HM INSURANCE GROUP

Health Care Reform Fees Overview

June 6, 2013

Please note that this information is based on our understanding of the Patient Protection and Affordable Care Act of 2010, as amended, and guidance as of the date of this publication.

This is for general informational purposes only and is not intended to constitute legal advice or a recommended course of action in any given situation and should not be relied upon in making decisions of a legal nature.

IT'S OUR POLICY TO PROTECT.

Contents

- Reform Fee Overview and Impact on Cost

- Fee Specific Deep Dives
  - PCORI Fees
  - Transitional Reinsurance Fee
  - Risk Adjustment Fee
  - Health Insurance Tax

Healthcare Reform & Assessments – Facts
PPACA's Effect on Insurance / Costs

Reform Measure	Effective date	Individual	Fully insured	Self funding	Stop loss
Transitional Reinsurance fee	1/1/2014, no fee assessed beyond 2016		X	X	
Health Insurance Tax	1/1/2014	X	X		
Exchange Fee	2014, monthly fee proposed	X			
Cadillac Tax (2018)	1/1/2018		X	X	
Patient-Centered Outcomes Research Institute (PCORI) Fee	Policy years end on or after 10/1/2012 and before 10/1/2019	X	X	X	
Risk adjustment program	Effective date 1/1/2014	X	X		

Note: Preliminary based on current interpretation of regulations; fees are subject to change

Sources: HHS.gov, IRS.gov, Analysis of HHS proposed Notice of Benefit and Payment Parameters 12/7/2012

