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American Benefits Council
Preparing for PPACA
Webinar

Session #16
Transitional Reinsurance and PCORI Fee Regulations

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** *Note: Slides 24 and 48 have been updated to reflect additional information on the deductibility of the PCORI Fee*

Overview

» Two Fees

1. PCORI Fee

2. Transitional Reinsurance Program Contribution (“TRP Contribution”)

Total Revenue (Billions)
(2010-2019)

Relevant Formula

Fee Liability = [Per Capita Fee X Subject Lives]

Methodology

» Steps to determining the amount of fee liability for a given plan or policy –

1. Is the plan a subject plan? Do any exceptions apply?
2. What is the per capita fee amount per covered life/reinsurance contribution enrollee?
3. How many individuals are covered by the plan using one of the approved counting methods? Check to see if any aggregation or like rules apply to reduce double counting
4. Multiply the per capita fee by the number of covered individuals
5. Remit and pay the amount owed to HHS and Treasury at the appropriate times

PCORI Fee

Total Revenue (Billions)
(2010-2019)

PCORI Fee

- Imposes a once annual fee on:
  - Issuers of "specified health insurance policy" (IRC § 4375) AND
  - Plan sponsors of an "applicable self-insured health plan" (IRC § 4376)
- Intended to fund comparative effectiveness research – "Patient-Centered Outcomes Research Trust Fund"
- Limited duration
  - Applies to plan/policy years ending on or after October 1, 2012 but before October 1, 2019 (i.e., 2012 to 2018 calendar year plan years)
- Fee collected in subsequent year
- No small employer exception

PCORI Fee

- Proposed regulations published in April 17, 2012 Federal Register
- On December 5, 2012, the IRS released for public inspection final regulations regarding the PCORI Fee ("Final Regulations")

PCORI Fee

- "Specified health insurance policy" (IRC § 4375)
  - Any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the US (place of abode)

- "Applicable self-insured health plan" (IRC § 4376)
  - Any plan for providing accident or health coverage if any portion of the coverage is provided other than through an insurance policy
  - "Accident and health coverage" – any coverage that would be specified health insurance policy if insured
  - Must be established or maintained by certain entities, including employers, VEBAs, MEWAs

PCORI Fee

» Excludes:

– Coverage substantially all of which consists of Code section 9832(c) "HIPAA-excepted" benefits, including:

- The following benefits in general:
  - Coverage only for accident, or disability income insurance, or any combination thereof
  - Coverage issued as a supplement to liability insurance
  - Liability insurance, including general liability insurance and automobile liability insurance
  - Workers' compensation or similar insurance
  - Automobile medical payment insurance
  - Credit-only insurance
  - Coverage for on-site medical clinics
  - Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits
- The following benefits, if offered separately:
  - Limited scope dental or vision benefits
  - Benefits for long-term care, nursing home care, home health care, community-based care
- The following benefits, if offered as independent, noncoordinated benefits:
  - Coverage only for a specified disease or illness
  - Hospital indemnity or other fixed indemnity insurance
- The following benefits, if offered as a separate insurance policy:
  - Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of title 42)
  - Coverage supplemental to the coverage provided under chapter 55 of title 10
  - Similar supplemental coverage provided to coverage under a group health plan

PCORI Fee

- Also excludes:
  - "Exempt governmental programs" – Medicare, Medicaid, CHIP, certain Indian tribal programs
    - But not plans where a governmental entity is acting as the employer plan sponsor
  - Expatriate plans if designed and issued specifically to cover primarily employees who are working and residing outside US
    - Final regulations extend exception to self-funded plans
    - Residing = place of abode
    - Provides that if the address on file for the "primary insured" is outside of the US, the primary insured as well as any spouse and dependents may be treated as having the same place of abode and not residing in the US

PCORI Fee

» Also excludes:

– Stop loss and indemnity reinsurance

• Note: Increased state and federal scrutiny of low-attachment stop-loss

– EAPs, wellness programs, disease management programs if they do not provide significant benefits in the nature of medical care or treatment

• The final regulations provide no further gloss on what constitutes “significant benefits”

PCORI Fee

- Includes:
  - Some health FSAs/HRAs
    - No fee liability for stand-alone HIPAA-excepted FSAs
    - No additional fee for integrated FSAs or HRAs (although the related major medical plans would result in fee liability)
    - Stand-alone HRAs and stand-alone non-HIPAA-excepted FSAs would give rise to fee liability (unless can take advantage of no-double-counting rule)

