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BENEFITS BRIEF

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PCORI & Reinsurance Fees—Keeping Them Straight

Plan Sponsors and issuers will soon be required to pay fees to fund two new programs established by the Patient Protection and Affordable Care Act ("ACA")—a relatively small Patient Centered Outcomes Research Institute fee ("PCORI Fee"), due July 31, 2013, and a more significant transitional reinsurance program contribution ("Reinsurance Fee"), due January 14, 2015 in most cases. While the PCORI Fee and the Reinsurance Fee are both calculated based upon the number of "covered lives" under a plan and use similar methodologies for counting those lives, there are significant differences between the two fees, such as the amount of the fee, due date, payment method, and treatment of individuals covered by retiree medical plans. The chart below provides a high level overview of some key distinctions between the PCORI Fee and the Reinsurance Fee, and the discussion that follows highlights issues to keep in mind when reporting and paying these fees.

	PCORI Fee	**Reinsurance Fee**
	Mechanics of Payment	
Due Date	Report and pay the PCORI fee by July 31st of the year following the last day of the policy or plan year. The first PCORI fee must be reported and paid on July 31, 2013.	Report annual enrollment count (based on the first 9 months of the year) to CMS by November 15th of the benefit year, beginning on November 15, 2014. Within 30 days of submission of the annual enrollment count or by December 15th, whichever is later, the Department of Health and Human Services ("HHS") will notify the contributing entity of the Reinsurance Fee to be paid for the applicable benefit year. Payment is due within 30 days of the date of this notification.
Applicable Plan Years	Plan and policy years ending on or after October 1, 2012 and before October 1, 2019.	Calendar years 2014, 2015 and 2016.

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	PCORI Fee	Reinsurance Fee
Who makes the payment, and how?	*Self-Insured Plan* – The plan sponsor must file Form 720 and pay the required PCORI fee directly to the Internal Revenue Service ("IRS"). TPAs cannot pay the fee on behalf of a plan. *Fully Insured Plan* – The issuer of a "specified health insurance policy" must file Form 720 and pay the required PCORI fee directly to the IRS. For Form 720 and Instructions, see: http://www.irs.gov/uac/Form-720,-Quarterly-Federal-Excise-Tax-Return.	*Self-Insured Plan* – The plan itself is responsible for the reinsurance contributions but may elect to use a TPA or ASO contractor to transfer the reinsurance contributions. For every state, all of the contributions from the self-insured market will be collected by HHS even if the state has a State-operated reinsurance program. *Fully Insured Plan* – The issuer is responsible for the reinsurance contributions. In a state-operated program, the state may collect fully insured market contributions within its state or request that HHS do so on its behalf. When HHS is operating the program on behalf of a state, HHS will collect the contributions from the fully insured market.
Calculating the Fee	The fee is equal to $1 per covered life for each plan or policy year ending on or after October 1, 2012 and before October 1, 2013. The fee then increases to $2 per covered life for each plan or policy year ending on or after October 1, 2013 and before October 1, 2014. For plan or policy years ending on or after October 1, 2014, the fee is increased based on increases in the projected per capita amount of National Health Expenditures.	The annual fee for 2014 will be $63 ($5.25/month) per covered life and will decrease in 2015 and 2016. The $63 rate is a national uniform contribution rate and does not vary by state. The regulations do not specify the rates for 2015 or 2016. States may elect to collect more than the amounts that would be required under the national contribution rate to provide funding for administrative expenses or additional reinsurance payments. If a State elects to collect more than the national contribution rate, it must notify HHS within 30 days of publication of the national contribution rate.
Counting Covered Lives		
Safe Harbor Methods in Regulations	• Actual Count Method • Snapshot Method • Form 5500 Method • Member Months Method (Issuers only) • State Form Method (Issuers Only) See discussion following chart for further explanation.	• Actual Count Method • Snapshot Count Method • Snapshot Factor Method • Form 5500 Method See discussion following chart for further explanation.