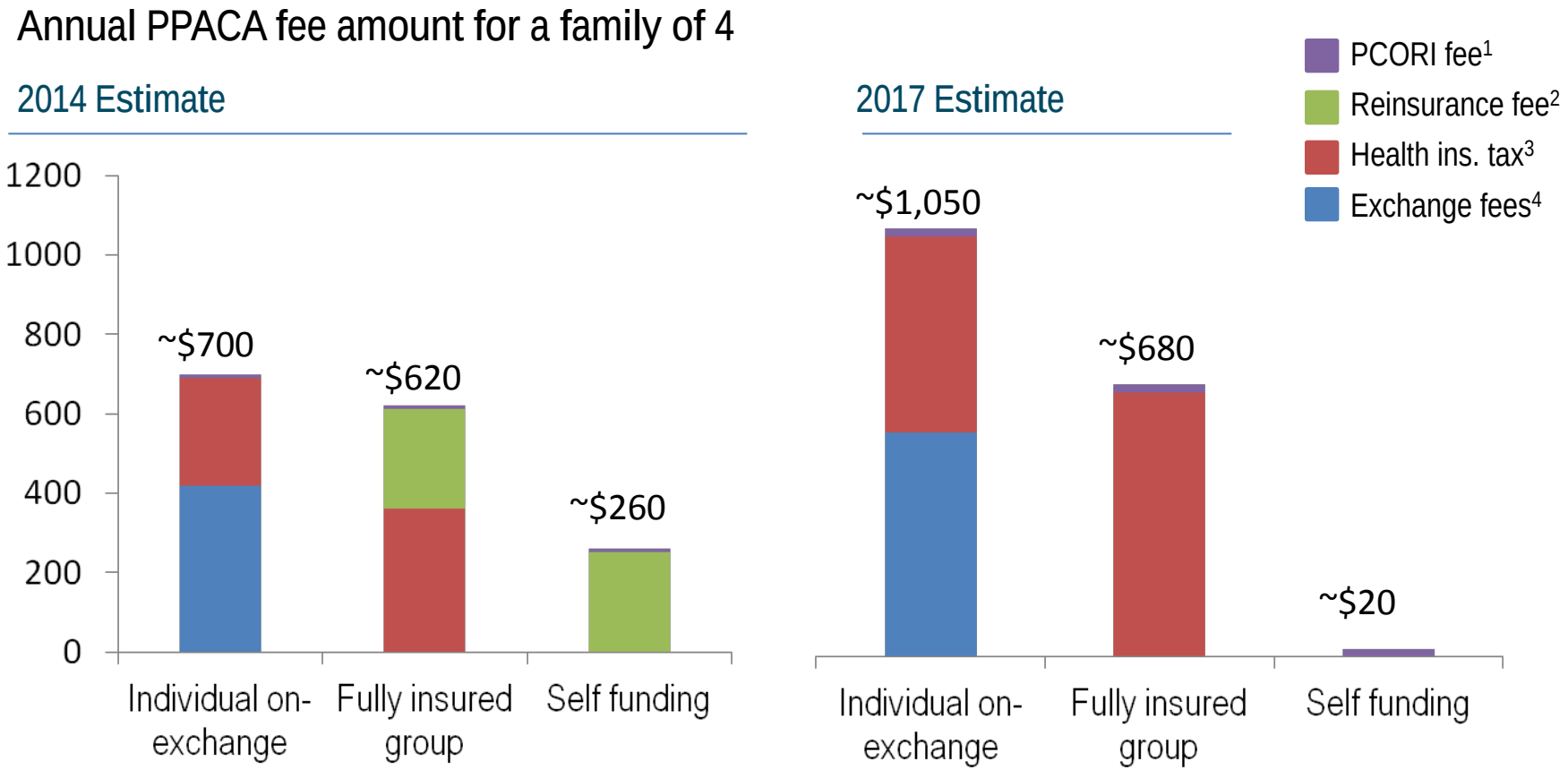
Federal Activity
Summary of Reform Fees

Fee name	Description	Fee amount
Transitional reinsurance fee	▪ Fully insured (FI) and self-funded (SF) plans pay to stabilize individual market	▪ $63 PMPY in 2014 ▪ $42 PMPY in 2015
Health insurance tax (HIT)	▪ Tax on FI plans based on earned health insurance premiums	▪ 2.3% in 2014
Exchange fee	▪ Fee on FI carriers participating on exchange to support the exchange	▪ 3.5% of premium proposed by HHS
Cadillac Tax (starts 2018)	▪ Tax on high cost health FI/SF insurance plans to employees/retirees	▪ A nondeductible 40% excise tax above cap
PCORI fee	▪ Fee across nearly all FI/SF plans to fund evidence-based medicine	▪ $1 PMPY in 2013 ▪ $2 PMPY in 2014
Risk adjustment	▪ Admin fee paid by FI carriers on exchange to fund risk adjustment program	▪ $1 PMPY in 2014

Note: Excludes individual and employer penalties and risk corridor (net neutral)
Sources: HHS.gov, IRS.gov

