**INTERNATIONAL MEDICAL ADMINISTRATORS, INC. (IMA)**

**Important Notice: ACA's PCORI Fee and Self-Insured Plans**

Under the Affordable Care Act (ACA), your group health plan is required to pay a Patient-Centered Outcomes Research Institute (PCORI) fee for plan years ending in 2012 (continuing through 2019). While questions about this PCORI Fee and your specific situation should be directed to your tax adviser or legal counsel, the following is an overview of the fees, information on remitting payment, and the types of coverage impacted by the fees.

The PCORI Fees are temporary and assessed for each member or covered life (employees, spouses and dependents) under your health plan. The fees are paid annually, and they have payment schedules, fee amounts and exclusions.

**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 Payment Schedule**

Under the ACA, plan sponsors are responsible for paying the PCORI Fee directly to HHS and IMA, as your TPA, is not allowed to remit this fee on your behalf. The fee is in effect from 2012 to 2019. Like the Reinsurance Fee, the PCORI Fee is assessed on each covered life. Here is the fee schedule:

• For plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2013, the fee is $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.

**Calculating Your Membership Count for PCORI Fee**

The IRS provides four counting methods for determining the number of members covered by your health plan. Annual membership counts are based on all twelve months of the calendar year regardless of plan year or renewal date. Calculating the number of covered lives under your plan will directly affect the amount of your payment for the PCORI Fees. You should calculate the number of covered lives under more than one counting method to determine the one that is most favorable. 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. If you sponsor multiple plans, you must use the same method 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 first nine months of the plan year.

2. Snapshot Dates:

Count the total number of covered lives on a single day in each of the first three quarters and divide the total by four.

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.

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.

**Case example: Estimating the PCORI Fee Using the Snapshot Date Method**

ABC Health Plan counts its members on the last day of the four quarters of the plan year.

| January 1 | April 1 | July 1 | October 1 | Total Divided by 4 | Members x $1 |
|---|---|---|---|---|---|
| 1,000 Members | 950 Members | 950 Members | 1000 Members | 975 Members | $975<br><br>Estimated fee due July 31 of 2013 |

**Remitting the PCORI Fee**

Unlike the Transitional Reinsurance Fee, you will not be invoiced for the PCORI Fee. 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 include 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 than the Transitional 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)

**Membership Count Support**

Employers may have the most accurate information when determining the number of lives covered under their health plans. Your IMA representative can also provide a membership count to you for the PCORI Fee using the Snapshot method. We encourage you to compare numbers you may receive from your IMA representative to the number of covered lives you have calculated for the PCORI Fee. According to ACA, the employer is ultimately responsible for the accuracy of the membership counts and payment of fees.

**Important Considerations**

The PCORI Fees are based on your membership counts, and you should analyze which is the most cost-effective way to determine your membership count. Here are some important things to consider as you 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, IMA's data may only represent a portion of your plan membership. Our membership count should be helpful to you, but you are ultimately responsible for the membership count.

2. Coverage Considerations:

Certain types of coverage are excluded from the PCORI Fees (e.g. Expatriate-only plans). Be sure to review your plan documents to determine if coverage is subject to the fee IMA can share technical information about these fees, but we cannot provide legal advice to the Health Plan.

3. Fluctuations in Employment:

You may experience variations in staffing levels that will affect your membership count. Normal employment fluctuations should be taken into account so you can effectively determine membership count. This may include seasonal workers, for example, if an employer typically increases staffing in a particular quarter.

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 comingled 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. Considering these factors, we encourage you to assess your membership count and compare the figure using more than one counting method.

**To read the final regulations on the PCORI Fee, see http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf.**