PCORI Fee

- Also includes:
  - Retiree coverage including via retiree-only plans
    - Note: different rules apply for the TRP Contribution
  - Continuation coverage
    - Preamble states “no basis” to exclude individuals enrolled in continuation coverage and that they “must be taken into account”
    - Includes COBRA, state “mini-COBRA”, voluntary continuation coverage

PCORI Fee

- Per capita fee
  - $1 per covered life for plan/policy years ending on or after October 1, 2012 and before October 1, 2013 (i.e., 2012 calendar year plan year)
  - $2 per covered life for plan/policy years ending on or after October 1, 2013 and before October 1, 2014 (i.e., 2013 calendar year plan year)
  - $2+ thereafter – Adjusted for increase in health costs in later years (i.e., 2014-2018 calendar year plan years)

PCORI Fee

» Average number of lives covered – **self-insured plans**

– **Actual Count Method** – Add the total of lives covered (not just primary insureds/participants) for each day of the plan year and divide that total by the number of days in the plan year

– **Form 5500 method** – Provided the Form 5500 is filed no later than the due date for the payment of the PCORI Fee, i.e., July 31 of the next year:

- For plans with only self-only coverage – Add the total participants covered at the beginning and end of the plan year, as reported on the Form 5500, and divide by two

- For plans with more than just self-only coverage – Add the total participants covered at the beginning and end of the plan year, as reported on the Form 5500, and do NOT divide by two

– Note: Issuers cannot use the Form 5500 method, but may use the state form or member months method

PCORI Fee

» Average number of lives covered – **self-insured plans**

- **Snapshot Methods**
  - **Generally** – Add the totals of lives covered or participants (depending on whether using the Factor or Count method below) on a date during the first, second or third month of each quarter of the plan year (or more dates in each quarter if an equal number of dates in each quarter), and divide that total by the number of dates on which a count was made (for example, January, April, and July)
  - **Two specific methods**
    - **Snapshot Factor** – As of the dates set forth above, determine the sum of (i) number of participants with self-only coverage, and (ii) the number of participants with coverage other than self-only coverage on the date multiplied by 2.35, and divide such sums by the number of dates used
    - **Snapshot Count** – The number of lives covered on a date equals the actual number of lives covered on a designated date. Add up these actual numbers and divide by the number of dates used

PCORI Fee

» Average number of lives covered – **self-insured plans**

– **Example of Actual Count Method:** Employer A is the plan sponsor of a self-insured group health plan ("Plan A"), which has a calendar year plan year. Employer A calculates the sum of lives covered under the Plan A for each day of the plan year ending December 31, 2013 as 3,285,000. The average number of lives covered under Plan A for the plan year ending December 31, 2013 is therefore equal to 3,285,000 divided by 365, or 9,000. To calculate Employer A's PCORI Fee liability, Employer A must multiply 9,000 by the applicable per capita fee, i.e., $2, for a resulting fee liability of $18,000.

PCORI Fee

» Average number of lives covered – **self-insured plans**

– **Example of Snapshot Count Method:** Employer B is the plan sponsor of a self-insured health plan ("Plan B"), which has a calendar year plan year and which provides both self-only and family coverage. Employer B elects to use the Snapshot Count Method to determine its fee liability for the plan year ending December 31, 2013, so it decides to determine the number of covered lives on the first day of each quarter. Employer B determines there are covered lives as of the first day of each quarter equal to: 2,000, 2,100, 2,050, and 2,050. To determine its fee liability, Employer B adds together these four data points (i.e., 2,000 + 2,100 + 2,050 + 2,050 = 8,200) and divides the sum by 4, which results in an average number of covered lives of 2,050. Employer B then multiplies 2,050 by the applicable per capita fee of $2, for a fee liability of $4,100.

PCORI Fee

» Average number of lives covered – **self-insured plans**

– **Example of Form 5500 Method:** Employer C's self-insured health plan ("Plan C") offers self-only and family coverage. Plan C has a calendar year plan year. Employer C seeks to determine its PCORI Fee liability using the Form 5500 Method for the plan year ending December 31, 2012 Employer C files its Form 5500 for the 2013 plan year by July 31, 2013. Employer C reported on the 2012 Form 5500 5,000 participants at the beginning of the plan year and 5,400 participants at the close of the plan year. To calculate its PCORI Fee liability, because Employer C has both self-only and family coverage, Employer D must add together 5,000 and 5,4000 and then multiple the resulting sum by the applicable per capita fee amount, i.e., $1, which results in a fee liability of $10,400 for Employer C.