Healthcare Reform & Assessments – Facts

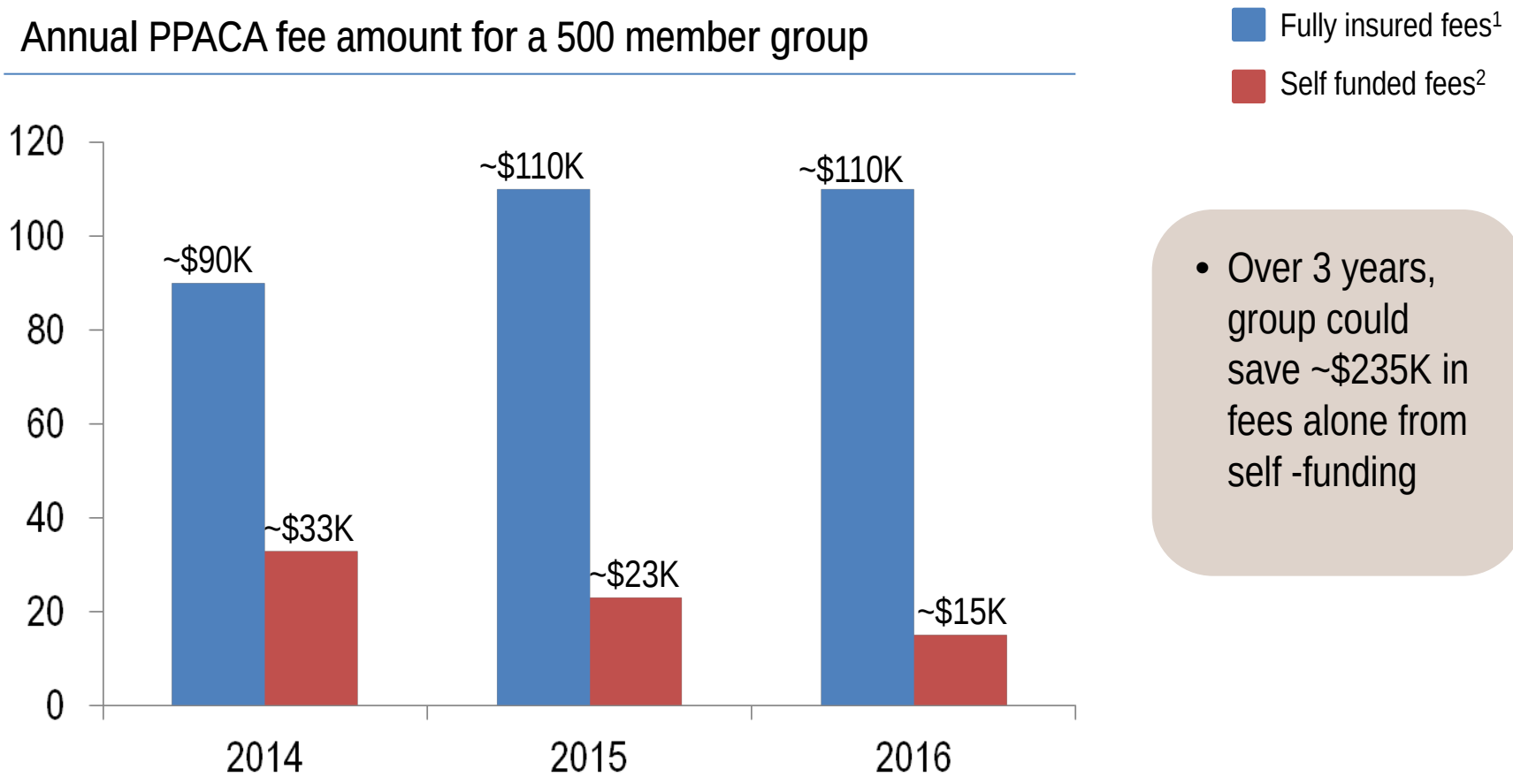
PPACA Fees (Estimated Amount for Family of 4)



1. PCORI Fees are $1 PMPY in 2013; $2 PMPY in 2014 and increase thereafter based on health expenditure data (Source: IRS)
2. $63 per member; per year; tax sunsets in 2016 (Source: IRS)
3. Estimated premium impact of annual fees assessed on health insurance plans (Source: Oliver Wyman)
4. Assumes annual $12K cost per family; 10% annual premium growth and 3.5% fee; not applicable off-exchange

