

**PALM BEACH COUNTY  
BOARD OF COUNTY COMMISSIONERS**

## AGENDA ITEM SUMMARY

Meeting Date: December 15, 2015      ☒ Consent      ☐ Regular  
    ☐ Ordinance      ☐ Public Hearing

**Department: Risk Management**

**Submitted By: Risk Management**

**Submitted For: Risk Management**

## I. EXECUTIVE BRIEF

**Motion and Title: Staff recommends motion to:**

- A) **approve** payment of the required Transitional Reinsurance Program Annual Enrollment Contribution Submission in the amount of \$317,819.92 due for the Affordable Care Act's (ACA) Transitional Reinsurance Program as established by Section 1341 of the ACA, and;
- B) **delegate** the County Administrator or her designee as the Authorizing Official for Reporting Entity's Acknowledgment, as defined by the ACA, to verify and acknowledge the annual enrollment count, supporting data, and accompanying required contribution as stated above.


**Summary:** The ACA established the Transitional Reinsurance Program to stabilize premiums in the individual health insurance market and ACA exchanges. Contributing Entities, as defined by 45 CFR 153.20, including the Board's self-insured group health plan, are required to pay annual contributions for the 2014, 2015, and 2016 benefit (calendar) years. The contribution is due by January 15, 2016 and represents \$44.00 per enrolled participant for the current benefit year. Countywide (HH)

**Background and Justification (or Policy Issues):** The ACA was signed into law by President Obama in March of 2010 and implements systematic changes throughout the health insurance industry, many of which apply to the County's self-insured health plan. The Transitional Reinsurance Program Annual Enrollment Contribution offers several counting methods for self-insured health plans. Staff used the "Snapshot Factor" method of determining the number of covered lives in the plan, for which the required \$44.00 must be paid. This method, which calculated 7,223.18 total covered lives, is the most cost effective calculation available under the regulations of the ACA. The regulations allow plans to pay the contribution in one payment due January 15, 2016, or in two payments, the first of which is due January 15, 2016 in the amount of \$33.00 per covered life, with the balance of \$11.00 due by November 15, 2016. Staff recommends the first option in order to save the costs of additional administrative effort. The fee for the 2016 benefit year is currently scheduled to reduce to \$27.00 per covered life.

**Attachments:**

- ## 1. ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form

Recommended By: Nancy L Bolton 11/12/15  
Department Director Date

Approved By:  Date: 12/1/15  
County/Deputy/Assistant County Administrator

## II. FISCAL IMPACT ANALYSIS

### A. Five Year Summary of Fiscal Impact

Fiscal Years	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>
Capital Expenditures					
Operating Costs	\$317,819.92				
External Revenues					
Program Income (County)					
In-Kind Match (County)					
Net Fiscal Impact					
# ADDITIONAL FTE POSITIONS (Cumulative)	0	0	0	0	0

Is Item Included In Current Budget?	Yes	X	No					
Budget Account	Exp No.: 5012	Fund	Dept 700	Unit	7315	Obj	4901	
	Rev No.:	Fund	Dept	Unit		Obj		

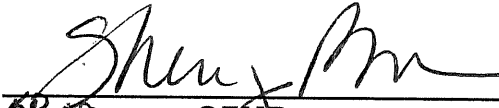
### B. Recommended Sources of Funds/Summary of Fiscal Impact:

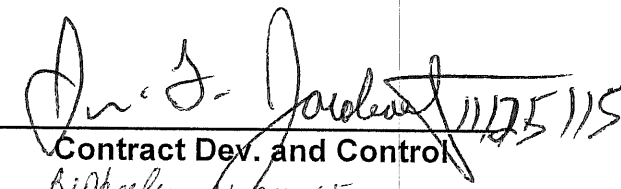
Employee Health Insurance Fund/ Budget Line 5012-700-7315-4901	
2015 Contribution Per Life	\$44.00
Covered Lives	7,223.18
Total Contribution FY2015	\$317,819.92

### C. Departmental Fiscal Review:

## III. REVIEW COMMENTS

### A. OFMB Fiscal and/or Contract Dev. and Control Comments:

  
\_\_\_\_\_  
11/19 11/20 OFMB

  
\_\_\_\_\_  
Contract Dev. and Control  
Biohealth 1.25-15

### B. Legal Sufficiency:

  
\_\_\_\_\_  
Assistant County Attorney

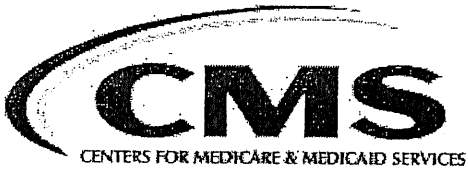
### C. Other Department Review:

\_\_\_\_\_  
Department Director

REVISED 9/03  
ADM FORM 01

(THIS SUMMARY IS NOT TO BE USED AS A BASIS FOR PAYMENT.)

