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Practice Area: Compensation and Benefits/ERISA & Employer Health Plans Team

If you are an employer that sponsors a self-insured health plan for your employees, you will be subject to two new fee requirements under the Affordable Care Act ("ACA") this year and the next few years.* The first fee, the Patient Centered Outcomes Research Institute ("PCORI") fee, is effective for plan years ending on or after October 1, 2012 and before October 1, 2019. *For an employer sponsor of a plan with a plan year that ended between October 1, 2012 and December 31, 2012,* ***the first PCORI payment is due July 31, 2013***. The second fee, the transitional reinsurance fee, will be effective for 2014, 2015 and 2016. Sponsors of self-insured plans will be required to file an enrollment report with the Department of Health and Human Services by November 15 of each of the three years that the fee will be in effect. The first transitional reinsurance enrollment report will be due November 15, 2014. The PCORI and transitional reinsurance fees are assessed on health insurance companies and employer sponsors of self-insured health plans. This *Update* focuses on the rules for sponsors of single-employer self-insured health plans.

PCORI FEE

Q-1: What is PCORI?
The ACA established PCORI, a private, nonprofit corporation, to assist patients, clinicians, purchasers and policy-makers in making informed health decisions through the synthesis and dissemination of clinical research findings.

Q-2: Are sponsors of all self-insured health plans subject to the PCORI fee, including health reimbursement accounts ("HRAs") and flexible spending accounts ("FSAs")?
Except as provided in this paragraph, the employer-sponsor of any plan that provides accident and health coverage is subject to the fee if any portion of the coverage is provided on a self-insured basis. Plans that are exempt from the Health Insurance Portability and Accountability Act ("HIPAA") are exempt from the PCORI requirements. Exempt plans include (but are not limited to): plans that provide "excepted benefits", e.g., limited scope dental or vision insurance offered separately, long term care insurance offered separately, coverage only for a specified disease, and benefits provided under a health flexible spending arrangement (including HRAs and FSAs) if other group health plan coverage is made available to the covered employees and the maximum benefit payable to any participant for a year does not exceed the greater of: 1) two times the employee's salary reduction election, or 2) $500 plus the employee's salary reduction election. If an employer sponsors an HRA or FSA plan that provides benefits that exceed these limits, the HRA or FSA is subject to the PCORI fee, but see ***Q-5***, below, for when an HRA or FSA may be aggregated with another self-insured plan maintained by the same employer. An employee assistance program, disease management program or wellness program is not subject to the PCORI fee if the program does not provide significant benefits in the nature of medical care or treatment.

Q-3: How much is the PCORI fee?
The amount of the PCORI fee in plan years ending between October 1, 2012 and September 30, 2013 is $1 multiplied by the average number of lives covered under the plan, including active and former employees, spouses, dependents and COBRA beneficiaries. For plan years ending between October 1, 2013 and September 30, 2014, the fee will be $2 per average covered life. Thereafter, the amount of the fee will be increased by the percentage increase in the per capita National Health Expenditures determined by the Department of Health and Human Services.

Q-4: How is the average number of covered lives determined for purposes of calculating the PCORI fee?
For a plan year beginning before July 11, 2012 and ending on or after October 1, 2012, a plan sponsor may use any reasonable method for determining the average number of lives covered under the plan. For all other plan years, a plan must use one of the following methods for determining this average. A plan sponsor must use the same method for the entire plan year, but may use a different method from one plan year to the next.

Actual Count Method
A plan sponsor may determine the average number of lives covered by the plan during 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 plan year.

Snapshot Method
Alternatively, a plan sponsor may determine the average number of lives covered by the plan during a plan year by adding the totals of lives covered on one or more dates during the first, second or third month of each quarter of the plan year and dividing that total by the number of dates on which a count was made. The following rules apply to the testing dates under the Snapshot Method:

- An equal number of dates must be used in each quarter
- Each date used in the second, third and fourth quarter must be within three days of the corresponding date used in the first quarter
- All dates must fall within the same plan year
- The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days

The number of lives covered on a designated date may be determined using one of the following methods:

Snapshot Factor Method. Under this method, the number of lives covered on a date is equal to the sum of:

- The number of participants with self-only coverage on that date plus
- The number of participants with coverage other than self-only coverage on that date multiplied by 2.35.

Snapshot Count Method. Under this method, the number of lives covered on a date equals the actual number of lives covered on the designated date.

Form 5500 Method
The third alternative for determining the average number of lives covered under a plan for a plan year is based on the Form 5500 or Form 5500-SF annual report that is filed for the plan for that plan year. This method is available only if the annual report is filed no later than the due date for reporting and paying the fee for the plan year in question. Under this method, if the plan offers only self-only cover, the average number of lives covered for the plan year is the sum of the total participants covered at the beginning and the end of the plan year, as reported on the annual report, divided by two. If the plan offers both self-only coverage and coverage for other family members, the average number of lives covered for the plan year is the sum of total participants covered at the beginning and the end of the plan year, as reported on the annual report.