Healthcare Reform & Assessments – Facts

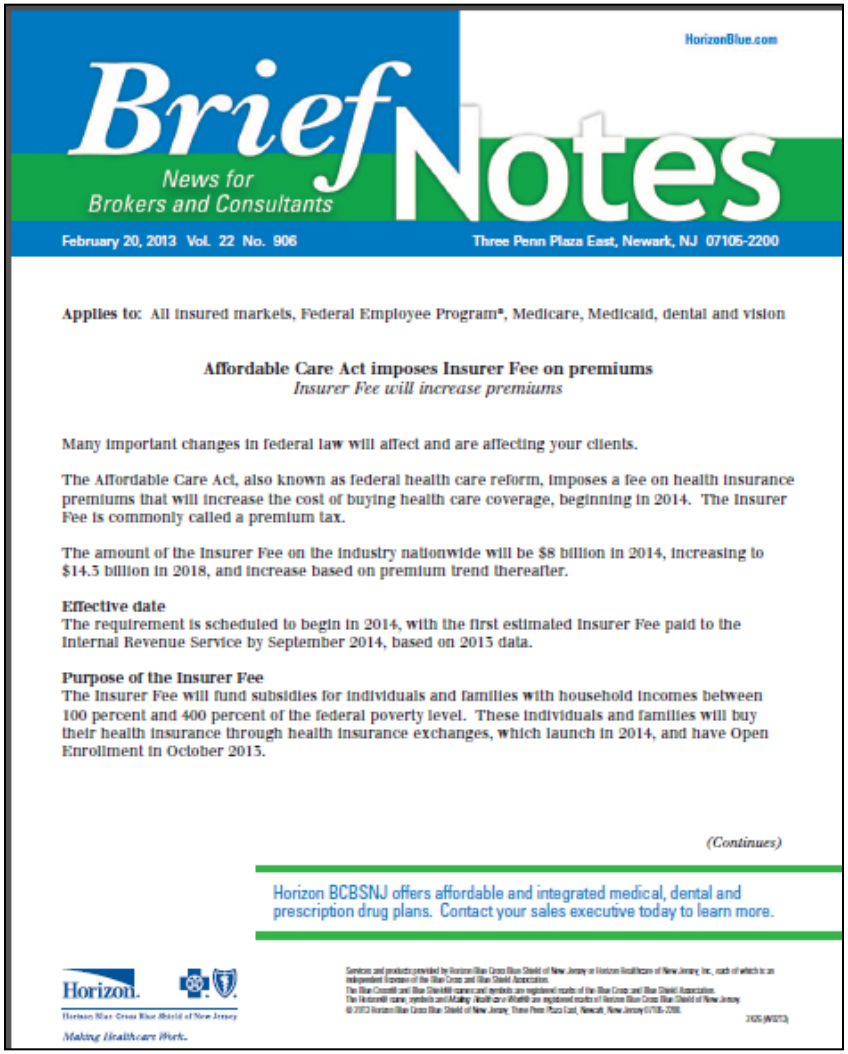
PPACA Fees (Estimated Amount for a 500 member group)



- Over 3 years, group could save ~$235K in fees alone from self -funding

1. Assumes $400 PMPM with 10% increase at renewal; assumes all fees apply as noted on previous page; effective date 1/1/2014
2. Assumes all fees apply as noted on previous page

Fully Insured Carriers Communicate They Will Pass Through Fees



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Brief Notes

News for Brokers and Consultants

February 20, 2013 Vol. 22 No. 906 Three Penn Plaza East, Newark, NJ 07105-2200

Applies to: All insured markets, Federal Employee Program®, Medicare, Medicaid, dental and vision

Affordable Care Act imposes Insurer Fee on premiums

Insurer Fee will increase premiums

Many important changes in federal law will affect and are affecting your clients.

The Affordable Care Act, also known as federal health care reform, imposes a fee on health insurance premiums that will increase the cost of buying health care coverage, beginning in 2014. The Insurer Fee is commonly called a premium tax.

The amount of the Insurer Fee on the industry nationwide will be $8 billion in 2014, increasing to $14.3 billion in 2018, and increase based on premium trend thereafter.

Effective date
The requirement is scheduled to begin in 2014, with the first estimated Insurer Fee paid to the Internal Revenue Service by September 2014, based on 2013 data.

Purpose of the Insurer Fee
The Insurer Fee will fund subsidies for individuals and families with household incomes between 100 percent and 400 percent of the federal poverty level. These individuals and families will buy their health insurance through health insurance exchanges, which launch in 2014, and have Open Enrollment in October 2015.

(Continues)

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- Horizon BCBS in February 2013 notified its brokers that health premiums would increase to pay the increased costs associated with the non-deductible Health Insurer Tax
  - Horizon would charge approximately 125% of the fee as the tax is nondeductible
- Horizon has begun charging for the tax in renewals for 51+ groups
- Starting with the March 2013 renewals, groups will be billed over 12-months
- Total fees estimated to be collected by Horizon in 2014 are $162M in 2014

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2. FEE SPECIFIC "DEEP DIVES"

a. PCORI Fee
b. Transitional Reinsurance Fee
c. Risk Adjustment Fee
d. Health Insurance Tax