PCORI Fee

- Anti-double-counting rule for self-insured plans only
  - Need same sponsor, same plan year, all self-funded
  - Does not apply for insured arrangements
    - However, the final regulations provide that a plan sponsor can disregard individuals covered under an insured plan/component/benefit package of a larger self-funded plan if such individuals are only covered under such insured plan/component/benefit package

PCORI Fee

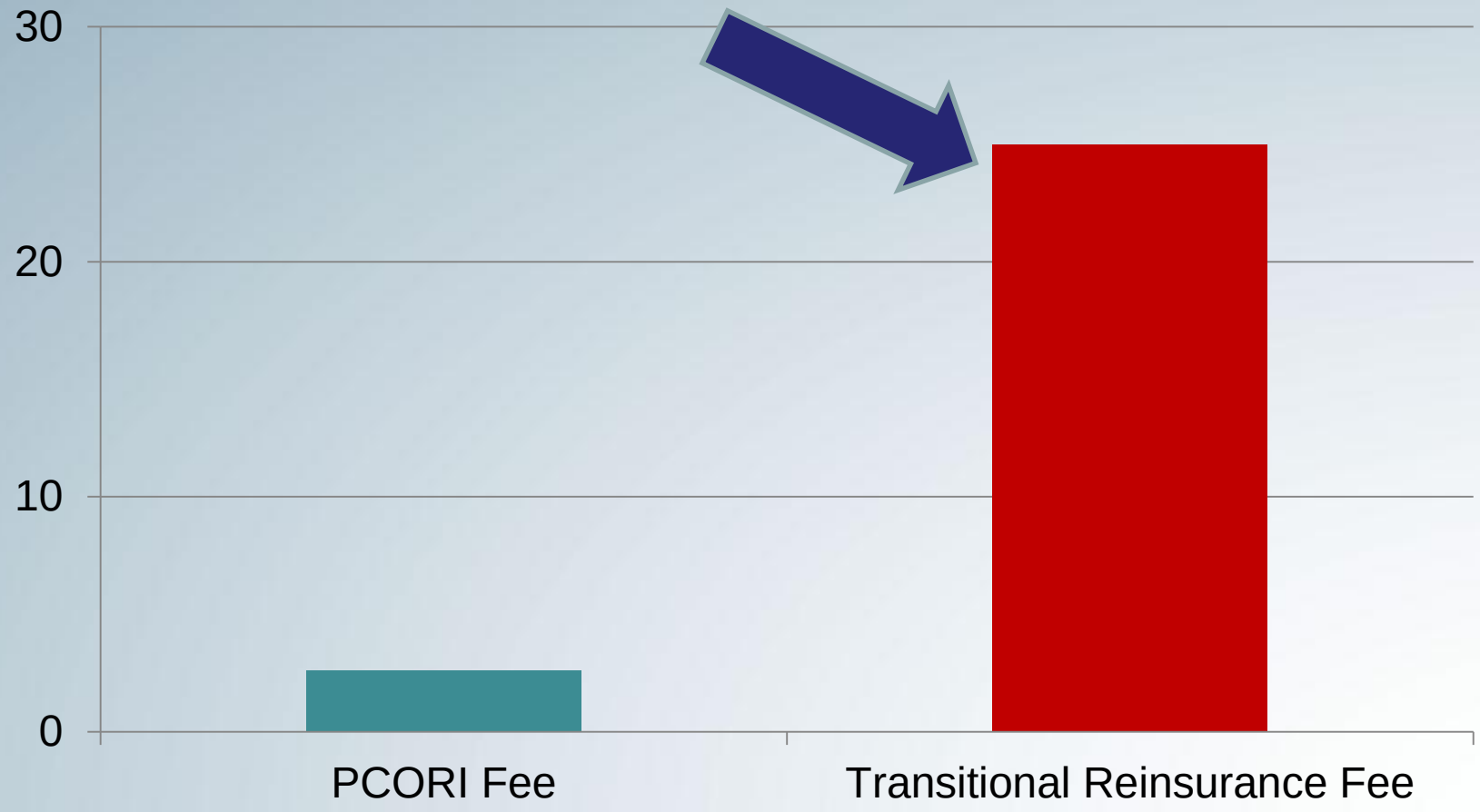
- Reporting and remittance of fee
  - Report and pay once a year, by July 31 of the subsequent calendar year
    - Rejected allowing for reporting and remittance in connection with extended Form 500 filing, i.e., October 15 of next year
  - Use Form 720 to report and remit fee
    - Final regulations do not allow for corrected filings; however, applicable penalties may be abated for reasonable cause
  - Third-party reporting is not permitted

