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HEALTH CARE REFORM
New Reinsurance Fees for Group Health Plans

The Department of Health and Human Services ("HHS") has issued final regulations creating a national reinsurance program to stabilize premiums for individual health insurance coverage offered through the Health Insurance Exchanges ("Exchanges"). The reinsurance program will be funded by fees imposed on insurance carriers and third party administrators ("TPAs") of self-funded group health plans for the first three years the Exchanges operate. These fees or "contributions" will then be re-distributed to insurance carriers that provide individual health coverage to high risk individuals through the Exchanges.

The following outlines how the program will impact group health plans.

$25 Billion in New Fees for 2014 – 2016
The program will impose significant cost for all employer sponsored group health plans.

- ***National Reinsurance Fees.*** Under the Health Care Reform Act, fees collected through the reinsurance program on a national basis must total $10 billion for 2014, $6 billion for 2015 and $4 billion for 2016.

- ***Early Retiree Reinsurance Program ("ERRP") Fees***. The Health Care Reform Act requires HHS to collect additional reinsurance fees to offset the cost of the ERRP in the amount of $2 billion for 2014, $2 billion for 2015 and $1 billion for 2016.

- ***State Reinsurance and Administrative Fees.*** States may also collect additional reinsurance contributions and fees for their administrative costs. A state must publish a notice setting forth these additional fees by March 1, 2013 if it wishes to collect additional funds during the 2014 benefit year.

Entities Required to Contribute

- ***Third party administrators of self-funded group health plans.*** The final regulations do not define third party administrators. The proposed regulations provided that third party administrators are the claims processing entities for self-insured group health plans. According to the proposed regulations, if the self-insured plan processes its own claims, then it will be considered a third-party administrator.

- ***Insurance Carriers*** for group and individual health plans are also required to

make contributions.

A self-funded group health plan for purposes of the program includes grandfathered plans but does not include a plan that offers coverage solely of "excepted benefits" as defined by HIPAA (*e.g.* coverage for a specified disease or stand-alone vision or dental coverage). Importantly, fees will be imposed on third party administrators of stand-alone health reimbursement account plans (HRAs), wellness programs, and employee assistance plans (EAPs) if these benefits are not "excepted benefits".

Contribution Amount. The specific contribution amount will be determined based on the total number of covered participants and dependents who reside in a state. HHS will publish the 2014 contribution amount in future guidance called the "Annual Notice of Benefit and Payment Parameters", which is scheduled for publication in October 2012.

Timing of Contributions. Contributions are made on a quarterly basis beginning in January 2014.

Failure to Make the Required Contribution. The regulations do not discuss the consequences of failing to make the required contribution.

Data Collection. Each TPA or insurance carrier must submit to HHS and each applicable reinsurance entity data required to substantiate contribution amounts, in the format and with the timing specified by HHS or the state.

Action Steps. We recommend that employers budget accordingly for these fees. Also, employers that sponsor stand-alone HRAs, wellness programs, and EAPs may want to evaluate their eligibility requirements and consider limiting enrollment to only those employees and their dependents who are covered under the group health to reduce their reinsurance fees. This will also make it easier to collect and provide participation data to HHS and any applicable reinsurance entity.

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