2a. PCORI Fee

- IRS issued the final rule on Fees on Health Insurance Policies and Self-Insured Plans for Patient-Centered Outcomes Research Institute Trust Fund (PCORI) on December 6th, 2012

- ACA imposes an annual fee on health insurers and employer sponsored self-funded health plans, for each policy or plan year ending on or after 10-1-2012 and before 10-1-2019
  - $1 will be assessed on policy years 10/1/2012 to 9/30/2013 and
  - $2 for policy years 10/1/2013 to 9/30/2014
  - Fees will be adjusted for the following years based on health expenditure data

- The fee is due to the IRS by 7/31 of the year following the last policy or plan year

- The issuer or plan sponsor must use the Form 720 (excise tax form) available on the IRS website

Sources: Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund, Final Regulations, IRS, December 6, 2012; Buck Consultants, fyi For Your Information, Reinsurance and other fees could impact employer health care costs, Volume 35, Issue 83, October 23, 2012.

2a. What Entity Pays the PCORI Fee ?

- The issuer of a specified health insurance policy will pay the fee for fully insured plans
- For employer sponsored self-funded health plans the fee shall be paid by the plan sponsor
  - Issuers and plan sponsors are responsible for all reporting, calculating, paying and filing requirements related to the fee
- The final regulations do not permit or include rules for third-party reporting or payment of the PCORI fees

Source: Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund, Final Regulations, IRS, December 6, 2012

2a. Calculation of the PCORI Fee

For a fully insured policy or self funded plan

- Annual PCORI fee = Average number of lives covered for the policy/plan year x the applicable dollar amount

- The average number of lives covered under the specified health insurance policy must be determined using
  - Actual count method
  - Snapshot method
  - Member months method or
  - State form method

- The average number of lives covered under the self-funded plan must be determined using
  - Actual count method
  - Snapshot method or
  - Form 5500 method

Source: Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund, Final Regulations, IRS, December 6, 2012

2b. Transitional Reinsurance Fee

Overview

- Designed to help stabilize insurance premium in the individual and small group markets. i.e., minimize impact of adverse selection
- $25 billion to be collected over a three-year period (2014---2016)
  - States opting to establish a state run reinsurance program may impose additional contribution fees and requirements
- Reinsurance fees to be collected from fully insured and self-funded plans
- $63 PMPY (per member per year) in 2014- $252 per family of four per year
  - Number may drop to ~$42 PMPY in 2015 and even further in 2016
  - Collections scheduled to end in 2017
- Rate impact on individual market over three years (~10% based on outside actuarial estimates)

Source: Final Notice of Benefit and Payment Parameters, March 1, 2013 (45 CFR Part 153 (Federal Register)

2b. Transitional Reinsurance Fee

- Transitional Reinsurance Contribution
- Benefits the individual market with contributions collected from the fully insured and self-funded plans beginning in 2014 and continuing through 2016
- Critical element in helping to ensure a stabilized individual market in the first few years of Exchange operation
  - Provides funding to issuers that incur high claims cost for enrollees (individual market)
- States may establish a reinsurance program, regardless of whether a State Exchange is formed
  - States that opt to operate a program, must contract with a non-profit reinsurance entity to run the program
  - Note: Comments under the Final Rule indicate **less than 10 states** have announced an intention to establish a reinsurance program
- In lieu of a state operated program, HHS will establish and operate the reinsurance program

Source: Final Notice of Benefit and Payment Parameters, March 1, 2013 (45 CFR Part 153 (Federal Register)

2b. Transitional Reinsurance Fee

Reinsurance Payment Parameters

- The Final Rule sets the payment parameters for the reinsurance program:
  - Attachment point of $60,000 for 2014 (Point at which reinsurance commences)
  - Reinsurance cap of $250,000 (Point at which reinsurance ends)
  - Uniform co-insurance rate of 80% (Percentage of claims reimbursed above the attachment point and below the reinsurance cap)

Source: Final Rule Notice of Benefit and Payment Parameters, March 1, 2013 – 45 Code of Federal Regulations 153.100 et seq.

2b. Transitional Reinsurance Fee

Is the Contribution Applicable To Self-funded Groups?