PCORI Fee

- Treated as an excise tax
  - Whether the PCORI Fee is deductible remains unclear. The IRS indicates the issue is under consideration
  - To the extent not deductible, it would increase employer costs to the extent of the marginal federal income tax rate
- May not be paid with ERISA plan assets
  - Per the statute, the PCORI Fee runs to the plan sponsor and not the plan itself
  - This is in contrast to the transitional reinsurance program contribution, which is payable from plan assets

Transitional Reinsurance Program Contribution

Total Revenue (Billions)
(2010-2019)



TRP Contribution

» Section 1341 requires health insurance issuers, as well as certain plan administrators on behalf of self-insured group health plans, to make contributions to raise revenue to pay for –

- the Transitional Reinsurance Program for a three-year period beginning January 1, 2014 ($20 billion)
  - 2014 - $10 billion
  - 2015 - $6 billion
  - 2016 - $4 billion

- Early Retiree Reinsurance Program ("ERRP") ($5 billion)
  - 2014 - $2 billion*
  - 2015 - $2 billion
  - 2016 - $1 billion*

* Comments are requested as to whether the $2 billion for ERRP for 2014 should be delayed for collection in 2016

TRP Contribution

- Section 1341 of PPACA requires the HHS Secretary, in consultation with the National Association of Insurance Commissioners ("NAIC"), to implement standards enabling states to establish and maintain a 3-year transitional reinsurance program ("Transitional Reinsurance Program") during the implementation of health reform

- Each state's Transitional Reinsurance Program is intended to assist issuers who provide individual insurance market coverage to high-cost enrollees during the implementation of health reform both inside and outside the exchange

TRP Contribution

- Earlier this year, HHS issued final regulations ("Final Regulations") regarding the Transitional Reinsurance Program
- The Final Regulations provided very helpful guidance, but many questions remained
- On November 30, 2012, HHS released for public inspection new proposed regulations ("New Proposed Regulations"), which provide very helpful and clarifying guidance
  - Note: Comments are due by December 31, 2012 (because comment deadline is based on date available for public inspection, not publication in the Federal Register)

TRP Contribution

- Things to keep in mind
  - This fee is NOT the PCORI fee
  - The fee applies for a 3-year period from 2014 to 2016
  - The fee applies to certain insured and self-funded plans
  - The fee is collected in the SAME year (versus in arrears)
  - Like the PCORI Fee, there is no small employer exception
  - HHS has authority over this fee, not Treasury, which has authority regarding the PCORI and annual health insurer fees
    - Thus, similar, but different rules apply

TRP Contribution

- The TRP Contribution is also a per capita fee
- The Final Regulations provided little insight regarding the amount of the per capita fee
  - Some estimates were that the fee could be anywhere from $61 per person for 2014 to as high as $105 per person
- New Proposed Regulations provide for a monthly fee of $5.25 per person for 2014 or $63 annually per person
  - To the extent that the $2 billion of ERRP monies for 2014 are delayed in whole until 2016, this should serve to reduce the fee to approximately $4.50 per month per person for 2014 or $54 annually per person
- The per capita fee here is MUCH greater than the PCORI fee (which is $1 per capita for 2012 (collected in 2013) and $2 per capita through 2019, subject to indexing)

TRP Contribution

- The per capita fee applies to each "reinsurance contribution enrollee" under the plan
  - Effectively, encompasses each covered life under the plan
    - Includes employees, spouses, dependents, and any other individuals receiving coverage under the plan at issue
  - Issue of "double counting"
    - The New Proposed Regulations provide that if a plan sponsor maintains two or more group health plans or health insurance plans (or a group health plan with both insured and self-insured components) that collectively provide major medical coverage for the same covered lives, then these can be treated a single self-insured plan for purposes of the TRP

TRP Contribution

- Who is liable for the fee?
  - Depends on whether the plan is insured or self-funded
    - **If insured, then liability runs to the issuer**
      - Note: It should be expected that the fee will be passed on to plan sponsors in the form of increased premiums. This is due, in part, to the fact that such amounts do not adversely affect the issuer for MLR purposes (but could give rise to increased scrutiny by state or federal regulators as part of rate review)

TRP Contribution

» Who is liable for the fee?

