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FIDUCIARY MATTERS

The Transitional Reinsurance Program Plan Sponsors: Time to pay more!

The Affordable Care Act (ACA) establishes three premium stabilization programs to transfer payments to and among health insurance issuers that cover individuals with higher health risks, to even out the underwriting risks of health insurance issuers and to provide greater payment stability as insurance market reforms are implemented.

1. The transitional "reinsurance program" intends to reduce the uncertainty of insurance risk in the individual market by partially offsetting the risk of high-cost enrollees.
2. The transitional "risk corridors program" intends to manage and soothe rate uncertainty for Qualified Health Plans (QHPs) by limiting the amount of issuer losses and gains.
3. The permanent "risk adjustment program" intends to transfer payments from health insurance issuers with low risk populations to issuers that attract higher-risk populations, such as those with chronic conditions.

The three programs are summarized as follows in the July 15, 2011, Department of Health and Human Services ("HHS") proposed rule on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment[1] as follows:

Program:	**Reinsurance**	**Risk Corridors**	**Risk Adjustment**
What:	Provides funding to plans that enroll highest cost individuals	Limit issuer loss (and gains)	Transfers funds from lowest risk plans to highest risk plans.
Program Oversight:	State or State Option if no State-Run Exchange.	HHS	State option to operate if the State establishes an Exchange.
Who Participates (Contributing Entities):	All issuers and TPAs on behalf of group health plans contribute funding; non-grandfathered individual market plans (inside and outside the Exchange) are eligible for payments.	Qualified Health Plans (QHPs)	Non-grandfathered individual and small group market plans, inside and outside the Exchange
When:	Throughout the year	After reinsurance and risk adjustment	Before June 30th of the year following the benefit year
Why:	Offsets high cost outliers	Protect against inaccurate rate-setting	Protects against adverse selection.
Time Frame:	3 years (2014–2016)	3 years (2014–2016)	Permanent

[1] http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf

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The Transitional Reinsurance Program
Plan Sponsors: Time to pay more!

This discussion focuses **only** on the plan sponsor responsibility portion (as a contributing entity) under the Transitional Reinsurance Program based on the December 7, 2012, HHS proposed rule[2].

The Transitional Reinsurance Program established under ACA § 1341 is a 3-year program looking to plan sponsors (if self funded via third party administrators) and insurers to contribute to a pool that helps to stabilize premiums for coverage in the individual market from 2014 through 2016. The total contributions to be collected from contributing entities are codified as follows:

	National Reinsurance Pool ACA § 1341(b)(B)(iii)	US Treasury Contribution (to be reimbursed by entities beginning 2016) ACA § 1341(b)(B)(iv)	Total
Y2014	$10 billion	$ 2 billion	$12 billion
Y2015	$ 6 billion	$ 2 billion	$ 8 billion
Y2016	$ 4 billion	$ 1 billion	$ 5 billion
Total	$20 billion	$ 5 billion	$25 billion

Further, ACA § 1341(b)(B)(ii) allows for the collection of additional amounts for administrative expenses. Taken together, these three components make up the total dollar amount to be collected from contributing entities for each of the three years of the reinsurance program under the national per capita contribution rate.

Calculating the National Per Capita Contribution Rate

Each year the "national per capita contribution rate is calculated" as follows and is announced in its annual "HHS notice of benefit and payment parameters" to include the value for each component:

$$\text{National per capita Contribution Rate} = \frac{\text{National Reinsurance Pool (83.2\%)} + \text{Treasury Contribution (16.6\%)} + \text{Administrative Costs (0.2\%)}}{\text{Estimate of Enrollees in Plans Required to Make Reinsurance Contributions}}$$

[2] HHS Notice of Benefit and Payment Parameters for 2014 http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf

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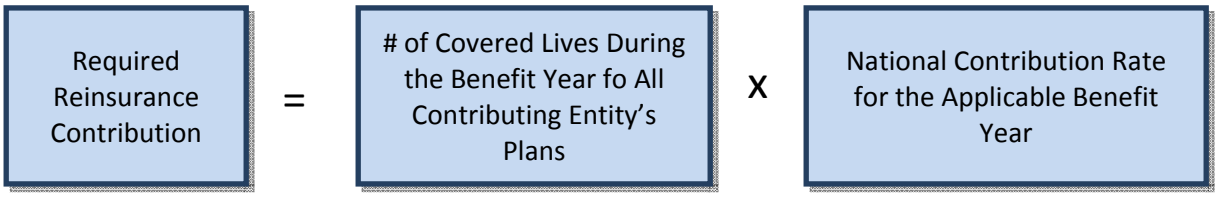
Calculating the Reinsurance Contribution

HHS proposes the following formula in calculating the required reinsurance contribution:



HHS further proposes that each contributing entity is required to report an annual enrollment count of the average number of covered lives by November 15th of each benefit year. Within 15 days of submission of the annual enrollment count or by December 15th, whichever is later, HHS will notify each contributing entity of the reinsurance contribution amounts to be paid based on that annual enrollment count. A contributing entity remits contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year.