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	PCORI Fee	Reinsurance Fee
Are retirees counted?	Yes; fee applies to specified health insurance policies or applicable self-insured health plans that provide accident and health coverage to retirees, including retiree-only policies and plans.	Generally not; when an individual has both Medicare and employer-provided group health coverage, the group health coverage will only be considered "major medical coverage" upon which a Reinsurance Contribution will be assessed if it pays primary to Medicare under the Medicare Secondary Payer rules.
Statutory Employees (e.g., life insurance agents) counted?	Yes; the fee is based on "covered lives," which includes all individuals covered under the plan or policy.	Yes; the fee is based on "covered lives," which includes all individuals covered under the plan (unless Medicare exception, described above, applies).
Consolidated Omnibus Budget Reconciliation Act ("COBRA") Qualified Beneficiaries Counted?	Yes; the fee is based on "covered lives," which includes all individuals covered under the plan or policy. Therefore, to the extent that COBRA continuation coverage is provided for a plan or policy that is subject to the fee, COBRA qualified beneficiaries are counted.	Yes; the fee is based on "covered lives," which includes all individuals covered under the plan or policy. Therefore, to the extent that COBRA continuation coverage is provided for a plan or policy that is subject to the fee, COBRA qualified beneficiaries are counted.
May the Fee be Paid from Plan Assets?		
Single-Employer Plan	No; in the preamble to the regulation, Department of Labor ("DOL") states that because the fee is a tax assessed against the plan sponsor, the fee may not be paid with plan assets.	Yes; because the fee is assessed against the plan, plan assets may be used to pay it.
Multiemployer Plan	Yes; the agencies have created a special exception for multiemployer plans so that plan assets may be used to pay the fee.	Yes; because the fee is assessed against the plan, plan assets may be used to pay it.
May the Fee be Passed Along to Participants?		
By Issuer	Yes; nothing in the Code or regulations prevents an issuer from recovering this fee through increases in premiums.	Yes; nothing in the ACA or regulations prevents an issuer from recovering this fee through increases in premiums.
By Self-Funded Plan	If properly structured; note that if plan is subject to ERISA, need to use caution to avoid paying fee from plan assets (e.g., salary reduction contributions).	Yes; nothing in the ACA or regulations prevents a plan sponsor from recovering this fee through increases in participant contributions.
Are Special Arrangements Subject to the Fee?		
Health Savings Account ("HSA")	No; an HSA is generally not considered a plan sponsored by an employer, so should not be considered an applicable self-insured health plan that is subject to the fee. However, high deductible health plans are subject to the fee.	An HSA is not considered "major medical" coverage, so it is not counted for purposes of calculating the fee. However, high deductible health plans are considered major medical.

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	PCORI Fee	Reinsurance Fee
Health Reimbursement Arrangement ("HRA")	An HRA is not subject to a separate fee if the plan sponsor also maintains a separate applicable self-insured health plan within the same plan year. In such circumstances, the plan sponsor is permitted to treat the HRA and the other plan as a single applicable self-insured health plan and pay the PCORI Fee once with respect to each life covered under the HRA and other plan. However, the regulation does not permit a plan sponsor to treat the HRA and fully-insured plan as a single plan for purposes of the fee. Note that the regulations provide a special rule that permits a plan sponsor to assume one covered life for each employee with an HRA and for each employee with an FSA that is not an excepted benefit.	An HRA that is integrated with a group health plan is excluded from Reinsurance Contributions.
Employee Assistance Plan, Wellness Program, Disease Management Program	These programs are excluded from the fee if the program does not provide significant benefits in the nature of medical care or treatment (See Notice 2004-50, Q&A-10 for illustrative guidance).	Excluded from the fee if the program does not provide "major medical coverage," 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.
Puerto Rico Health Plans/Policies	Yes; the term "United States" is defined in the regulations to include any "possession of the United States," specifically including Puerto Rico, so an issuer or plan sponsor in Puerto Rico would be subject to the fee.	No; under ACA section 1341, transitional reinsurance programs are to be established in each state. The definition of "state" for this purpose includes each of the 50 states and the District of Columbia. So, territories are not required to establish transitional reinsurance programs. Although it is possible that a territory could do so on a voluntary basis, Puerto Rico has not taken such steps.

