INTERNATIONAL MEDICAL ADMINISTRATORS, INC. (IMA)

Important Notice: ACA's Transitional Reinsurance Fee and Self-Insured Plans

Under the Affordable Care Act (ACA), your group health plan is required to pay a new Transitional Reinsurance Fee on Plan years from 2014-2016. This fee is paid to the government directly by you and is in addition to the Patient-Centered Outcomes Research Institute (PCORI) fee that began for plan years ending in 2012 (continuing until 2019). While questions about this Reinsurance 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 Transitional Reinsurance 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 different schedules, fee amounts and exclusions. The Reinsurance Fee may have a financial impact on your business, so you need to prepare for and fund this three-year fee.

Transitional Reinsurance Fee

The ACA requires self-funded group health plans to fund a Transitional Reinsurance Program in place from 2014 to 2016. The transitional reinsurance fee was designed to provide funding to insurers that incur high claim costs for enrollees in the individual marketplace. The fees are collected by the Department of Health and Human Services (HHS). Under HHS rules, you will submit your membership count to HHS, and the agency will calculate your fee and then send you an invoice.

Transitional Reinsurance Fee Payment Schedule

The Reinsurance Fee will be $63 per member annually for 2014, and $44 per member annually for 2015. 2016 fees have not yet been established. Self-funded plans are responsible for funding and paying the Reinsurance Fee. The fee is collected each year from 2014-2016, and the first payment is due Jan. 15, 2015, for the 2014 benefit year.

You must submit membership counts for 2014 to HHS by Nov. 15, 2014. Annual membership counts are based on the first nine months of the benefit year. HHS will invoice plans for the amount due by Dec. 15. We expect this same schedule in 2015 and 2016.

Remitting the Transitional Reinsurance Fee

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.

Key Dates for the Reinsurance Fee

November 15, 2014 - Membership counts due to HHS

December 15, 2014 - The latest date that HHS will invoice health plans

January 15, 2015 - Payment is due to HHS

Coverage Impacted by the Transitional Reinsurance Fee

The Reinsurance Fee generally applies to major medical coverage, including grandfathered plans. The following types of coverage are specifically **excluded** from the fee:

- 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
- Prescription drug benefit plans
- Retiree-only plans that pay secondary to Medicare
- Stop loss
- Plans covering tribal members and dependents (not employment-based plans)
- TRICARE
- Specified diseases or hospital indemnity coverage

• Stand-alone vision and dental (as long as they are excepted benefits under HIPAA)

Calculating Your Membership Count for Reinsurance Fee

The IRS provides four counting methods for determining the number of members covered by your health plan. Annual membership counts are based on the first nine 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 Reinsurance 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 three.

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 Reinsurance Fee Using the Snapshot Date Method

ABC Health Plan counts its members on the first day of the first three quarters of the plan year.

January 1	April 1	July 1	Total Divided by 3	Members x $63
1,000 Members	950 members	975 Members	975 Members	$61,425 Estimated payment for plan year 2014

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 Reinsurance 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 Reinsurance Fee. According to ACA, the employer is ultimately responsible for the accuracy of the membership counts and payment of fees. Membership counts for the Reinsurance Fee are due to HHS on Nov. 15, 2014.

Important Considerations

The Reinsurance 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 Reinsurance 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 Transitional Reinsurance Fee, see http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf.

REMINDER: The Transitional Reinsurance Fee is in addition to Patient-Centered Outcomes Research Institute (PCORI) Fee that began for plan years ending in 2012 and continuing until 2019. For information on the PCORI Fee, see http://www.imglobal.com/en/client-resources.aspx.