AMERICAN BENEFITS COUNCIL

December 12, 2012

SUMMARY: HHS RELEASES NEW PROPOSED REGULATIONS REGARDING TRANSITIONAL REINSURANCE PROGRAM

PREPARED BY SETH PERRETTA AND ALLISON ULLMAN OF CROWELL & MORING LLP

crowell moring

On November 30, 2012, the Department of Health and Human Services ("HHS") released for public inspection proposed regulations ("New Proposed Regulations") setting forth guidance with respect to, among other things, the standards related to reinsurance, risk corridors, and risk adjustment consistent with sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, as amended ("PPACA"). The New Proposed Regulations were published in the December 7, 2012 Federal Register. Comments are due by December 31, 2012.

Of particular interest to plan sponsors is the transitional reinsurance program established under Section 1341, which will require health insurance issuers, as well as certain plan administrators on behalf of self-insured group health plans, to make contributions to a transitional reinsurance program for the three-year period beginning January 1, 2014.

This memorandum discusses Section 1341 in light of all guidance issued to date, with an eye toward how the transitional reinsurance program may affect plan sponsors. As discussed in more detail below, Section 1341 is likely to result in additional costs for employer plan sponsors and, depending on whether the plan at issue is self-administered, certain additional reporting obligations.

OVERVIEW OF THE TRANSITIONAL REINSURANCE PROGRAM

Section 1341 requires the HHS Secretary, in consultation with the National Association of Insurance Commissioners ("NAIC"), to implement standards enabling states to establish and maintain a transitional reinsurance program pursuant to which health insurance issuers (with limited exception for certain types of insurance,

discussed in detail below), and certain plan administrators on behalf of group health plans, are required to make payments to an "applicable reinsurance entity" – a not-for-profit organization that carries out reinsurance functions under Section 1341 – for the three-year period beginning January 1, 2014. States are not required to establish a reinsurance program; if a state chooses not to establish a reinsurance program, then HHS will establish a reinsurance program for such state. Also, a state can establish a reinsurance program even if it does not establish a health insurance exchange.

Reinsurance contributions will be used to make reinsurance payments to health insurance issuers that cover high risk individuals in the individual market (excluding grandfathered health plans) for the three-year period beginning January 1, 2014. The transitional reinsurance program is intended to reduce the uncertainty of insurance risk and to stabilize premiums in the individual market during the first three years of operation of the state health insurance exchanges, i.e., 2014 through 2016, by making payments toward high cost cases as a result of adverse selection. This is intended to reduce risk by partially offsetting risk for high cost enrollees.

Section 1341 itself does not provide much detail as to the method for determining the required contribution of each affected health insurance issuer, or an administrator with respect to a self-funded group health plan; rather, Congress delegated broad regulatory authority to HHS to shape the contours of the transitional reinsurance program. Initial proposed regulations published in the July 15, 2011 Federal Register left many questions unanswered ("Initial Proposed Regulations"). Final regulations, published in the March 23, 2012 Federal Register ("Final Regulations"), provided additional guidance to states and issuers, as well as to administrators of self-funded group health plans, regarding the implementation and operation of the transitional reinsurance program; however, concerns were raised by numerous stakeholders regarding the administration of certain of the final rules. The New Proposed Regulations reflect increased stakeholder input and provide a modified set of rules regarding the mechanics and operation of the fee collection.

LIABILITY FOR TRANSITIONAL REINSURANCE CONTRIBUTIONS

The express language of Section 1341 requires that health insurance issuers and third party administrators "on behalf of group health plans" make contributions to the transitional reinsurance program for the three-year period beginning January 1, 2014 (although states are not prohibited from continuing a reinsurance program after the end of such three-year period).

Following the issuance of the Initial Proposed Regulations and the Final Regulations, questions remained regarding whether, with respect to self-funded coverage, the liability for the reinsurance contribution itself belongs to the self-funded plan or the third party administrator. The New Proposed Regulations provide much

needed clarification on this point and clearly state that the fee liability runs to the plan and not the third party administrator. This clarification appears to be based on the express language of Section 1341, which states that "[t]he Secretary shall include . . . the method for determining the amount each health insurance issuer and group health plan . . . is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014" (emphasis added).

The preamble to the New Proposed Regulations does leave open the possibility that a self-funded plan and/or the plan sponsor thereof may utilize a third party administrator for purposes of collecting and/or remitting the reinsurance contribution to HHS. Specifically, the preamble states that "[a]lthough self-insured group health plans are ultimately liable for reinsurance contributions, a third party administrator or administrative-services-only contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at the plan's discretion" (emphasis added). Presumably, to the extent the administrator and/or the plan sponsor wish for the administrator to remit the fee on its behalf, this should be set forth in the documents governing the contractual relationship (such as the administrative service agreement, for example).

Comment: Following the issuance of the Final Regulations, questions remained regarding if and how the fee applies to self-funded plans that are self-administered by the plan sponsor. As noted above, the preamble to the New Proposed Regulations makes clear that the fee liability runs to the self-funded plan and not the third party administrator (although the preamble does state that a plan could rely on such third party administrator to remit the fee to HHS on its behalf); thus, the question has been rendered moot in many respects. Additionally, the preamble to the New Proposed Regulations states that, "[a] self-insured, self-administered group health plan without a third-party administrator or administrative-services-only contractor would make its reinsurance contributions directly" to HHS.

GROUP HEALTH PLANS SUBJECT TO THE REINSURANCE CONTRIBUTION

Generally, issuers and self-insured group health plans ("contributing entities") must make reinsurance contributions with respect to group health plans that provide major medical coverage, with the exception of certain types of coverage, as set forth below. Whether a type of coverage constitutes a group health plan generally will require a determination of whether such coverage provides benefits consisting of "medical care" within the meaning of Internal Revenue Code Section 213.

Excepted Coverages – Generally

Following the issuance of the Final Regulations, many questions remained regarding whether certain types of coverages and arrangements could give rise to fee liability. Thankfully, the New Proposed Regulations provide some helpful clarifications in this regard. More specifically, pursuant to the New Proposed Regulations, contributions would be required with respect to health insurance coverage and self-insured group health plans except to the extent that:

(i) the self-funded plan or insurance is not major medical coverage (for example, prescription drug coverage);

(ii) in the case of health insurance coverage, the coverage is not considered to be part of an issuer's "commercial book of business" (for example, private Medicare or Tribal coverage may fall within this category); or

(iii) in the case of health insurance coverage, the coverage is not issued on a form filed and approved by a state insurance department (for example, expatriate coverage may fall within this category).

Additionally, the New Proposed Regulations propose to exclude the following types of coverage from reinsurance contributions:

- Coverage consisting solely of excepted benefits as defined by Section 2791(c) of the Public Health Service Act ("PHSA"), 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, or any combination thereof

        - Such other similar, limited benefits as are specified in regulations

    - 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

- Private Medicare, Medicaid, CHIP, State high-risk pools, and basic health plans (because these are not part of a "commercial" book of business);

- Health reimbursement arrangements ("HRAs") integrated with a group health plan;

- Health savings accounts ("HSAs");

- Health flexible spending arrangements ("FSAs") (apparently without regard to whether the FSA is an excepted benefit for purposes of PHSA Section 2791(c));

- Employee assistance plans ("EAPs"), 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); and

- Tribal coverage.

Comment: There is some overlap between the types of coverage excluded from the transitional reinsurance fee and the types of coverage excluded for purposes of the Patient-Centered Outcomes Research Institute ("PCORI") fee, as set forth in new Internal Revenue Code sections 4375 and 4376, and the new Form W-2 reporting requirements for applicable employer-sponsored plans, as set forth in Internal Revenue Code Section 6051(a)(14). However, the exclusions are not identical, so careful attention is required as to the PPACA provisions that may apply to a particular type of coverage.

Comment: Per the preamble to the Final Regulations, contributing entities must make reinsurance contributions on behalf of plans in the Federal Employees Health Benefits Program, state and local government employee plans, and grandfathered health plans. These requirements appear unchanged based on the New Proposed Regulations and appear to be considered "commercial" books of business.

EAPS, Disease Management, On-Site Medical

The New Proposed Regulations propose to exclude EAPs, disease management programs, and wellness programs from the transitional reinsurance fee if the program (whether self-insured or insured) does not provide major medical coverage. The New Proposed Regulations state that employers that provide one or more of the ancillary benefits described in this paragraph often sponsor major medical plans, which will be subject to the transitional reinsurance fee, absent other excluding circumstances.

Retiree-Only Coverage

Questions have arisen regarding whether retiree-only coverage is subject to the transitional reinsurance contribution requirements. With respect to retirees, the New Proposed Regulations provide that, when an individual has both Medicare coverage and employer-provided group health coverage, Medicare Secondary Payer ("MSP") rules under Section 1862(b) of the Social Security Act would be applicable, and the group health coverage would be considered major medical coverage only if the group health coverage is the primary payer of medical expenses (and Medicare is the individual's secondary payer) under the MSP rules. It is intended that the above rules also apply with respect to individuals entitled to Medicare because of disability or end-stage renal disease, as well.

Comment: Significantly, the treatment of retiree-only coverage for purposes of the transitional reinsurance fee is different than the treatment of retiree-only coverage for purposes of the PCORI fee. Whereas the transitional reinsurance fee draws upon the MSP rules to determine whether a retiree will trigger the fee, final regulations recently issued with respect to the PCORI fee confirm that the PCORI fee applies to a retiree-only plan.

Continuation Coverage

The New Proposed Regulations do not expressly address the treatment of continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or similar continuation coverage under other federal or state

law. Given that such continuation coverage is likely to constitute a group health plan, it seems that such coverage would be subject to the transitional reinsurance fee, in the absence of another applicable exclusion.

Comment: If continuation coverage is indeed considered a group health plan subject to the transitional reinsurance fee, it appears that all individuals enrolled in coverage by reason of federal COBRA, state mini-COBRA or the like, or voluntary continuation coverage, must be counted for purposes of the fee.

AMOUNT OF PER CAPITA TRANSITIONAL REINSURANCE CONTRIBUTION

As noted above, Section 1341 requires all health insurance issuers, and third party administrators on behalf of self-insured group health plans, to make contributions to support the transitional reinsurance program. The statute provides that, from 2014 through 2016, the aggregate contributions to be collected for and/or by all states will equal $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016, with such amounts solely to be used in paying claims under the transitional reinsurance program. An additional amount equal, on a national basis, to $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016 will be collected for deposit into the general fund of the U.S. Treasury.

The Final Regulations provide that the contribution amounts will be set based on a national contribution rate. Each "benefit year," which is defined to be a calendar year, HHS will set the national contribution rate in an annual HHS notice of benefit and payment parameters along with the proportion of the national contribution rate that will be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses of the applicable reinsurance entity for the state or HHS when carrying out the transitional reinsurance program. The New Proposed Regulations contain a draft notice of benefit and payment parameters for 2014. The Final Regulations permit a state to collect from issuers more than the amounts specified by the statute, if the state believes that such amounts are not sufficient to cover its transition reinsurance payments or to cover its administrative costs.

Rather than using a "percent of premium" approach to determine the amount that a contributing entity (i.e., an issuer or an administrator on behalf of a group health plan) must contribute in a year, the Final Regulations provide that a flat per capita amount will be used to determine fee liability.

The New Proposed Regulations propose that the flat per capita per month amount for 2014 would be $5.25 per covered life, per month, equivalent to $63 per covered life for the year. The New Proposed Regulations request comment on the proposed per capita fee, including regarding whether HHS has the authority to defer until 2016 a portion of the reinsurance payments that are to be paid to the U.S. Treasury to partially offset the

government's cost for the Early Retiree Reinsurance Program (i.e., the additional $2 billion due in 2014). If the amount is in fact deferred – either in whole or in part – the per capita fee would be decreased for 2014 to some extent.