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Patient Centered Outcomes Research Institute Fee

Background

Section 6301 of the Affordable Care Act amended the Code by adding new section 9511 to establish the Patient Centered Outcomes Research Trust Fund (the "Trust Fund"), which is the funding source for the Patient Centered Outcomes Research Institute ("PCORI"), intended to assist patients, clinicians and policy-makers in making informed health decisions by advancing the quality and relevance of evidence based medicine. The IRS issued proposed regulations on April 17, 2012 and final regulations on December 6, 2012. 77 Fed. Reg. 72721 (December 6, 2012).

Calculation of the Fee: Issuers

Under new Code section 4375, issuers will be assessed a fee of $1 for each policy year ending on or after October 1, 2012 and before October 1, 2013 to fund the Trust Fund. The fee then increases to $2 for policy years ending on or after October 1, 2013 and before October 1, 2014. Under Code section 4375(d), for policy years ending on or after October 1, 2014, the fee is increased based on increases in the projected per capita amount of National Health Expenditures. The fee is calculated by multiplying the average number of covered lives under "specified insurance policies." The regulation defines a "specified insurance policy" as an accident or health insurance policy issued with respect to individuals residing in the United States and excludes insurance policies if substantially all of its coverage is of "excepted benefits" which, among other benefits, includes limited scope dental and vision benefits. Code Section 9832(c)(2). Also excluded from the calculation are employee assistance programs, disease management programs and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment.

Calculation of the Fee: Plan Sponsors

Section 4376 of the Code imposes a fee on sponsors of an "applicable self-insured plan" for each plan year ending on or after October 1, 2012 and before October 1, 2019. Under Code section 4376(a) the fee is $1 for plan years ending on or after October 1, 2012 and before October 1, 2013. The fee then increases to $2 for plan years ending on or after October 1, 2013 and before October 1, 2014. For plan years ending on or after October 1, 2014, the fee increases based on the projected per capita amount of National Health Expenditures. Similar to the issuer assessment, the fee is calculated by multiplying the average number of covered lives under the plan.

An "applicable self-insured plan" is defined as a plan that provides accident and health coverage if any portion of the coverage is provided other than through an insurance policy and the plan is established or maintained by:

- one or more employers for the benefit of their employees or former employees;
- one or more employee organizations for the benefit of their members or former members;
- jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees;
- a voluntary employees' beneficiary association;
- by business leagues, chambers of commerce, real estate boards and other organizations formed under Code section 501(c)(6); or
- a multiple employer welfare arrangement.

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The regulations exclude from this definition a plan that provides excepted benefits, which, among other benefits, includes limited scope dental and vision benefits, employee assistance programs, disease management programs and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment. Additionally, plans designed to cover primarily employees who are working and residing outside the United States are excluded from the PCORI fee. The preamble to the PCORI Regulations states that retiree-only policies and plans fall under the definition of "applicable self-insured plans." Further, there is no exception for continuation coverage provided under COBRA, which means persons enrolled in coverage through COBRA are covered lives for purposes of the fee.

