines for the **2016 benefit year** are as follows:

TO MAKE A FULL CONTRIBUTION IN ONE PAYMENT (COMBINED COLLECTION):		
DATE	**ACTIVITY**	**CONTRIBUTION AMOUNT**
No later than Nov. 15, 2016	Submit the contribution form and **schedule payment**	
No later than Jan. 17, 2017	Pay full contribution amount	$27 per covered life
	Total:	**$27.00 per covered life**

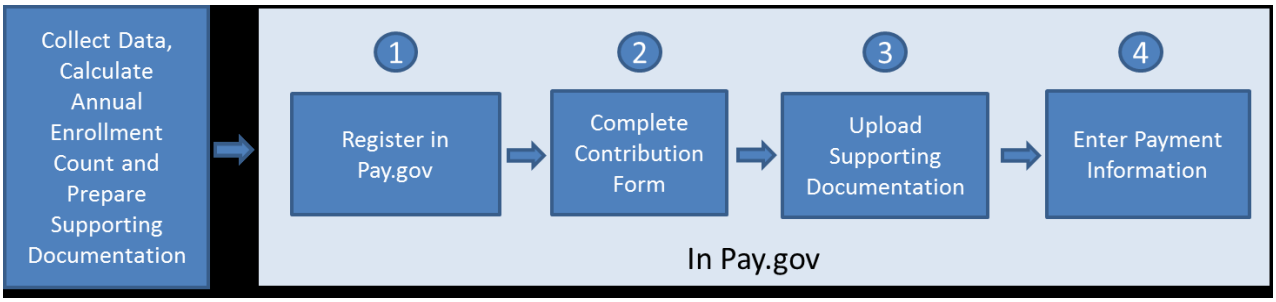
Collection Process

HHS provided general information about the collection process for reinsurance contributions in an FAQ issued on May 22, 2014. Under this process, a contributing entity (or a TPA on behalf of a contributing entity) can complete all the required steps (registration, submission of annual enrollment count and remittance of contributions) on www.pay.gov. CMS noted in FAQ 3338 that **an Automated Clearing House (ACH) process via Pay.gov is the only vehicle accepted for reinsurance contributions payment**. Contributing entities will use the ACA Transitional Reinsurance Annual Enrollment Contributions Submissions Form to submit their annual enrollment counts and schedule payment.

There is a specific contribution form for each benefit year, issued via www.pay.gov.

- The 2014 contribution form became available on Oct. 24, 2014.
- The 2015 contribution form became available on Oct. 1, 2015.
- As CMS announced on Sept. 19, 2016, the 2016 contribution form became available on Oct. 3, 2016.

On this contribution form, a contributing entity (or a TPA on its behalf) will provide basic company and contact information and the annual enrollment count for the applicable benefit year. The form will auto-calculate the contribution amounts. To complete the submission, entities will also submit payment information and schedule a payment date for remittance of the contributions. A contributing entity will complete all of the following steps in www.pay.gov:



HHS offers training on the pay.gov collection process. To receive notices from HHS regarding upcoming trainings and to review training resources, register on www.regtap.info.

CMS has also released the following guidance and educational materials:

- An **Annual Enrollment and Contributions Submission Form Manual** (for 2014, 2015 and 2016), which provides step-by-step instructions for completing and submitting the contribution form and supporting documentation, details on key elements and business concepts, and resources to further assist the contributing entity; and
- A **Supporting Documentation Job Aid Manual** (for 2014, 2015 and 2016), as well as a list of data fields required to be submitted with the supporting documentation, to help contributing entities create the supporting documentation that must be submitted with the contribution form.

According to FAQ 6447, the required supporting documentation must include information on each contributing entity and the annual enrollment count that is represented in the "Gross Annual Enrollment Count" entered in the Pay.gov form. Member level information is not required in the supporting documentation, which means that issuers do not need to list every individual enrollee.

Corrections or Supplemental Filing

On Nov. 13, 2014, CMS posted an alert message on Pay.gov providing instructions for correction or supplemental filing for the transitional reinsurance report and payment. In general, if the contribution payment has not been processed, misreporting can be corrected by simply refiling through Pay.gov. If the contribution payment has already been processed, the contributing entity must generally refile the form with the correct annual enrollment count, and will be refunded the payment associated with the erroneous filing.

- Reporting entities that **need to submit a second contribution** must log into Pay.gov, go to "View My Forms" and duplicate their previous submission (make sure "2nd Contribution" is selected).

- Reporting entities that **need to correct their Supporting Documentation attachment** should refer to the Job Aid Manual and Job Aid Spreadsheet.
- Reporting entities that **need to cancel a payment** must log in to Pay.gov and go to Payment Activity. The transaction should show up under "Pending Payments." If a "Cancel" button is shown, the payment may be canceled. If no "Cancel" button is available, the reporting entity will need to contact CMS at 877-292-6978 or reinsurancecontributions@cms.hhs.gov.

ARE THE FEES DEDUCTIBLE?

The IRS issued a set of FAQs to address the tax treatment of the ACA's reinsurance fees. Taxpayers generally may deduct ordinary and necessary business expenses, including most fees and taxes paid to the government. However, under the rules of the Internal Revenue Code (Code), deductions for ordinary and necessary business expenses may be disallowed, limited or deferred in some circumstances. According to the FAQs, a sponsor of a self-insured group health plan that pays reinsurance fees may treat the fees as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Code. This tax treatment applies whether the contributions are made directly by the plan sponsor or through a TPA or ASO contractor.

PENALTIES

On Aug. 7, 2014, CMS issued FAQ 3341 to address penalties for failing to pay reinsurance contributions on time. According to this FAQ, any amount owed to the federal government by an issuer and its affiliates for reinsurance is a determination of a debt and will be subject to federal debt collection rules. Additionally, reinsurance contributions are considered federal funds that would be subject to the False Claims Act.