– **The New Proposed Regulations clarify that if the plan is self-funded, the ultimate liability for the fee amount belongs to the plan sponsor and not the plan administrator**

• The statute and Final Regulations state that the third party administrator of a self-funded plan will pay the fee "on behalf of" the self-funded plan sponsor

TRP Contribution

programs for high risk conditions.

(3) DETERMINATION OF REQUIRED CONTRIBUTIONS.—

(A) IN GENERAL.—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) SPECIFIC REQUIREMENTS.—The method under this

TRP Contribution

- The New Proposed Regulations contemplate that a plan may utilize a TPA or ASO to remit the fee to HHS
  - The preamble states that, "[a]lthough self-insured group health plans are ultimately liable for reinsurance contributions, a third-party administrator or administrative-service-only contractor may be utilized for transfer of the reinsurance contributions"
    - Presumably, this would be accomplished via contract with the plan/sponsor and the TPA or ASO
- Although the New Proposed Regulations clarify that the liability for the fee amount belongs to the plan, questions remain regarding when and if a TPA or ASO may be liable for PHSA penalties for failing to remit a fee to HHS

TRP Contribution

- States have the right to charge additional fees with respect to issuers of *insured* coverage
  - Thus sponsors of insured small and large group plans could see additional fee liability imposed by states
- Can states levy additional fees against self-funded plans?
  - Section 1341(b)(3)(B)(3), states that, "[n]othing . . . shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis"
  - HHS restates states the above in the preamble to the New Proposed Regulations that, ""nothing in section 1341 of the Affordable Care Act or [the New Proposed Regulations] gives a State the authority to collect from self-insured group health plans covered by ERISA," and states that, "federal law generally preempts state law that relates to an ERISA-covered plan."
  - Although it appears section 1341 likely cannot be used by states as authority to levy additional fees against self-funded plans, query whether such action could nonetheless survive ERISA preemption (*see e.g.*, Michigan Health Insurance Claims Assessment Act (HICA Act))

TRP Contribution

» What types of plans and insurance are subject to the fee?

– The fee generally applies to all “health insurance coverage” and self-funded “group health plans”

  • Including FEHB plans and state and local governmental plans

– However, the following are excepted:

  • HIPAA-excepted coverages

  • In the case of health insurance, coverage that is not considered to be part of the issuer’s “commercial book of business”

  • In the case of health insurance, coverage that is not issued on a form filed and approved with a state insurance department

  • Self-funded group health plans or health insurance that do not provide major medical benefits

TRP Contribution

» Other types of excepted coverage/more specifically –

- Private Medicare, Medicaid, CHIP, State high-risk pools, and basic health plans (because these are not part of a "commercial" book of business)
- Health flexible spending arrangements ("FSAs") (apparently without regard to whether the FSA is an excepted benefit for purposes of PHSA section 2791(c) – because they are not major medical coverage)
- Health reimbursement arrangements ("HRAs") integrated with a group health plan (although TRP contributions would be required of the related group health plan)
- Health savings accounts ("HSAs")
- Employee assistance plans, disease management programs, and wellness programs "if they do not provide major medical coverage"
- Stop-loss and indemnity reinsurance policies;
- Military health benefits (e.g., TRICARE)
- Tribal coverage

TRP Contribution

- Retiree Coverage
  - The fee applies to retiree coverage unless the retiree coverage is secondary to Medicare coverage under the Medicare Secondary Payer ("MSP") Rules (including w/r/t disability and end-stage renal disease)
    - Thus –
      - Pre-65 retiree coverage likely would be subject to the TRP Contribution
      - Post-65 retiree coverage likely would not be subject to the TRP Contribution
    - The rule here is more generous to retiree coverage than under the PCORI Fee rules where the PCORI Fee applies to all retiree coverage