- The program will be funded, in part, by the self-insured market

- Contributing entities include:
  - Fully Funded Plans
  - Third Party Administrators (TPAs), on behalf of self-insured plans, may be utilized to transfer the reinsurance contributions from the self-insured plan to HHS
  - Self-insured plans processing their own claims will be responsible for making the contribution

Note: HHS will collect the reinsurance contributions regardless of whether a state elects to operate its own reinsurance program. Therefore, even though a state establishes a reinsurance program, HHS will collect the reinsurance contribution from all contributing entities for that state.

Source: 45 Code of Federal Regulations 153.400 et seq., and 153.220

2b. Transitional Reinsurance Fee

Is It Relevant That a Self-funded Plan Has Secured Stop Loss Insurance?

- No, stop loss insurance has no impact on the funding of the reinsurance program

- In other words, the contribution rate collected from or on behalf of a self-funded plan does not take into account whether there is any stop loss insurance coverage in place

Source: 45 Code of Federal Regulations 153.400(a)(2)(g)

2b. Transitional Reinsurance Fee

How Is the Contribution Rate Established?

- The national contribution rate will be determined by HHS for each benefit (i.e., calendar) year

- The Federal rules and guidelines established that the contribution rate will be applied on a per capita basis rather than a percentage of premiums

- Formula:
  - Reinsurance Contribution = Number of Covered Lives During the Benefit Year for all Contributing Entities x Per Capita Rate (also referred to as the National Contribution Rate)

Source: 45 Code of Federal Regulations 153.220 (c)

2b. Transitional Reinsurance Fee

Breaking Down The National Per Capita Rate

- According to the proposed rule, for the benefit year 2014, the following three components establish the national per capita rate:
  - The National Reinsurance Pool $10 Billion
  - The US Treasury Contribution $2 Billion
  - Administrative Costs $20 Million

- The national per capita rate will be calculated by dividing the sum of the three amounts (above) by the estimated number of enrollees in plans that must make reinsurance contributions

Source: Table 12 Proportion of Contribution Collected under the National Contribution Rate for Reinsurance Payments, Payments to US Treasury & Administration Expenses – 45 Code of Federal Regulations 220(c)

2b. Transitional Reinsurance Fee

Breaking Down The National Per Capita Rate

- For 2015:
  - National Reinsurance Pool $6 Billion
  - Treasury contribution $2 Billion
  - Administrative expenses $20 Million
- For 2016:
  - National Reinsurance Pool $4 Billion
  - Treasury contribution $1 Billion
  - Administrative expenses $20 Million
- States opting to operate a reinsurance program are permitted to increase the contribution rate to account for administrative expenses and reinsurance payments
- States may not decrease the contribution amount

Source: Proportion of Contribution Collected under the National Contribution Rate for Reinsurance Payments, Payments to US Treasury and Administration Expenses – 45 Code of Federal Regulations 220(c), 153.220(a) and (b)

2b. Transitional Reinsurance Fee

Breaking Down The National Per Capita Rate

Under the Final Rule, HHS established:

- For the benefit year 2014, the annual per capita contribution rate is $5.25 per enrollee per month or $63 annually per enrollee in plans that must make reinsurance contributions that yields $12.02 billion

- HHS developed a model that estimates market enrollment incorporating State and Federal policy choices and the behaviors of individuals and employers – Affordable Care Act Health Insurance Model (ACAHIM). ACAHIM uses Current Population Survey (CPS data adjusted for small populations at the State level, exclusion of undocumented immigrants and the population growth up to 2014 to assign individuals in various coverage markets)

Source: Final Rule Notice of Benefit and Payment Parameters, March 1, 2013 45 Code of Federal Regulations 220(c)

2b. Transitional Reinsurance Fee

Annual Enrollment Count

- No later than November 15 of each benefit year (2014, 2015 and 2016), a contributing entity must submit an annual enrollment count of the average number of lives of reinsurance contribution enrollees for the applicable benefit year

- Within 30 days of submitting the annual enrollment count or by December 15, whichever is later, HHS will notify each contributing entity of the amount to be paid. Payment must be made within 30 days after notice