ACA Transitional Reinsurance Program  
Annual Enrollment and Contributions Submission Form



*\* Required Fields*

Current Date: 11/16/2015

\* Legal Business Name (LBN): Palm Beach County Board of ~~County~~ Commissioners

\* Federal Tax ID Number: 59-6000785

Billing Contact

\* First Name: Brian \* Last Name: Palacios \* Job Title: Fiscal Manager II  
\* Email Address: BPalacios@pbcgov.org \* Telephone: (561) 233-5419 Ext:

Billing Address

\* Line 1: 301 N. Olive Avenue Line 2:   
\* City: West Palm Beach \* State: Florida \* Zip Code: 33401

Contact for Submission

\* First Name: Nancy \* Last Name: Bolton \* Job Title: Director, Risk Manage  
\* Email Address: nbolton@pbcgov.org \* Telephone: (561) 233-5441 Ext:

- \* Are you reporting for more than three (3) Contributing Entities? ☐ Yes ☒ No
- \* Are you both the Reporting Entity and Contributing Entity? ☒ Yes ☐ No

ACA Transitional Reinsurance Program  
Annual Enrollment and Contributions Submission Form



Contributing Entity 1:

\* Legal Business Name (LBN): Palm Beach County Board of County Commissioners

\* Federal Tax ID Number: 59-6000785 \* Organization Type: Nonprofit

Billing Address

\* Line 1: 301 N. Olive Avenue Line 2: \_\_\_\_\_

\* City: West Palm Beach \* State: Florida \* Zip Code: 33401

\* Domiciliary State: Florida

\* Benefit Year: 2015 \* Annual Enrollment Count for the applicable benefit year: 7,223.18

\* Indicate Type of Contributing Entity: Self Insured Group Health Plan

Other Type: \_\_\_\_\_

Contributing Entity 2:

\* Legal Business Name (LBN): \_\_\_\_\_

\* Federal Tax ID Number: \_\_\_\_\_ \* Organization Type: \_\_\_\_\_

Billing Address

\* Line 1: \_\_\_\_\_ Line 2: \_\_\_\_\_

\* City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* Zip Code: \_\_\_\_\_

\* Domiciliary State: \_\_\_\_\_

\* Benefit Year: 2015 \* Annual Enrollment Count for the applicable benefit year: \_\_\_\_\_

\* Indicate Type of Contributing Entity: \_\_\_\_\_

Other Type: \_\_\_\_\_

Contributing Entity 3:

\* Legal Business Name (LBN): \_\_\_\_\_

\* Federal Tax ID Number: \_\_\_\_\_ \* Organization Type: \_\_\_\_\_

Billing Address

\* Line 1: \_\_\_\_\_ Line 2: \_\_\_\_\_

\* City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* Zip Code: \_\_\_\_\_

\* Domiciliary State: \_\_\_\_\_

\* Benefit Year: 2015 \* Annual Enrollment Count for the applicable benefit year: \_\_\_\_\_

\* Indicate Type of Contributing Entity: \_\_\_\_\_

Other Type: \_\_\_\_\_

# ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form



\* Type of Filing

☒ New      ☐ Re-Filing      ☐ Resubmission      ☐ Invoice

\* Type of Payment (All payment types must be filed and scheduled by November 15th of the Benefit Year)

☐ First Collection - Contribution for Program Payments and Program Administration Funds  
(Regulatory Payment Due Date - January 15, 2016)

☐ Second Collection - Contribution for General Fund of the US Treasury  
(Regulatory Payment Due Date - November 15, 2016)

☒ Combined Collection - First Collection + Second Collection (as described above)  
(Regulatory Payment Due Date - January 15, 2016)

\* Benefit Year for Reporting Gross Annual Enrollment Count 2015

Total Applicable Benefit Year Contribution Rate	44.00
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* Annual Enrollment Count	7,223.18
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* Verify Annual Enrollment Count	7,223.18
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Contribution Rate for Program Payments and Program Administration Funds	33.00
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Contribution Amount Due for Program Payments and Program Administration Funds	238,364.94
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Contribution Rate for General Fund of the US Treasury	11.00
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Contribution Amount Due for General Fund of the US Treasury	79,454.98
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Total Contributions Due for the Applicable Benefit Year	317,819.92
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**Previous Pay.gov Tracking ID**

Invoice Number 008796

Verify Invoice Number

Invoice Payment Amount	\$ 1,789.00
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Annual Enrollment Count

Verify Annual Enrollment Count

- ☒ The Annual enrollment count entered in this Form is accurate and matches the aggregate enrollment count by entity in the Supporting Documentation, if applicable.
- ☒ Acknowledgment: My acknowledgment is on behalf of my organization and the contributing entity or entities for which the data and accompanying payment(s) are being submitted. My acknowledgment legally and financially binds my organization and each contributing entity to the applicable laws, regulations and program instructions of the Affordable Care Act (ACA). By my submission, I certify that the data are true, correct and complete. If my organization or any contributing entity becomes aware that data are untrue, incorrect or incomplete, CMS shall be promptly informed. If CMS identifies a discrepancy or has questions about the data being submitted, I agree to be the contact for responding to such questions. I acknowledge that the provisions of the Affordable Care Act specifically make payments made by or in connection with an Exchange subject to the False Claims Act if those payments include any Federal funds. This includes, but is not limited to, the transitional reinsurance program established under Section 1341 of the Affordable Care Act.

Authorizing Official for Reporting Entity's Acknowledgment

\* First Name: Verdenia                      \* Last Name: Baker                      \* Job Title: County Administrator

\* Email Address: VBaker@pbcgov.org \* Telephone: (561) 355-2712 Ext: