Self-funded Employer's Guide

Transitional Reinsurance Fee and Patient-Centered Outcomes Research Institute Fee

UnitedHealthcare®
To fund some of the changes mandated by the Affordable Care Act (ACA), several new taxes and fees will impact your group health plan. Two of these fees, the Transitional Reinsurance Fee and the Patient-Centered Outcomes Research Institute (PCORI) Fee, are paid to the government directly by you.

While questions related to your specific situation should be directed to your tax advisor or legal counsel, we would like to share an overview of the fees, information on remitting payment and the types of coverage impacted by the fees.

The Reinsurance and PCORI Fees are both temporary and assessed on a per capita basis. That means the fee is paid for each member or covered life (employees, spouses and dependents) under your health plan. While both fees are paid annually, they have different schedules, fee amounts and exclusions.

Because the Reinsurance Fee, in particular, will have a financial impact on your business, we want to share this information now so you have time to prepare for and fund this three-year fee.
About the Transitional Reinsurance Fee

The ACA requires health insurance issuers and self-funded group health plans to fund a Transitional Reinsurance Program that will be in place from 2014 to 2016. Through the program, reinsurance fees are distributed to health insurance issuers in the non-grandfathered individual market. The assumption is that the individual market, which also includes health insurance purchased through individual Exchanges (also called Health Insurance Marketplaces) may disproportionately attract individuals at risk for high medical costs. Reinsurance payments will be made to reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers’ risk associated with high-cost enrollees.

Reinsurance Fees are collected by the Department of Health and Human Services (HHS) for each health plan that meets minimum value. The fees are based on your enrollment count for the first nine months of the calendar year. The reinsurance dollars will then be used by a reinsurance entity to make payments to eligible health insurance issuers that offer health insurance through the individual market.

Transitional Reinsurance Fee Amount

The health reform law specifies the total amounts of the Reinsurance Fee that must be collected: $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, totaling $25 billion.

- In 2014, the Reinsurance Fee is $5.25 per member per month ($63 per member per year).
- In 2015, the fee is $3.67 per member per month ($44 per member per year).
- In 2016, the fee is yet to be determined.
- States also may collect fees if they establish their own reinsurance program.

UnitedHealthcare must remit the Reinsurance Fee for its fully insured coverage, but our customers with self-funded plans are responsible for submitting their enrollment counts, funding and paying the Reinsurance Fee.

Transitional Reinsurance Fee Payment Schedule

The Reinsurance Fee may be submitted in one payment or in two installments. If submitting as one payment, the full amount is due by Jan. 15. If paying in two installments, for the 2014 calendar year, of the $63 per member per year rate, the first installment of $52.50 goes to reinsurance payments and administrative expenses and is due Jan. 15. The second installment of $10.50 goes to the U.S. Treasury and is due November 15, 2015.

Enrollment counts are determined based on the first nine months of the calendar year regardless of plan year or renewal date. The enrollment count only needs to be submitted once per year.

Key Dates for the 2014 Reinsurance Fee

- **November 15, 2014**
  Membership counts due to HHS

- **January 15, 2015**
  The due date for making the first payment, if paying in two installments. Last day to make the full payment, if making one payment.

- **November 15, 2015**
  The due date for making the second installment of the 2014 payment.
Submitting Membership Counts and Payment for the Transitional Reinsurance Fee

The federal government issued guidance outlining how to submit the annual enrollment count to HHS:

- Use the form on Pay.gov (www.pay.gov), a web-based application where forms and online payments to government agencies can be submitted.
- Provide basic company and contact information, the annual enrollment count for the applicable year and upload supporting documentation.
- Pay.gov will auto-calculate the contribution amounts.
- Decide if you want to submit the Reinsurance Fee in one payment or two installments, and schedule payment date(s).
- Payment will be automatically deducted from the designated account on the dates selected.
- Contact your bank and add Agency Location Code (ALC +2 value) 7505008015 to your list of approved companies for ACH automatic debits. Failure to do this may delay your payment to the government.
- Submit the number of covered lives via pay.gov by Nov. 15.

Training on this process is available. Register on https://www.regtap.info/ to receive training notices.

See Calculating Your Membership Count for Either Fee to review the four counting methods.

The Department of Labor (DOL) has advised that payment of the Reinsurance Fee would be considered a permissible expense of the plan under Title I of the Employee Retirement Income Security Act of 1974 (ERISA) because the payment is required under the ACA.

The Internal Revenue Service (IRS) has indicated that a sponsor of a self-funded group health plan that pays the Reinsurance Fee may treat the contributions as an ordinary and necessary business expense, subject to disallowances or limitations under the Code. This tax treatment applies whether the contributions are made directly or through a third-party administrator or administrative-services-only contractor.

Coverage Impacted by the Transitional Reinsurance Fee

The Reinsurance Fee is paid once per covered life on plans that provide major medical coverage and meet minimum value, including grandfathered plans.

The Reinsurance Fee does not apply to supplemental or secondary coverage including the following types of coverage:

- Accident-only coverage
- Children’s Health Insurance Program (CHIP)
- Employee Assistance Programs (EAP) or wellness programs that do not provide major medical benefits
- Expatriate-only plans
- Flexible Savings Accounts within the meaning of Section 125 of the Code
- Health Reimbursement Arrangements that are integrated with major medical coverage
- Health Savings Accounts
- Indemnity reinsurance policy
- Medicaid
- Medicare
- Medicare Advantage plans
- Medicare supplement coverage that meets the requirements of Section 1882(g)(1)
- Part D prescription drug benefits
- Plans covering tribal members and dependents (not employment-based plans)
- Plans that do not meet minimum value
- Prescription drug benefit plans
- Retiree-only plans that pay secondary to Medicare
- Stop loss
- TRICARE
- Specified diseases or hospital indemnity coverage
- Stand-alone vision and dental (as long as they are excepted benefits under HIPAA)
About the PCORI Fee

The Patient-Centered Outcomes Research Institute (PCORI) Fee helps fund research that evaluates and compares health outcomes, clinical effectiveness, and the risks and benefits of medical treatments and services.

PCORI Fee Amount and Payment Schedule

Under the ACA, health insurance issuers and plan sponsors are responsible for paying the PCORI Fee. The fee is in effect from 2012 to 2019. The PCORI Fee is assessed on each covered life (employees, retirees, spouses and dependents).

Here is the fee schedule:
• For plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2013, the fee was $1 per member per year.
• For plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014, the fee is $2 per member per year.
• For plan years ending in any fiscal year beginning on or after Oct. 1, 2014, the fee is indexed for medical inflation.
• The fee will not apply to policy or plan years ending after Sept. 30, 2019.

Payment must be submitted by July 31 of the calendar year immediately following the last day of the plan year.

Case example: Calculating the PCORI Fee Using the Form 5500 Method

Next Level Logistics determined that it has 350 employees and 835 lives covered under its plan using the Form 5500 method, after comparing the results of this count with other counting methods. Its plan year runs from Oct. 1, 2012, to Sept. 30, 2013.

For Next Level Logistics, the $1 per member per year fee in the amount of $835 is due on July 31, 2014. (Remember, if Next Level Logistics’s plan year ended on or between Oct. 1, 2012 to Dec. 31, 2012, the PCORI Fee would have been due July 31, 2013.) The payment of the PCORI Fee is based on the date the plan ends, not when it begins, and the fee must be filed on Form 720 by July 31 of the calendar year immediately following the last day of the plan year.

Assuming Next Level Logistics still has 835 covered lives for the second year of the PCORI Fee ($2 per member per year), a payment of $1,670 will be due on July 31, 2015.

Remitting the PCORI Fee

Unlike the Reinsurance Fee, you will not submit membership counts via pay.gov nor will you receive an invoice or notice for the PCORI Fee. Instead, you’ll need to file federal excise tax return Form 720. Payment must be submitted with the form by July 31 of the calendar year immediately following the last day of the plan year. (Third-party administrators are prohibited under the health reform law from remitting the fee for you.)

The PCORI Fee is imposed on the plan sponsor, not the group health plan. For this reason, sponsors generally may not pay the fee with ERISA plan assets, which includes participant contributions. But the DOL has indicated that the board of trustees of a multiemployer plan (which has no other source of funding), as well as a voluntary
employees’ beneficiary association (VEBA) providing retiree-only coverage, may use plan assets to pay the fee. This is in contrast to the Reinsurance Fee, which is payable from ERISA plan assets.

The IRS stated that the PCORI Fee will be tax-deductible by employer groups (i.e., sponsors of self-funded group health plans) as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Code.

Coverage Impacted by the PCORI Fee

The PCORI Fee applies to grandfathered, medical, pharmacy, retiree-only, any accident or health insurance coverage (including a policy under a group health benefit plan) issued to individuals residing in the United States. This fee does not apply to the following types of coverage (this list is different from the Reinsurance Fee exclusions):

- Children’s Health Insurance Program (CHIP)
- Employee Assistance Programs (EAP) or wellness programs
- “Excepted benefits,” as defined under HIPAA, such as stand-alone vision or dental plans
- Expatriate coverage (those working outside the United States and their spouses and dependents)
- Flexible Spending Accounts, when they meet the excepted benefits test
- Health Reimbursement Arrangements, when they meet the excepted benefits test
- Health Savings Accounts
- Indemnity reinsurance policies, where the reinsuring company accepts all or part of the risk of loss under the policy and the issuing company retains its liability for covered lives
- Medicaid
- Medicare
- Stop loss, where the issuer is liable for all losses in excess of a specified amount and where the plan sponsor retains its liability for losses
- TRICARE
- Federal programs for providing care to Indian tribes (other than through insurance)

Special Counting Rules for Multiple Self-funded Plans

If the plan sponsor of a self-funded plan has more than one self-funded plan (e.g., one for medical, another for pharmacy) it may treat them as a single self-funded plan for purposes of these fees to avoid double counting of the members.

If you have a flexible spending account (FSA), that is not an excepted benefit, or a health reimbursement arrangement (HRA) and also have a fully insured medical plan, then you may treat each participant’s account as covering a single life. The plan sponsor is not required to count spouses or other dependents. (The special rule does not apply if you have another self-funded plan.)

If you have an FSA/HRA and also an applicable self-funded health plan (that is not an FSA or HRA), the arrangements may be treated as one plan. In this case, the special counting rule for FSAs/HRAs would not apply.

These special counting rules apply only to self-funded plans.
Calculating Your Membership Count for Either Fee

The IRS provides four counting methods for determining the number of members covered by your health plan, and you may already have the information at your fingertips.

Remember that when determining the number of covered lives for the Reinsurance Fee, annual membership counts are based on the first nine months of the calendar year regardless of plan year or renewal date. For the PCORI Fee, covered lives are counted during the entire year.

Calculating the number of covered lives under your plan will directly affect the amount of your payment for the Reinsurance and PCORI Fees, so it must be performed carefully. We recommend that you calculate the number of covered lives under more than one counting method to determine the one that is most favorable.
With certain differences noted below, these methods may be used to calculate both the Reinsurance Fee and the PCORI Fee. (A different counting method may be used for each fee.) You must use the same method consistently for the duration of any year, but may use a different method from one plan year to the next. Many of you have multiple plans, so it’s important to know that the same method must be used for all plans during the plan year.

1. **Actual Count:** Count the total covered lives for each day of the plan year and divide by the number of days in the plan year. (For the Reinsurance Fee, you only count lives during the first nine months of the plan year; for the PCORI Fee you count lives for the full 12 months of the year.)