- Methods for counting lives:
  - Fully funded plans: 1) Actual Count; 2) Snapshot Count; and 3) Snapshot Factor Method
  - Self-insured plans: 1)Actual Count; 2) Snapshot Count; 3) Snapshot Factor Method; and 4) Form 5500

Source: Final Rule Notice of Benefit and Payment Parameters, March 1, 2013 – 45 Code Federal Regulations 153.405

2b. Transitional Reinsurance Fee

Proportions of Collected Contributions

- Proportion of Contributions Collected under the National Contribution Rate for Reinsurance Payments, Payments to U.S. Treasury and Administrative Expenses

- If the total contribution collections are less than or equal to $12.02 billion, then the monies collected will be distributed as follows:
  - 83.2% = Reinsurance payments
  - 16.6% = Payments to the US Treasury
  - .02% = Administrative expenses

Source: Table 12 Proportion of Contribution Collected under the National Contribution Rate for Reinsurance Payments, Payments to US Treasury & Administration Expenses 45 Code of Federal Regulations 220(c)

2b. Transitional Reinsurance Fee

Who Collects the Contribution?

- In all states, HHS will collect the contribution annually from all contribution entities and TPAs (i.e., on behalf of self-insured plans)
  - Note: Previously, under the proposed final rule, States were permitted to elect to collect from fully insured plans or choose HHS to conduct the collection. The election is no longer an option for states

- States may contract with or establish a non-profit reinsurance administrator to collect the contribution from fully insured plans
  - In certain instances, states may contract with multiple administrators subject to geographic coverage areas
  - Funding for the administration of the reinsurance program may also be included in the contribution rate in order to eliminate any additional state or federal funding for the reinsurance program's operation (i.e., administration expenses and reinsurance)

Source: Final Rule Notice of Benefit and Payment Parameters, March 1, 2013 – 45 Code of Federal Regulations 153.220

2b. Transitional Reinsurance Fee

IRS Treatment of Contributions

In an FAQ released by the IRS, it determined:

- Health insurance issuers may treat the contributions as ordinary and necessary expenses paid or incurred in carrying on a trade or business, subject to dis-allowances and limitations, or as a reduction to taxable income under Subchapter L
  - Transitional Reinsurance Fee is tax deductible
- Sponsors of self-insured plans may treat the contributions as ordinary and necessary expenses subject to any applicable disallowances or limitations under the Tax Code. This treatment applies whether the contributions are made directly or through a TPA
- In addition, the DOL advised HHS the payment of reinsurance contributions would constitute a permissible expense for plan purposes of Title I of ERISA because the payment is required by the plan under ACA

Source: IRS-ACA Section 1341 Transitional Reinsurance Program FAQs – Q2 Updated 2012-11-30 and Final Rule of Benefit Parameters, March 1, 2013 (Federal Register)

2c. Risk Adjustment

- The permanent State-based risk adjustment program will provide payments to health insurance issuers that disproportionately attract high-risk populations; **funds will be transferred** from issuers with lower risk enrollees to issuers with higher risk enrollees
  - No net contributions, only a **redistribution** from low-risk to high-risk plans
  - Funds transfer after year-end under a **retrospective** methodology
- For States not approved to operate or that opt to forgo operating a state based risk adjustment program, HHS will operate the program
- The risk adjustment program applies to non-grandfathered individual and small group market plans inside and outside the exchange
- Plans providing benefits through policies that begin in 2013, with renewal dates in 2014, would not be subject to risk adjustment until renewal in 2014

Sources: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule, HHS, March 23, 2012 The Impact of '3Rs" Programs on Insurers: How Big, How Soon, How to Prepare, AIS Webinar, January 31, 2013. HHS Notice of Benefit and Payment Parameters, Final Rule, March 1, 2013.

