HHS Final Rule on Transitional Reinsurance Fee Adds to Employer Costs

March 2013

A transitional reinsurance fee is being added to the penalties and taxes imposed on employers and their fully insured and self-insured group health plans by the Patient Protection and Affordable Care Act (Affordable Care Act). Effective April 30, 2013, and applicable for plan years beginning on or after January 1, 2014, self-insured and fully insured group health plans will have to pay a transitional reinsurance fee—$63 per capita in 2014—to fund the first year of a three-year reinsurance program to help stabilize premiums for individuals and small groups in the Exchanges (marketplaces).

This Aon Hewitt bulletin discusses the amount of the fee, what entities have to pay and when, which plans are excluded, how to count lives, and tax deductibility, all of which are included in the final rule issued March 1, 2013 by the Department of Health and Human Services (HHS).

How Much Did You Say?

The contribution rate for 2014 is $63 per capita for all fully insured and self-insured group health plans providing major medical coverage. The fee applies to all enrollees in a plan, including employees, pre-65 retirees, COBRA participants, spouses, and dependents. Each plan's fee for a given year is equal to the number of covered lives multiplied by the contribution rate for the applicable year.

States that choose to operate their own reinsurance program may impose an additional fee on fully insured group health plans, but not on self-insured group health plans governed by ERISA. Only Maryland and Connecticut have chosen to operate their own reinsurance program in 2014.

Who’s Paying and When?

The final rule defines a contributing entity as a health insurance issuer or a self-insured group health plan. The definition was revised from the Affordable Care Act and the proposed rule to clarify that a self-insured group health plan is ultimately responsible for paying the fee, although it may use a third-party administrator (TPA) or an administrative services only (ASO) contractor to actually make the payment. A self-insured, self-administered group health plan would pay HHS directly.

Contributing entities must submit to HHS, no later than November 15 of 2014, 2015, and 2016, the annual enrollment count of the number of covered lives for the applicable calendar year (regardless of the plan year). HHS will then notify each entity by the later of December 15 or 30 days after the submission of the annual enrollment count, the reinsurance contribution amounts to be paid. Reinsurance contributions must be paid to HHS within 30 days after the date of the notice. HHS will provide details on the submission of enrollment counts and contributions in future guidance.

The final rule provides that the reinsurance contributions are a permissible plan expense because the payment is required by the plan.
Plans Subject to the Fee

Plans that provide major medical coverage are liable for the reinsurance fee. Major medical coverage is defined as health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments, including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings, including inpatient, outpatient, and emergency room settings. This includes coverage under a Taft Hartley plan for collectively bargained employees, COBRA coverage, and coverage for part-time employees. It also includes court-ordered voluntary employees’ beneficiary associations (VEBAs), although HHS notes that many VEBAs may be excluded from reinsurance contributions because they do not provide major medical coverage.

Plans Not Subject to the Fee

The following types of plans are excluded from the reinsurance fee:

- HIPAA-excepted benefits, such as stand-alone vision, dental plans, and on-site medical clinics;
- Health savings accounts (HSAs);
- Health reimbursement arrangements (HRAs) that are integrated with a group health plan (although the reinsurance fee would be paid on the group health plan);
- Employee assistance plans that do not provide major medical coverage;
- Disease management programs and wellness programs, to the extent they do not provide major medical coverage;
- Stop-loss and indemnity reinsurance policies;
- Self-insured group health plans or health insurance coverage that is limited to prescription drug benefits;
  - This includes retiree drug plans such as employer group waiver plans and other employer-sponsored Part D plans
- All expatriate coverage;
- Military health programs, such as TRICARE;
- Health programs operated under the authority of the Indian Health Service; and
- Plans or coverage provided by an Indian Tribe to its tribal members, spouses, and dependents (and other persons of Indian descent closely affiliated with the tribe) but not self-insured tribal coverage for tribal employees.

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1 Expatriate coverage is exempt from the insurance reform provisions of the Affordable Care Act until plan years ending on or before December 31, 2015, and is considered to be minimum essential coverage. Expatriate coverage is defined as an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage. See FAQ XIII, which was issued on March 8, 2013, at: [http://www.dol.gov/ebsa/faqs/faq-aca13.html](http://www.dol.gov/ebsa/faqs/faq-aca13.html)
Which Lives Count?