2. **Snapshot Count Method:** Count the total number of covered lives on a single day in each quarter (or more than one day) and divide the total by the number of dates on which a count was made. (The date or dates must be consistent for each quarter. The Reinsurance Fee only looks at the first three quarters of the plan year.)

3. **Snapshot Factor:** In the case of self-only coverage and other than self-only (e.g., family or self-only plus one) coverage, determine the sum of: (1) the number of participants (i.e., employees or retirees) with self-only coverage, and (2) the number of participants (i.e., employees or retirees) with other than self-only coverage multiplied by 2.35. The Snapshot Factor requires a minimum of four data points, once each quarter. The timing should be generally consistent from quarter to quarter.

4. **Form 5500 Method (Annual Return/Report of Employee Benefit Plan):**
   - For self-only coverage, determine the average number of participants by combining the total number of participants at the beginning of the plan year with the total number of participants at the end of the plan year as reported on the Form 5500 and divide by 2.
   - For plans with self-only and other than self-only (e.g., family or self-only plus one) coverage the average number of total lives is the sum of total participants covered at the beginning and the end of the plan year, as reported on Form 5500.

**More on Form 5500**
- This may be the most accessible method for many private sector employers. Plan administrators of an employee benefit plan subject to ERISA must file Form 5500 each year.
- It is generally filed by employers in the private sector with 100 or more employees. Small employers with plan assets must also file Form 5500.
- Form 5500 only shows your number of participants, which are employees and/or retirees (not spouses or dependents).
- State and local government plans (including tribal government plans), churches and tribal plans do not file this form, so the Form 5500 method is not available to these groups.
- UnitedHealthcare does not have access to this form.

**Case example: Estimating the Reinsurance Fee Using the Snapshot Count Method**

Kevco Manufacturing counts its members on the first day of the first three quarters of the plan year.

<table>
<thead>
<tr>
<th>Month</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>1,989</td>
</tr>
<tr>
<td>April</td>
<td>1,882</td>
</tr>
<tr>
<td>July</td>
<td>1,990</td>
</tr>
</tbody>
</table>

5,861 divide by 3

1,954

Average membership count for the first nine months of the year x $5.25 fee x 12 months = $123,102 estimated payment for 2014
Membership Count Support

Here are three sources to find your membership count:

1. **Use your own membership data.** Employers have the most accurate information when determining the number of lives covered under the health plans.

2. **Use Employer eServices*, if available to you.** Find the membership by month on Employer eServices under Reports, then Membership, then click on Membership by Month report. Use the report to find membership counts for either the Reinsurance Fee or the PCORI Fee. These numbers can be used to determine the number of covered lives using the Snapshot or Snapshot Factor methods.

3. **Use UnitedHealthcare’s Reinsurance Fee membership report.** Your UnitedHealthcare representative will provide a monthly enrollment summary report for each medical plan you have administered by UnitedHealthcare. The report will be:
   - available in early October
   - supplied at no charge
   - aligned with the data requested by HHS
   - representative of the data available to UnitedHealthcare

   You can use this report to calculate your membership using the Snapshot Method. Because the report only represents the data available to UnitedHealthcare, we encourage you to compare these numbers to the number of covered lives you have calculated for the Reinsurance Fee using other counting methods, including Form 5500 if available to you.

   It’s important to note that customers who are new to UnitedHealthcare may not have nine months of membership data available. And, customers with multiple health insurance carriers or third-party administrators will need to contact them to find their true membership count.

**UnitedHealthcare will not supply membership counts, outside of Employer eServices, for the PCORI Fee.** Although the membership counts for the Reinsurance Fee are not due until Nov. 15, 2014, the PCORI Fee, on the other hand, was due for many organizations by July 31, 2013. Most companies will have made two annual PCORI fee payments before the first Reinsurance Fee payment is due. In addition to different payment schedules, the PCORI Fee is calculated based on the number of members for 12 months and the Reinsurance Fee for nine months.