Special Rules for Health FSAs and HRAs
The following special rules apply to FSAs and HRAs that are not exempt from the PCORI requirements under the rules described in ***Q-2***, above:

- If an employer does not maintain a self-insured health plan other than a health FSA or HRA, the employer may treat each participant's FSA or HRA as covering a single life. That is, the employer may disregard the participant's spouse and dependents covered by the FSA or HRA when determining the average number of covered lives.
- If a health FSA or HRA has the same plan sponsor and same plan year as another self-insured health plan (other than another health FSA or HRA), the two arrangements may be treated as a single plan for purposes of counting the participants in the health FSA or HRA. (See ***Q-5***, below.) The special counting rule for stand-alone FSAs and HRAs in the preceding paragraph, then, applies only to participants who do not participate in the other self-insured health plan. The participants in the health FSA or HRA that participate in the other self-insured plan will be counted under the Actual Count Method, the Snapshot Method or the Form 5500 method, whichever applies to that other plan.

Special Rule for Health Plan with Self-Insured and Fully Insured Options
If a health plan other than a health FSA or HRA provides accident and health coverage through fully-insured options and self-insured options, the plan sponsor may disregard the lives that are covered solely under the fully-insured options in determining the average number of covered lives under the self-insured plan.

Q-5: If we have multiple self-insured health plans, e.g., a major medical plan, prescription drug plan and an HRA or FSA that is not exempt under the rules summarized above, must we pay the PCORI fee for each plan?
Not necessarily. Two or more self-insured plans that provide for accident and health coverage maintained by the same plan sponsor and that have the same plan year may be treated as a single self-insured health plan for purposes of the PCORI fee rules.

Q-6: If we have multiple self-insured plans with different plan years and some employees are covered under more than one plan, must we include the employee (and his or her covered family members, if applicable) in calculating the average covered lives for each plan that covers the employee (and his family, if applicable)?
Yes. If the self-insured plans have different plan years, then the plan sponsor must calculate the PCORI fee for each plan separately.

Q-7: How and when is the PCORI fee reported and paid to the IRS?
The PCORI fee is reported on IRS Form 720, "Quarterly Federal Excise Tax Return," and paid to the Internal Revenue Service once a year, by July 31 of the calendar year immediately following the last day of the applicable plan year.

Q-8: Is the PCORI fee deductible?
Yes. Although excise taxes such as the PCORI fee are not usually deductible, the IRS has determined that the PCORI fee is deductible as an ordinary and necessary business expense.

TRANSITIONAL REINSURANCE FEE

Q-1: What is the transitional reinsurance program?
The ACA established the transitional reinsurance program to stabilize insurance premiums in the individual market during 2014, 2015 and 2016, the first three years of the new health insurance marketplace provided by state and federal exchanges. The program will provide reinsurance payments to health insurance companies that cover high-risk individuals in the individual market who will be able to get coverage without regard to their preexisting conditions under the guaranteed issue requirements of the ACA. In contrast to the PCORI fee, which is paid to and administered by the IRS, the transitional reinsurance fee will be paid to and administered by the Department of Health and Human Services ("HHS").

Q-2: Are sponsors of all self-insured group health plans subject to the transitional reinsurance fee, including HRAs and FSA?
HRAs, FSAs and health savings accounts ("HSAs") are not subject to the reinsurance fee. Employer-sponsored self-insured plans that provide major medical benefits are generally subject to the fee. In addition to HRAs, FSAs and HSAs, arrangements that are exempt from the reinsurance fee include (but are not limited to): plans that provide coverage that is secondary to Medicare; plans that consist solely of "excepted benefits" under HIPAA; employee assistance plans, disease management programs and wellness programs that do not provide major medical coverage; and prescription drug plans.

Q-3: How much will the transitional reinsurance fee be?
The reinsurance fee for all of an employer's self-insured plans is the number of covered lives for the benefit year multiplied by the contribution rate for that year. HHS estimates that the contribution rate for 2014 will be $63 per covered life.

Q-4: How will the number of covered lives be determined for purposes of calculating the transitional reinsurance fee?
The number of lives covered during a benefit year will be calculated using one of three methods similar to (but not exactly the same as) the methods for calculating the PCORI fee, described under Q-4 of the preceding section.

Q-5: If we have multiple self-insured health plans covering the same employees, must we pay the transitional reinsurance fee for each plan?
No. If an employer sponsors two or more plans, including at least one self-insured plan other than a plan that consists solely of excepted benefits, prescription drug benefits, HRAs, FSAs or HSAs, that collectively provide major medical coverage for the same covered lives simultaneously, the multiple plans must be treated as a single group health plan for purposes of calculating the reinsurance fee. Special rules apply to determining the reinsurance fee for multiple group health plans that are treated as a single plan for purposes of determining the reinsurance fee.

Q-6: How and when is the transitional reinsurance fee reported and paid to HHS?
Not later than November 15 of the 2014, 2015 and 2016 benefit years, an employer that sponsors a self-insured major medical plan must submit an annual enrollment count of the number of covered lives for the benefit year to HHS. Within 30 days of the submission of the annual enrollment count or, if later, by December 15 of the benefit year, HHS will notify the employer of the reinsurance contribution amount to be paid for that benefit year. The employer must then remit the payment to HHS within 30 days after the date of the notification.

Q-7: Is the transitional reinsurance fee tax deductible?
Yes. As with the PCORI fee, the transitional reinsurance fee is deductible as an ordinary and necessary business expense.

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* On July 2, 2013, the Obama Administration announced that it is postponing the effective date of the employer "shared responsibility or "pay or play" rules that apply to employers with over 50 full time employees to 2015. The announcement specified that that action does not affect any other provisions of the ACA. Consequently, it appears that employers that sponsor self-insured health plans will be required to comply with the PCORI and transitional reinsurance fee requirements.

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