According to HHS, based on the proposed approach, the estimate is $5.25 contribution per capita per month or $63 per capita per year for 2014. For an employer with 2000 covered lives, this represents an additional $126,000 in healthcare costs.

Counting Covered Lives

(A) For Self-Insured Group Health Plans (§ 153.405(e))
One of the following methods must be used to determine the average number of covered lives for purposes of calculating any reinsurance contribution amount due:

(1) Actual Count Method (§ 153.405(d)(1)) - The sum total of the number of lives covered for each day of the first nine months of the benefit year and dividing that total by the number of days in the first nine months; or

(2) Snapshot Count Method (§ 153.405(d)(2)) - Adding the total number of lives covered on a certain date during the same corresponding month in each quarter (e.g. one day in the third week of the second month of each quarter), or an equal number of dates for each quarter, over three quarters and dividing the total by the number of dates on which a count was made.

(3) Snapshot Factor Method (§ 153.405(e)(2)) - Adding the totals 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 quarter and dividing that total by the number of dates on

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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 and a factor of 2.35[3]. For this purpose, the same months must be used for each quarter (e.g. first month of each quarter).

(4) Form 5500 Method (§ 153.405(e)(3)) - Use date from the ''Annual Return/Report of Employee Benefit Plan'' filed with the Department of Labor (Form 5500) for the last applicable plan year, even though the data may reflect enrollment in a previous benefit year. 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.

(B) For Plans with Self-Insured and Insured Options (§ 153.405(f))
One of the following methods must be used to determine the average number of covered lives for purposes of calculating any reinsurance contribution amount due :

(1) Actual Count Method

(2) Snapshot Count Method

(C) For Multiple Plans (with at least one Insured Plan or all self-insured plans)
A "multiple plans" plan sponsor is one that maintains two or more group health plans or health insurance plans (or a group health plan with both insured and self-insured components) that collectively provide major medical coverage for the same covered lives. These multiple plans must be treated as a single self-insured group health plan for purposes of calculating any reinsurance contribution amount due. This approach would prevent the double counting of a covered life and prohibit plan sponsors that provide such major medical coverage from splitting the coverage into separate arrangements to avoid reinsurance contributions on the grounds that it does not offer major medical coverage.

[3] The preamble to the proposed PCORTF Rule explains that ''the 2.35 dependency factor reflects that all participants with coverage other than self only have coverage for themselves and some number of dependents. The Treasury Department and the IRS developed the factor, and other similar factors used in the regulations, in consultation with Treasury Department economists and in consultation with plan sponsors regarding the procedures they currently use for estimating the number of covered individuals.''

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The plan sponsor is expected to generate or obtain a list of the participants in each plan and then analyze the lists to identify those participants that have major medical coverage across all the plans collectively. When calculating the average number of covered lives across two or more plans, the same counting method must be used across all of the multiple plans, because they

would be treated as a single plan for counting purposes. Depending on the plan type, the respective methods must be used to determine the average number of covered lives applied across the multiple plans as a whole for purposes of calculating any reinsurance contribution amount due:

Multiple Plans Comprised of Only Self-Insured options -
(1) Actual Count Method,
(2) Snapshot Count Method, or
(3) Snapshot Factor Method

Multiple Plan Including At Least One Insured Options -
(1) Actual Count Method or
(2) Snapshot Count Method

The following information must be determined by the Multiple Plans plan sponsor and reported to HHS, in a manner and timeframe specified by HHS:
(A) The average number of covered lives calculated,
(B) The counting method used and
(C) The names of the multiple plans being treated as a single group health plan as determined by the plan sponsor.

EXCEPTIONS
Two types of plans are not subject to the reinsurance contribution:
(1) if the benefits provided by any health insurance or self-insured group health plans are limited to excepted benefits within the meaning of the PHS Act § 2791(c)[4]
- Coverage only for accident, or disability income insurance, or any combination thereof
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability insurance and automobile liability insurance

[4] http://democrats.energycommerce.house.gov/documents/20100917/PHSA027.pdf

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- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- Limited scope dental or vision benefits.
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
- Such other similar, limited benefits as are specified in regulations.
- Coverage only for a specified disease or illness.
- Hospital indemnity or other fixed indemnity insurance.

(2) If benefits provided by any health insurance or self-insured group health plan are limited to prescription drug coverage, that prescription drug coverage need not be aggregated so as to reduce the burden on sponsors who have chosen to structure their coverage in that manner.

Summary

In an effort to promote market reform and to realize the three primary goals of access, affordability and quality under ACA, a system of payment transfer is being installed. Healthcare reform expects plan sponsors, large employers and insurance issuers (Contributing Entities) to subsidize the issuers of Qualified Health Plans in Public Exchanges beginning in 2014. The expected outcome is to stabilize health care premium initially for individuals and small businesses acquiring health insurance through the Exchanges and make healthcare affordable to all by bending the healthcare curve in the long term. In the meantime, private employers should expect to shoulder a significant portion of the costs through higher premiums.

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