2c. Risk Adjustment Fees

- HHS will collect a **user fee** to support administration of the HHS operated risk adjustment
- HHS estimates its costs at **$20 million** and will set the user fee rate as a national per capita rate in order to spread the cost of the program across issuers of risk adjustment covered plans based on enrollment
- Currently, HHS projects the per capita risk adjustment user fee at no more than **$1 per enrollee per year**
  - The user fee will be collected in **June of the year following the benefit year**
- For benefit year 2014, HHS is establishing a **per capita annual user fee rate of $0.96**, which will be applied as a per-enrollee-per-month risk adjusted user fee of $0.08

Source: Final Notice of Benefit and Payment Parameters, March 1, 2013 45 Code of Federal Regulations 153.320

2d. Health Insurance Tax (HIT)

- Beginning 1/1/2014, carriers offering fully insured coverage in the individual, small & large group markets will pay a tax on earned health insurance premiums
  - Self-funded plans are exempt
  - The insurer will pay the tax based on the proportion of their premiums to total premiums for all covered entities
- Estimates show that from 2013 to 2022 the tax will total $101.7 billion
  - 2014: $8 billion (2.3% of fully insured premium)
  - 2015: $11.3 billion (3.25%)
  - 2016: $11.3 billion (3.25%)
  - 2017: $13.9 billion (4.0%)
  - 2018: 14.3 billion (4.11%) and increasing thereafter based on premium growth
- Tax is nondeductible

2015-2018 estimates assume that the market size is stable. If the market grows the % may reduce but the amount collected per person will remain same

Source: Section 9010 of PPACA and Section 1406 of the Reconciliation Act

2d. Health Insurance Tax (HIT)

- Covered entities must report net premium written for health insurance for U.S. health risks during the prior year to IRS by May 1 of the fee year
  - The IRS will notify entities of the amount of the annual fee no later than August 31 of the fee year
  - The insurer fee is due to the IRS no later than September 30 of the fee year

- The penalty for failure to submit required reports is
  - $10,000 plus the lesser of
  - $1,000 times the number of days during failure to submit or
  - The amount of entity's fee for with the report was required

Source: IRS Health Insurance Providers Fee, proposed rule, March 1, 2013.

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APPENDIX

PPACA Impact Due to Non-Fee Items
Self-Insured Groups NOT Impacted

Other Reform Measure	Effective Date	Individual	Fully Insured	Self-Insured
Medical Loss Ratio Limits	07/01/2012	X	X	
Prohibition Of Discrimination Based On Salary	Effective 180 days from enactment	X	X	
Review of Premium Increases	Effective upon enactment	X	X	
Annual Limitation on Deductibles	01/01/2014		X	
Essential Health Benefits	01/01/2014	X	X	
Guaranteed Issue of Coverage	01/01/2014	X	X	
Guaranteed Renewability	01/01/2014	X	X	
Rating Restrictions*	01/01/2014	X	X	
Risk Corridors	01/01/2014		X	
Qualified Health Plan Certification	01/01/2014	X	X	

*Rating restrictions based on age, geography, family size & tobacco use

Sources: HHS.gov, IRS.gov, **Analysis of HHS proposed Notice of Benefit and Payment Parameters 12/7/2012

PPACA Impact Due to Non-Fee Items Impacts Individuals, Fully Insured and Self-Insured Groups

Other Reform Measure	Effective Date	Individual	Fully Insured	Self-Insured
Dependent Coverage To Age 26	Effective 180 days from enactment	X	X	X
Prohibition On Rescissions	Effect 180 days from enactment	X	X	X
Prohibition of Discrimination Based On Health Status	Under 19 years of age - 180 days from enactment, otherwise 1/1/14	X	X	X
Summary of Benefits and Coverage	Within 2 years of enactment - must provide standard summary document	X	X	X
Prohibition On Lifetime And Annual Limits	No limits on EHBs on or after 1/1/14; graduated limits may apply for plan years prior to 1/1/14	X	X	X
Coverage Of Preventative Health Services	01/01/2013	X	X	X
90-day maximum Waiting Period	Plan years beginning on or after 1/1/14	X	X	X
Prohibition Of Preexisting Conditions	01/01/2014	X	X	X

Sources: HHS.gov, IRS.gov, **Analysis of HHS proposed Notice of Benefit and Payment Parameters 12/7/2012