PERSONS COUNTED FOR PURPOSES OF THE CONTRIBUTION

The flat per capita amount referenced in the preceding section will be applied to all "reinsurance contribution enrollees" of such contributing entities.

A "reinsurance contribution enrollee" is defined to mean an individual covered by a plan for which reinsurance contributions must be made. For purposes of employer-sponsored plans, this appears to mean that a plan's total reinsurance contribution is based on the number of enrollees covered under the plan for the relevant period, including non-employee beneficiaries such as spouses and dependents. In other words, the per capita fee does not apply solely to the employee participant; it also applies to all other individuals covered under the plan.

Amount of Reinsurance Contributions Owed by the Plan Sponsor or Issuer	=	Number of Enrollees Covered Under the Plans or Policies at Issue	x	Per Capita Fee

Comment: Given the proposed amount of the transitional reinsurance fee, it appears that the transitional reinsurance fee will result in significantly greater fee liability on a plan-by-plan basis than the PCORI fee, which is limited to $1 times the average number of covered lives in the first year of the PCORI fee, and $2 times the average number of covered lives in later years of the PCORI fee.

PERMISSIBLE COUNTING METHODS

The New Proposed Regulations provide details as to how a health insurance issuer may determine the average number of covered lives of reinsurance contribution enrollees under a health insurance plan for a benefit year for purposes of the annual enrollment count. These methods are similar to the methods permitted for purposes of the fee to fund PCORI.

Specifically, health insurance issuers may use any of the following methods:

(i) The *actual count method*, pursuant to which a health insurance issuer would

add the total number of lives covered for each day of the first nine months of the benefit year and divide that total by the number of days in those nine months;

(ii) The *snapshot count method*, pursuant to which a health insurance issuer would add the totals of lives covered on a date or dates during the same corresponding month in each of the first three quarters of the benefit year, and divide that total by the number of dates on which a count was made;

(iii) The *member months method* or *state form method*, pursuant to which a health insurance issuer would multiply the average number of policies for the first nine months of the applicable benefit year by the ratio of covered lives per policy calculated from the NAIC Supplemental Health Care Exhibit.

Self-insured plans may use the actual count method, a modified version of the snapshot count method, or the Form 5500 method, pursuant to which the plan would use data from the Form 5500 for the last applicable plan year.

Plans with Both Insured and Self-Insured Options

The New Proposed Regulations propose to apply a special counting rule to plans that offer both self-insured and insured options. Pursuant to such special rule, to determine the number of covered lives of reinsurance contribution enrollees under a group health plan with both self-insured and insured options for a benefit year, either the actual count or snapshot method for health insurance issuers must be used.

Aggregation Rules Applicable to Plan Sponsors Maintaining Two or More Group Health Plans

The New Proposed Regulations also propose to apply certain aggregation rules to plan sponsors that maintain 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. The aggregation rules would require such plans to be treated as a single self-insured group health plan for purposes of determining the amount of any transitional reinsurance fee due. Exceptions are provided for PHSA Section 2791(c) excepted benefits and for prescription drug coverage.

Comment: The preamble notes that this aggregation rule would prevent the double counting of a covered life for major medical coverage offered across multiple plans, and prohibit plan sponsors from splitting such coverage into separate arrangements to

avoid reinsurance contributions on the grounds that it does not offer major medical coverage.

Where at least one of the plans is an insured plan, the plan sponsor must use either the actual count or snapshot method for health insurance issuers, applied across the multiple plans as a whole. The preamble to the New Proposed Regulations emphasizes that the applicable counting methods operate on a "benefit year" basis, which is defined to be the calendar year, and that the applicable counting methods all apply on that basis, despite the plan years of the plans at issue. In addition, certain HHS reporting requirements would have to be fulfilled.

Where none of the plans is an insured plan, the plan sponsor must use either the actual count or snapshot method otherwise available with respect to self-insured plans. In addition, certain HHS reporting requirements would have to be fulfilled.