Payment from Plan Assets and Tax Treatment

The PCORI Regulation includes a footnote addressing whether the PCORI Fee may be paid out of plan assets, and states that DOL has advised that because the fee is imposed on plan sponsors (instead of the plan), the PCORI fee generally does not constitute a permissible expense of the plan for purposes of ERISA, and therefore must be paid by the plan sponsor "...although special circumstances may exist in limited situations." 77 Fed. Reg. 72722. The agencies subsequently published an FAQ providing that, in the case of a multiemployer plan defined in ERISA section 3(37), unless the plan document specifies a source other than plan assets for payment of the fee under Code section 4376, payment from plan assets would be permissible under ERISA. The FAQ also states that there may be rare circumstances where sponsors of employee benefit plans that are not multiemployer plans would also be able to use plan assets to pay the Code section 4376 fee, such as a VEBA that provides retiree-only health benefits where the sponsor is a trustee or board of trustees that exists solely for the purpose of sponsoring and administering the plan and that has no source of funding independent of plan assets. However, other plan sponsors required to pay the fee under Code section 4376 may not use plan assets to pay the fee even if the plan uses a VEBA trust to pay benefits under the plan. See FAQ #8, available at: http://www.dol.gov/ebsa/faqs/faq-aca11.html. Where the fee cannot be paid from plan assets, it may still be possible to pass the fee along to participants, but such repayment would need to be properly structured.

The IRS issued an internal memorandum dated May 31, 2013 indicating that health insurance issuers and plan sponsors may generally deduct the required PCORI Fee under section 162 of the Code as an ordinary and necessary business expense paid or incurred in carrying on a trade or business. The memorandum noted that the IRS did not take into account any special rules relating to deferred compensation or the taxation of insurance companies under Subchapters D and L of Chapter 1 of the Code, respectively, suggesting that those rules could impact deductibility in certain cases.

Practice Pointer: The PCORI Regulations do not include a concept of an "affiliated group" whereby two or more entities that are related through common ownership are treated as one for federal income tax purposes. The default rule under the Code is that every entity that sponsors a plan is required to pay taxes. Plan sponsors should review their plan documents to determine whether the legal entity sponsoring the plan is the parent company or, alternatively, whether the plan document contemplates each subsidiary or affiliated entity is a plan sponsor. Plan documents may need to be amended to allow the parent company to pay the PCORI Fee.

Special Rule for Multiple Self-Funded Arrangements Established or Maintained by the Same Plan Sponsor

The PCORI Regulation provides that two or more arrangements established or maintained by the same plan sponsor that are self-funded, provide for accident and health coverage *and* have the same plan year, may be treated as a single self-insured health plan for the purposes of calculating the PCORI Fee. If the arrangement is treated as a single plan under this rule, then the same life covered under each of the plans would count as only one covered life under

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the plan for purposes of calculating the fee. For example, if a plan sponsor has self-funded major medical coverage through one plan and self-funded prescription drug coverage through a separate plan, the plan sponsor is not required to pay a covered life assessment on the same individual twice. However, if coverage is provided through a combination of self-funded and insured benefits, this exception does not apply (i.e., the plan sponsor would pay the fee for the self-funded coverage and the issuer would pay the fee for the insured coverage). Similarly, if self-funded coverage is provided by two separate plan sponsors, this rule does not apply.

Methods to Calculate the Number of Covered Lives

The PCORI Regulation provides that issuers and sponsors of self-funded plans may use any of the following methods to calculate the fee: 1) the actual count method; 2) the snapshot method; or 3) the Form 5500 method. In addition, issuers are permitted to use the state form method and the member months method. Each of the counting methods is described in more detail below. For the first year the fee is in effect, the regulation provides that plan sponsors may determine the average number of lives covered under the plan for a plan year using "any reasonable method" and contains specific transition relief for issuers.

- **Actual Count Method**: In general, an issuer or plan sponsor may determine the average number of lives covered under a plan for a plan year by adding the totals of lives covered for each day of the plan year and dividing that total by the number of days in the policy year.

- **Snapshot Method**: In general, an issuer or plan sponsor may determine the average number of lives by adding the number of lives covered on a date during the first, second or third month of each quarter of the plan year. Each date used for the second, third and fourth quarter must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy year or plan year. The 30th and the 31st day of the month are treated as the last day of the month for purposes of determining the corresponding dates for a calendar year plan. For plan sponsors, the snapshot method is divided into two separate rules, either of which a plan sponsor may use:

    - **Snapshot Factor Method:** Under the snapshot factor method, the number of lives covered on a date is equal to the sum of (i) the number of participants with self-only coverage on that date; plus (ii) the number of participants with coverage other than self-only coverage on the date multiplied by 2.35.
    - **Snapshot Count Method:** Under the snapshot count method, the number of lives covered on a date equals the actual number of lives covered on the designated date.