TRP Contribution

- Continuation Coverage
  - The New Proposed Regulations do not expressly address the treatment of continuation coverage
    - In contrast to the Final Regulations regarding the PCORI Fee, which expressly state that the PCORI Fee applies to continuation coverage
  - Nonetheless, it appears very likely that the TRP Contribution will apply to individuals enrolled in continuation coverage under a group health plan
    - This appears to be the case regardless of whether it is by reason of federal COBRA, state “mini-COBRA” and the like, or voluntary continuation coverage

TRP Contribution

- When is the TRP Contribution due and how will it be collected?
  - Final Regulations provided for the fee to be due and collected on a quarterly basis beginning January 1, 2014 – no more…
  - New Proposed Regulations provide for once annual collection
  - HHS will be collecting all TRP Contributions owed by self-funded plans
  - Proceeds to be distributed to issuers based on need
  - No state-by-state data reporting is required

TRP Contribution

- When is the TRP Contribution due and how will it be collected?
  - The New Proposed Regulations require the fee to be due and collected at the close of each year – generally NOT after year-end as is the case with the PCORI Fee
    - **November 15** – Plan or issuer must submit to HHS its annual enrollment count
    - **Within 15 days of report submission or December 15 if later** – HHS notifies plan or issuer of TRP Contribution amount to be paid to HHS
    - **Within 30 days of HHS notification of TRP contribution liability** – Plan or issuer must remit the fee amount to HHS

TRP Contribution

» Counting Methods to determine number of reinsurance contribution enrollees – **self-insured plans**

– **Actual Count Method** – Add the total of lives covered (not just primary insureds/participants) for each day of the first nine months of the calendar year and divide that total by the number of days in those nine months

– **Form 5500 method** – Use the most recently filed Form 5500 for the plan at issue

- For plans with only self-only coverage: Add the total participants covered at the beginning and end of the plan year, as reported on the Form 5500, and divide by two
- For plans with more than just self-only coverage: Add the total participants covered at the beginning and end of the plan year, as reported on the Form 5500, and do NOT divide by two

– Note: Issuers cannot use the Form 5500 method, but may use a modified state form or member months method

TRP contribution

» Counting Methods – **self-insured plans**

– **Snapshot Methods**

- **Generally** – Add the totals of lives covered or participants (depending on whether using the Factor or Count method below) on a date during the first, second or third month of each of the first three quarters of the plan year (or more dates in each quarter if an equal number of dates in each quarter), and divide that total by the number of dates on which a count was made (for example, January, April, and July)
- **Two specific methods**
  - **Snapshot Factor** – As of the dates set forth above, determine the sum of (i) number of participants with self-only coverage, and (ii) the number of participants with coverage other than self-only coverage on the date multiplied by 2.35, and divide such sums by the number of dates used
  - **Snapshot Count** – The number of covered lives on a date equals the actual number of covered lives on a designated date. Add up these actual numbers and divide by the number of dates used

TRP Contribution

» Penalties

– The penalties of section 2723 of the PHSA apply without regard to any limitations regarding group health plans

• Very generally, $100 per day per affected individual

– Note: Technical drafting error regarding cross-reference to penalties; although congressional intent appears clear that penalties shall apply

• Unclear how the penalties could apply to the ASO in the event it is relied upon by the plan/sponsor to remit the TRP contribution to HHS

TRP Contribution

- Ordinary and necessary business expense; thus, may be tax deductible
- May be paid from ERISA plan assets
  - Unlike the PCORI Fee, which runs to the plan sponsor, the TRP Contribution runs to the plan
  - The preamble to the New Proposed Regulations states that, "[t]he Department of Labor has reviewed this proposed rule and has that paying required reinsurance contributions 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 as interpreted in this proposed rule"

	PCORI Fee	TRP Contribution
Applicable years	2012-2018 for calendar year plans	2014-2016
Plan versus calendar year application	Plan year	Calendar year
Authority	Treasury/IRS	HHS
Per capita fee amount	Small	Big
Due date	July 31 of NEXT calendar year	December 31 of SAME calendar year
Small employer exception?	No	No
Applies to all retiree coverage?	Yes	No, unless Medicare is secondary payer
Applies to continuation coverage	Yes	Appears yes
Applies to FSAs?	Yes, if not HIPAA-excepted	No
Tax deductible?	Unclear; depends on whether ordinary and necessary	Yes
Payable from ERISA plan assets?	No	Yes