According to the health reform law, the employer is ultimately responsible for the accuracy of the membership counts and payment of fees.

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**Case Example: Comparing Membership Counts for the Reinsurance Fee**

DuVail Industries has more than 100 employees and is subject to the Form 5500 filing requirement. Its plan provides for family group health plan coverage.

Using the Snapshot Count Method, it determined its membership for the first three quarters of the year is 201, 250 and 265. The average of these counts is 239. DuVail then contacts its plan accountant and learns that the participant count (employees and/or retirees only) on its prior year Form 5500 at the beginning of the year was 105 and at the end of the year was 115. The sum of these two counts is 220. Accordingly, DuVail Industries elects to use the Form 5500 method for determining the number of covered lives for the Reinsurance Fee.
Why UnitedHealthcare Does Not Remit the Fees for You

The Reinsurance and PCORI Fees are based on your membership counts, and you are in the best position to analyze which is the most cost-effective way to determine your membership count. The final rule also prohibits third-party administrators from remitting the PCORI Fee on behalf of self-funded customers. Here’s why you, and not your TPA, should determine the number of covered lives under your plan:

1. **Variations in Plan Design:** Sponsors of self-funded plans have flexibility in their plan design. This includes benefit offerings from different issuers, HMOs and TPAs. Groups sometimes adopt policies that allow members to freely transfer from one benefit offering to another. You are permitted to provide coverage to the same employees through more than one group health plan simultaneously. Due to this flexibility, our data will only represent a portion of your plan membership. Our membership count, while helpful, is not necessarily sufficient to support a covered lives determination.

2. **Coverage Considerations:** Certain types of coverage are excluded from the Reinsurance and PCORI Fees. Be sure to review your plan documents to determine if coverage is subject to the fee or if it does not meet minimum value. Although UnitedHealthcare can share technical information about these fees, we are not in the position to review your plan documents and provide legal advice.

3. **Fluctuations in Employment:** You may experience variations in staffing levels that will affect your membership count. Although your human resource department is aware of these employment trends, we are not. Normal employment fluctuations should be taken into account so you can effectively count covered lives consistent with the health reform law. This may include seasonal workers, for example, when a retailer may increase staffing in the fourth quarter to gear up for the holiday season.

4. **Dependency Variables:** There are variations under the approved counting methods. This variation stems, in part, from the fact that Form 5500 only captures the number of participants (i.e., employees and retirees) and not total covered lives. Due to this limitation, self-funded employers may extrapolate the number of covered lives assuming a “rough” dependency factor of 2.0 (i.e., each employee will have one dependent). Although ERISA customers with a high ratio of dependents per employee might benefit from use of the Form 5500 method, those with a low ratio of dependents per employee might not. For this reason, we suggest that you compare figures using different counting methods.

5. **Limitations of Form 5500:** If Form 5500 is available, it is an important tool to be used when ERISA plan administrators count covered lives. The Form 5500, however, may disclose information about ERISA welfare benefit plans, which includes a range of benefits, including health, life, disability and death benefits. This means that participants in non-group health plans may be commingled on Form 5500 with group health plan participants. When determining your membership count, the plan fiduciary using the Form 5500 method would need to coordinate closely with your accountants to determine which participants are disclosed on Form 5500. (UnitedHealthcare does not have access to Form 5500.)
Considering these factors, we encourage you to assess your membership count and compare the figure using more than one counting method. If you have questions about the counting methods or submitting fee payment, please contact your tax advisor or legal counsel.
This information is based upon UnitedHealthcare's interpretation of the Snapshot Method of counting covered lives, which is one of four counting methods approved by the IRS. It is also predicated on the eligibility information that the customer has provided UnitedHealthcare throughout the year. Because UnitedHealthcare does not know whether a Snapshot count is the most appropriate method to be used for your group health plan, it is important that you compare this Snapshot count with the results you may obtain under other available counting methods. Each of the different counting methods may produce different results which will affect the amount of your fees.

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