- **Form 5500**: An issuer or plan sponsor may determine the average number of lives covered under a plan for a plan year based on the number of participants reported on the Form 5500 or the Form 5500-SF, provided that the Form 5500 or the Form 5500-SF is filed no later than the due date for the fee, or July 31st.

    - **Practice Pointer**: Plan sponsors that file an extension will not be able to use the Form 5500 counting method, since the Form 5500 or Form 5500-SF would not be filed by the July 31st deadline.

- **Member Months Method (Issuer Only)**: An issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months reported on the NAIC Supplemental Health Care Exhibit filed for that calendar year. Under this method, the average number of lives covered under the policies in effect for the calendar year equals the member months divided by 12.

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The regulation provides a special rule for calculating the fee in the first year whereby the average number of lives covered for that year is multiplied by ¼ which is deemed to be the average number of lives for policy years ending on or after October 1, 2012 and those before January 1, 2013. For the last year of the fee, the average number of lives is multiplied by ¾ which is deemed to be the average number of lives covered for policies with policy years ending on or after January 1, 2019 and before October 1, 2019.

- **State Form Method (Issuer Only)**: An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that is filed with the issuer's state of domicile and a method similar to the Member Months Method, if the form reports the number of lives covered in the same manner as member months are reported on the NAIC Supplemental Health Care Exhibit.

The PCORI Fee must be reported on Form 720 by July 31st for policies or plans with policy or plan years ending in the previous calendar year.

Reinsurance Contribution

The ACA directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. The reinsurance program will provide payments to health insurance issuers in the individual market that cover higher-risk populations to more evenly spread the financial risk borne by issuers. The Department of Health and Human Services ("HHS") will collect contributions from health insurance issuers and self-insured group plans in all States using a national per capita uniform contribution rate ("Reinsurance Contribution"). A final rule setting forth details regarding the Reinsurance Contribution was published in the Federal Register this past March. 78 Fed. Reg. 15410 (March 11, 2013). This final rule largely adopted a proposed rule that was published just a few months earlier. 77 Fed. Reg. 73118 (December 7, 2012). Prior regulations published by HHS relating to the reinsurance program contained few details regarding the mechanics of the payment. See 76 Fed. Reg. 41930 (July 15, 2011); 77 Fed. Reg. 17220 (March 23, 2012).

Calculation of the Fee

The Reinsurance Contribution is calculated based on covered lives with "major medical coverage," which 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. For purposes of the program, limited scope coverage (i.e., hospital indemnity coverage, stand-alone dental or vision coverage) would not be considered "major medical coverage." When an individual has both Medicare and employer-provided group health coverage, the group health coverage will only be considered "major medical coverage" if it pays primary to Medicare under the Medicare Secondary Payer rules (employers are permitted to estimate the number of individuals actually enrolled in Medicare using any reasonable method).

The regulations provide that an HRA is excluded from Reinsurance Contributions if it is integrated with major medical coverage. For purposes of calculating the fee, HSAs are not deemed "major medical" coverage, and are excluded from Reinsurance Contributions. However, Reinsurance Contributions generally would be required for the high deductible health plan because it would constitute major medical coverage. Health FSAs within the meaning of Code section 125 are excluded from the fee, as are employee assistance plans, disease management programs and wellness programs that do not provide major medical coverage. Similarly, a stand-alone prescription drug plan would not constitute "major medical coverage." With regard to COBRA covered individuals, to the extent such

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individuals are enrolled in "major medical coverage" they will need to be counted for purposes of calculating the Reinsurance Contribution.

