Affordable Care Act (ACA) Reinsurance Fee

The Affordable Care Act (ACA or health care reform law) created a transitional reinsurance program during the first three years (2014-2016) of the exchange’s operation. The program is a national program, but states can establish supplemental programs.

The program aims to help stabilize premiums for coverage in the individual market and lower the effects of adverse selection. This is done by giving reinsurance payments to issuers that sign up high-cost individuals in non-grandfathered individual market plans.

Reinsurance contributions and payments
As stated by the Department of Health and Human Services (HHS), the reinsurance program requires health insurers and third-party administrators (TPAs) to make contributions to the reinsurance program to reinsure individual market insurers who cover people with expensive claims. The contributions are required for both fully insured and self-funded plans. The group market is required to make these contributions, but will not receive payments under the reinsurance program. Reinsurance payments are only provided to individual market insurers who insure high claimants in non-grandfathered plans.

The regulation requires that HHS collect all contributions under a national rate, which was a fee of $5.25 per member per month in 2014. In 2015, the fee is estimated to be $3.67, and for 2016 it is $2.25. However, states are allowed to implement supplemental programs and require additional contributions.

Paying the fee for fully insured plans
The fee is included in monthly billing statements for fully insured plans.

Paying the fee for self-funded plans
HHS came out with new guidelines stating that self-funded employers will be responsible for paying the ACA Reinsurance Fee, but the administrator can make the payment for them.

Earlier draft regulations required the administrator to make the payment for the self-funded employer. Based on this, we were going to let the employer pay Anthem on a monthly basis starting in January 2014. When the payments to HHS were due later this year, Anthem was going to make the payments.

However, in most cases it is better if the self-funded employer makes its own payment straight to HHS rather than having Anthem collect monthly payments and send fees to HHS for these reasons:

1. **Cash flow advantage** – With a monthly payment, Anthem started collecting in January 2014. If the employer pays HHS directly, the payment is not due until close to a year later. At $5.25 per member per month in 2014, $3.67 in 2015 and $2.25 in 2016, the amounts will be large.
2. **Lower fees** – The regulation offers four methods to count the membership on which the fees are based. The employer may model the impact of each of four membership calculation methods and choose the method which they believe is best for them. Anthem would need to use the same membership basis for each employer. This is the same way that would be used for insured business.
3. **Control** – The regulations say the self-funded employer will be responsible for the fees. By paying directly, this ensures that the payments are made correctly and according to their preferences.
4. **Integration** – Certain self-funded employers use various administrators for parts of their plans. For example, they may have coverage in one location with one administrator and in another place with a different administrator. In these cases, the employer will need to gather the information for all locations and make the payment.
HHS submission timelines for self-funded plans

<table>
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<tr>
<th>The employer must submit a report with enrollment counts each year by November 15 of 2014 through 2016.</th>
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<tr>
<td>HHS will tell the employer of the total amount due each year by December 15 of 2014 through 2016.</td>
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<tr>
<td>The employer must send payment to HHS within 30 days after HHS sends a notice with the total amount due.</td>
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Enrollment counting methods for employers with self-funded health plans

a) Actual count method – An employer determines the average number of lives by adding the total number of lives covered for each day for January through September and dividing by the number of days during that time. The employer will need to get daily covered lives from their own records.

b) Snapshot method – The plan sponsor determines the average number of lives by adding the total number of the lives covered on a date or dates during the first, second or third month of each calendar quarter and dividing by the number of days on which a count is made. The date or dates used in each quarter must be within three days of the date in that quarter that corresponds to the date in the first quarter.

c) Snapshot factor method – The employer calculates the number of lives for employee-only coverage in the same way as with the Snapshot method. The employer will accumulate the number of employees with dependent coverage in the same way as for those with employee-only coverage, and then multiply by 2.35. The employer then adds the count for employee-only coverage and the calculated count for employees with dependent coverage.

For an employer with a high number of covered dependents, this method might greatly lower the cost.

d) Form 5500 method – The plan sponsor uses the average number of the beginning and ending lives in their most recent Form 5500. Since the 5500 does not include information on beginning covered lives, we assume that this means the ending membership as reported in the last Form 5500. The information for this method must come from the employer’s records. For an employer who had increasing plan participation, this method might significantly lower the cost.

The membership counting methods provided for self-funded employers are the same as those which are available for calculation of the Comparative Effectiveness Research fees (also known as PCORI fees), which self-funded employers will submit directly. The time periods to be used are different from those used for the PCORI fees.

Please note that there are special rules for employers who offer both insured and self-funded plans, for example if they offer insured HMO coverage and self-funded PPO coverage.

This is our best understanding of the submission requirements and counting methods, but these are not meant to be legal advice. Self-funded employers should check with their own legal advisor.

Questions and answers

Q. Who determines how much the ACA Reinsurance Fee will be and how is it calculated?
A. The rate is established by HHS. However, states are allowed to establish supplemental programs and require additional contributions.

Q. Is there any way to reduce or eliminate the ACA Reinsurance Fee?
A. The ACA Reinsurance Fee is part of a temporary program which will decline for three years and then be eliminated.

Q. Will Anthem collect this fee on behalf of fully insured and self-funded groups?
A. We will include the fee on a pro-rated basis for our fully insured customers. Self-funded customers should pay the fee directly to HHS (refer to the benefits above).

Q. Is the ACA Reinsurance Fee tax deductible for sponsors of self-funded plans?
A. Yes, the IRS has issued guidance and FAQs stating that the ACA Reinsurance Fee is tax deductible as an ordinary and necessary business expense.
Q. How does an employer with a fully insured plan treat the ACA Reinsurance Fee?
A. The ACA Reinsurance Fee is imposed upon the health insurer, not the employer. For that reason, an employer does not get a tax deduction for the ACA Reinsurance Fee.

Q. What is the anticipated impact of this fee?
A. There is an anticipated impact to health insurance rates for the 3 years the fee is in place, but the impact will decrease each year until it is eliminated after 2016.

Q. What type of rate impact is expected?
A. The most significant changes to rates due the ACA Reinsurance Fee and all other health care reform provisions will be in markets for individuals and small employers, where the rating constraints, product constraints, new benefit mandates and new taxes will have the biggest impact. The impact will vary significantly between each individual and each small employer.

Q. What type of analysis has been done on the expected impact of all the health care reform provisions?
A. Examples of analyses that show the range of impact include the following:
  - A report, led by former CBO Director, Doug Holtz-Eakin of the American Action Forum, looked at the specific impacts of the ACA reforms taking place in 2014 and how premiums may be affected. The survey found:
    - On average, premiums for young, healthy people in the individual and small group market would jump 169 percent
    - Costs for older, less healthy people in the individual and small groups markets would decrease by an average of 22 percent
  - A study by the actuarial firm Milliman in Ohio that shows the range of changes expected for small employers will range from a decrease of 25 percent to an increase of 130 percent
  - In Indiana, Milliman found that the increase in premiums in the individual market beginning in 2014 could range from 75 percent to 95 percent, and rates for others would decrease
  - Other studies conducted by Dr. Jonathan Gruber of MIT in Maine, Wisconsin, Minnesota, and Colorado found that premium impacts in the individual market may increase as much as 85 percent and increases in the small group premiums may increase more than 20 percent

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