Comment: The preamble to the New Proposed Regulations states that HHS would not permit the member months method, the state form method, or the Form 5500 method to be used with respect to aggregated plans, given that such methods do not easily permit aggregate counting, since the identities of the covered lives are not available on those forms.

ANNUAL COLLECTION OF TRANSITIONAL REINSURANCE CONTRIBUTIONS

The New Proposed Regulations provide that the reinsurance contributions are to be collected on an annual basis. This marks a change from the Final Regulations, which provided that the reinsurance contributions were to be collected on a quarterly basis beginning on January 15, 2014. HHS notes in the New Proposed Regulations that this change is being proposed for administrative simplicity.

As proposed, issuers and plans will be required to report to HHS its annual enrollment count by November 15th of each year for the same calendar year. HHS will then provide a notice of fee liability to the issuer or plan sponsor by December 15th or fifteen days after receipt of the annual enrollment count, whichever is later. Upon receipt of the notice of fee liability, plans and issuers will have 30 days to remit their fees to HHS.

CENTRALIZED COLLECTION PROCESS AND NO STATE-BY-STATE DATA REPORTING REQUIRED

The New Proposed Regulations provide that HHS will collect all contributions from health insurers and self-insured plans, even where a state decides to operate its own

reinsurance program. This is intended to help streamline the collection process so that insurers and self-insured plans are not responsible for making payments to each individual state. HHS indicates that a centralized collection process for all contributing entities will facilitate the allocation and disbursement of funds, and will streamline the contribution submissions process for health insurance issuers who operate in multiple states. HHS expects to distribute the proceeds to states based on need.

Comment: Initially, HHS considered matching the reinsurance contribution with each subject enrollee to ensure that the reinsurance contribution is delivered to the state in which the enrollee resides. This would have raised significant issues for employers and issuers alike as it would have required employers to report to HHS not only aggregate enrollee count data, but also a state-by-state breakdown of where covered enrollees reside. Thankfully, HHS has changed course and it does not appear that this state-by-state reporting will be required of issuers and plan sponsors.

ABILITY OF STATES TO COLLECT ADDITIONAL AMOUNTS FROM ISSUERS AND SELF-FUNDED PLANS

The New Proposed Regulations provide that a state operating its own reinsurance program may elect to collect more than the amounts based on the national contribution rate set forth in the annual HHS notice of benefit and payment parameters for administrative expenses of the applicable reinsurance entity or additional reinsurance payments. If a state establishes a reinsurance program and elects to collect more than the amounts that would be collected based on the national contribution rate for administrative expenses or for additional reinsurance payments, then the state must notify HHS within 30 days after publication of the proposed annual HHS notice of benefit and payment parameters of the additional contribution rate that it elects to collect for administrative expenses.

Comment: The New Proposed Regulations provide that the national reinsurance payment parameters are calculated to expend all reinsurance contributions collected under the national contribution rate. The New Proposed Regulations provide that, similarly, the additional funds collected by a state for reinsurance payments or additional state funds are to be reasonably calculated to cover all additional reinsurance payments projected to be made under the state supplemental payment parameters.

The Final Regulations provided that a state establishing a reinsurance program may either directly collect additional reinsurance contributions for administrative expenses and reinsurance payments when a state elects to collect from health insurance issuers, or to have HHS collect contributions from health insurance issuers for administrative expenses. The New Proposed Regulations change this policy, providing that a state

operating its own reinsurance program will no longer be permitted to have HHS collect additional funds for administrative expenses.

The preamble to the New Proposed Regulations also state that, although a state may elect to collect additional reinsurance contributions for administrative expenses or reinsurance payments, nothing in Section 1341 or the New Proposed Regulations gives a State the authority to collect from self-insured group health plans covered by ERISA, and that federal law generally preempts state law that relates to an ERISA-covered plan.