The final rule is very similar to the proposed rule in providing several counting methods for self-insured and fully insured group health plans to use in determining the number of covered lives in a plan. If two or more self-insured plans collectively provide major medical coverage to the same covered lives, the plans will be treated as a single self-insured group health plan. The final rule allows an employer to count its group health plans in accordance with COBRA regulations for determining the number of group health plans an employer maintains, subject to the anti-abuse rule.

Counting Methods for Fully Insured Group Health Plans

Fully insured group health plans may count the number of covered lives using one of the following methods:

- **Actual Count**—An insurer adds the total number of lives covered in the first nine months of the benefit year and divides by the number of days in the first nine months;
- **Snapshot Count**—An insurer adds 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 of the benefit year and divides that total by the number of dates on which a count was made; or
- **Member Months or State Form Method**—An insurer multiplies 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.

Counting Methods for Self-Insured Group Health Plans

Self-insured group health plans may use the following methods to determine the number of covered lives:

- **Actual Count** or **Snapshot Count**—described above;
- **Snapshot Factor**—A plan adds the total number of lives covered on any date during the same corresponding month in each of the first three quarters of the benefit year and divides 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 to the product of the number of participants with coverage other than self-only coverage and a factor of 2.35; or
- **Form 5500 Method**—A plan uses the number of lives covered for the benefit year calculated based on the Form 5500 for the last applicable time period. The number of covered lives for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and end of the benefit year as reported on the Form 5500 divided by two. The number of covered lives for a plan offering self-only coverage and coverage other than self-only equals the sum of the total participants covered at the beginning and end of the benefit year as reported on the Form 5500.

Counting Methods for Plans With Self-Insured and Fully Insured Options

If an employer maintains a group health plan that offers both self-insured and fully insured options, a plan must use either the actual count or snapshot count method. The final rule also allows an insured or self-insured group health plan to use any of the counting methods, as applicable to each option, if it determines the number of covered lives under each option separately as if each coverage option provided major medical coverage (not including any coverage option that consists solely of excepted benefits, only
provides benefits related to prescription drugs, or is an HRA, HSA, or flexible spending arrangement (FSA)).

Consistency With PCORI Fee Not Required

The final counting rules are similar to the methods used to calculate the Patient-Centered Outcomes Research Institute (PCORI) fee; however, an employer may use a different counting method for purposes of the reinsurance contributions and the PCORI fee.

Medicare Secondary Payer (MSP) Rules Apply

The final rule provides that if Medicare pays primary for an individual, reinsurance contributions are not required on behalf of those enrollees. To determine a plan’s enrollment count while taking into account enrollees for whom the employer group health coverage is considered secondary to Medicare, the insurer or self-insured group health plan may use any reasonable method of estimating the number or percentage of its enrollees. For example, a contributing entity may calculate the percentage of enrollees for which the employer group health coverage is secondary under the MSP rules on the dates it uses when applying the snapshot counting method or actual count method, or on other periodic dates, and reduce the enrollment count calculated by that percentage. A contributing entity may also calculate the total enrollment of individuals for whom the employer group health coverage is secondary under the MSP rules on the last day of the third quarter and reduce the enrollment count.

If an individual is eligible for Medicare due to end-stage renal disease or disability, then whether reinsurance contributions would be required on behalf of the individual would depend upon whether the Medicare coverage is primary, as with the working-aged.

Is it Tax Deductible?

Further, as provided previously by the Internal Revenue Service (IRS), reinsurance contributions are deductible by insurers as ordinary and necessary business expenses paid or incurred in carrying on a trade or business. Plan sponsors of self-insured plans may also treat the contributions as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Internal Revenue Code. If the self-insured plan is a multiemployer plan or a plan funded through a VEBA, the employer or employers contributing to the plan may deduct their contributions to the plan, subject to any applicable disallowances or limitations under the Internal Revenue Code.

Resources


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