The annual per participant fee for 2014 will be $63 ($5.25/month) and will decrease in 2015 and 2016. The $63 rate is a national uniform contribution rate and does not vary by state. The regulations do not specify the rates for 2015 or 2016, but some health care analysts have estimated the 2015 rate to be about $42 per participant and the 2016 rate to be about $26.

Special Rule for Multiple Self-Funded Arrangements Established or Maintained by the Same Plan Sponsor

A plan sponsor that maintains two or more group health plans (including one or more group health plans that provide health insurance coverage) that collectively provide major medical coverage for the same covered lives simultaneously is generally required to be treated as a single group health plan for purposes of calculating any reinsurance contribution amount. However, the plan sponsor may treat the multiple plans as separate group health plans for purposes of calculating any reinsurance contribution if each separate plan is treated as providing major medical coverage. This rule is designed to prevent a plan sponsor from carving up one major medical plan into separate components (that independently would not constitute major medical coverage) for purposes of avoiding the fee.

Methods to Calculate the Number of Covered Lives

The regulations set forth a number of methods that issuers and sponsors of self-funded plans may use to determine the average number of covered lives to calculate the Reinsurance Contribution. These methods are similar to the methods permitted to calculate the PCORI Fee, discussed above. Plans with self-insured and insured options must use either the actual count or the snapshot count method described below.

- **Actual Count**: Add the number of lives covered for each day of the first nine months of the benefit year and divide that total by the number of days in those nine months.

- **Snapshot count**: Add the total number of lives covered on a certain date during the first three quarters of the benefit year, and divide that total by the number of dates on which a count was made. For this purpose, the same months must be used for each quarter and the date used for the second and third quarter must fall within the same week of the quarter as the corresponding date used for the first quarter.

- **Snapshot Factor Method (Self-Funded Plans Only)**: Add the number of covered lives on any date during the same corresponding month in each quarter, and divide 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 on the date to the product of the number of participant with coverage other than self-only coverage and a factor of 2.35 (which reflects that all participants with coverage other than self-only have coverage for themselves and some number of dependents). The corresponding dates for the second and third quarters of the benefit year must be within the same week of the quarter as the date selected for the first quarter.

- **Form 5500 Method (Self-Funded Plans Only)**: Calculate the number of lives covered for a plan that offers *only* self-only coverage by adding the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500 and dividing by two. Self-insured group health plans that offer self-only

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coverage and coverage other than self-only may calculate the number of lives covered by adding the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500.

- **Policy Method (Insured Plans Only):** Multiply 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, calculated using the prior National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (or a form filed with the issuer's State of domicile for the most recent time period).

Practice Pointer: Plan sponsors should calculate the PCORI Fee and the Reinsurance Contribution separately, as the counting rules under the methods described above vary between the two regulations.

By no later than November 15th of the year in which the fee is due (2014 – 2016), contributing entities are required to submit to HHS annual enrollment counts of the average number of covered lives of Reinsurance Contribution enrollees for each benefit year. Within 30 days of submission of the annual enrollment count or by December 15, whichever is later, HHS will notify each contributing entity of the Reinsurance Contribution amount to be paid based on that annual enrollment count. Contributing entities are required to remit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year.

Payment from Plan Assets and Tax Treatment

The preamble to the regulation states that DOL advised HHS that paying required contributions under the reinsurance program would constitute a permissible expense of the plan for purposes of Title I of ERISA because the payment is required by the plan under the Affordable Care Act. Further, the Internal Revenue Services provided guidance through an FAQ that sponsors of self-insured group health plans may treat reinsurance program contributions as "ordinary and necessary business expenses," subject to any applicable disallowances or limitations under the Code. This treatment applies whether the contributions are made directly or through a TPA or ASO contractor. The regulations note that commentators asked for guidance concerning whether the fee can be passed along to participants, but the regulations do not address this issue. In the absence of any rule to the contrary, it would seem that the reinsurance fee could be passed along to participants.

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