Comment: Questions remained following the issuance of the Final Regulations regarding whether Section 1341 provides states with authority to collect additional amounts not only from issuers, but also self-funded plans or their sponsors. In likely reliance upon the flush language of Section 1341(b)(3)(B)(3), which states that, "[n]othing . . . shall be construed to preclude a State from collecting additional amounts *from issuers* on a voluntary basis," HHS states 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 that federal law generally preempts state law that relates to an ERISA-covered plan." The statutory language as well as the statement in the preamble indicate that states should have difficulty finding authority by reason of Section 1341 to collect additional contributions from self-funded plans and their sponsors.

DEDUCTIBILITY OF TRANSITIONAL REINSURANCE CONTRIBUTIONS

Guidance issued by the IRS concurrently with the New Proposed Regulations provides that health insurance issuers will be able to treat payment of the transitional reinsurance contributions as tax-deductible as an ordinary and necessary business expense. This will help reduce the overall cost to subject employers.

Comment: The deductibility of the reinsurance contribution is to be distinguished from that of the PCORI fee. Unlike the reinsurance contribution, which is tax-deductible as a bona fide business expense, the PCORI fee is an excise tax set forth in Code sections 4375 and 4376 and, as such, is not tax-deductible (which has the effect of increasing the cost of the PCORI fee to the extent of the plan sponsor or issuer's marginal tax rate).

ABILITY TO PAY REINSURANCE CONTRIBUTIONS FROM ERISA PLAN ASSETS

A footnote contained in the preamble to New Proposed Regulations states that, "[t]he Department of Labor has reviewed this proposed rule and has advised 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." Accordingly, it appears that plan sponsors may elect to reimburse the cost of the annual fee from the respective plan, as permitted by ERISA and DOL regulations and guidance issued thereunder.

Comment: While reinsurance contributions may be properly treated as ERISA plan expenses, the DOL has taken the opposite view with respect to the PCORI fee. Pursuant to the preamble to the Final Rule issued by the Department of Treasury, by statute the liability for the PCORI fee runs to the plan sponsor and not the plan. Accordingly, unlike the reinsurance contribution that can be reimbursed from plan assets, the PCORI fee cannot be reimbursed from an ERISA plan.

PENALTIES FOR FAILURE TO PAY TRANSITIONAL REINSURANCE CONTRIBUTIONS

The transitional reinsurance fee was enacted as a stand-alone provision of the PPACA, and is not expressly included in the PHSA, despite the fact that HHS has authority to issue regulations with respect to the fee. Pursuant to PPACA section 1321, which indicates that the enforcement provisions of the PHSA will apply for purposes of the transitional reinsurance fee, it appears that the typical PHSA enforcement mechanisms and penalties will apply to a health insurance issuer or a group health plan that does not remit the required transitional reinsurance contributions to the state or HHS, as appropriate. In general, the maximum monetary penalty that may be imposed appears to be $100 per day per affected individual. Exactly how this penalty will apply in the context of the transitional reinsurance fee (e.g., whether a third party administrator on behalf of a self-insured group health plan will be liable, or how the number of "affected individuals" would be counted) remains unclear at present.

Comment: As noted above, the New Proposed Regulations provide clarification that the self-funded plan itself is liable for the amount of any reinsurance contribution owed. As further noted above, the preamble to the New Proposed Regulations contemplates that a self-funded plan sponsor may utilize a third party administrator to remit the annual fee to HHS. Although it appears that the ultimate liability for the fee itself belongs to the plan and not the administrator, it remains unclear the extent to which an administrator could face a penalty under the PHSA's enforcement provisions discussed above for failing to remit the fee to HHS where the plan sponsor has provided the fee to the administrator or is otherwise relying on the administrator to collect and remit the fee on behalf of the plan (or whether the administrator would just be subject to contractual claims and remedies brought by the plan or plan sponsor).

IRS CIRCULAR 230 NOTICE: As required by the Internal Revenue Service, we inform you that any tax advice contained in this document was not intended or written to be used or referred to, and cannot be used or referred to, (i) for the purpose of avoiding penalties under the Internal Revenue Code, or (ii) in promoting, marketing or recommending to another party any transaction or matter addressed in this document.

For more information, please contact Seth Perretta or Allison Ullman at Crowell & Moring LLP at (202) 624-2500.