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For your information

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IRS Issues Proposed Regulations on the Comparative Effectiveness Fee

The Internal Revenue Service (IRS) issued proposed regulations that provide rules regarding how the comparative effectiveness fee created by the Patient Protection and Affordable Care Act (PPACA) should be calculated and paid. Health insurers and sponsors of self-insured group health plans with calendar-year policy or plan years will be required to pay the fee for 2012 by July 31, 2013.

Background

PPACA created the Patient-Centered Outcomes Research Institute (PCORI), which is charged with promoting research to evaluate and compare the health outcomes and clinical effectiveness, risks and benefits of medical treatments, services, procedures and drugs. PCORI is to be funded in part by fees assessed on health insurers and sponsors of self-insured group health plans. This fee is commonly referred to as the "comparative effectiveness fee" or "PCORI fee".

The PCORI fee will first be assessed with respect to plan or policy years ending after September 30, 2012 (i.e., ending between October 1, 2012 and September 30, 2013). The fee will be equal to $1.00 times the average number of covered lives (employees and dependents) for the first plan or policy year ending on or after October 1, 2012. The fee will be equal to $2.00 times the average number of covered lives for policy or plan years ending after September 30, 2013. For plan or policy years beginning on or after October 1, 2013, the fee will be indexed to increases in National Health Expenditures. The fee will not be assessed for plan years ending after September 30, 2019, which means that for a calendar-year plan, the last year of assessment is the 2018 plan year.

If a group health plan is insured, the health insurer is responsible for calculating and paying the fee. If the plan is self-insured, the plan sponsor is responsible.

In the spring of 2011, the IRS issued Notice 2011-36, which requested comments on how the PCORI fee should be calculated and paid. On April 17, 2012, the Internal Revenue Service (IRS) published proposed regulations concerning the application of this fee. Comments on the proposed regulations are due by July 16, 2012. Although the regulations address the similar requirements for both health insurers and employer-sponsored plans, this *FYI* focuses on the requirements for employer-sponsored self-insured group health plans.

The Proposed Regulations

The proposed regulations provide guidance on a number of issues pertaining to the calculation and assessment of the fee.

Plans Subject to the Fee

The fee is imposed with respect to lives covered under an "applicable self-insured health plan." Generally an "applicable self-insured health plan" is a plan that provides accident and health coverage, other than through insurance and that is established or maintained by a plan sponsor for the benefit of its employees, former employees, members, former members or other eligible individuals. The preamble to the proposed regulations notes that the term includes retiree-only plans and health reimbursement arrangements (HRAs). The term also includes self-insured governmental plans, multiemployer plans, multiple employer welfare arrangements (MEWAs), voluntary employee beneficiary associations (VEBAs) and plans maintained by a rural electric cooperative or rural cooperative association. Certain governmental programs such as Medicare, Medicaid, and CHIP are exempt from paying the fees.

The proposed regulations clarify that the following benefits are not subject to the fee:

- Excepted benefits, including limited-scope dental and vision plans, onsite medical clinics, accident-only or disability-only plans and most flexible spending accounts (FSAs)
- Health savings accounts
- Employee assistance, disease management, and wellness programs that do not provide significant benefits for medical care or treatment
- Expatriate plans that primarily cover employees living and working outside the United States
- Stop loss coverage.

Rules for Multiple Self-Insured Arrangements

The proposed regulations permit multiple self-insured health arrangements to be treated as a single applicable self-insured health plan if they are established and maintained by the same plan sponsor and have the same plan year. For example, if a plan sponsor has one self-insured arrangement for medical benefits and another self-insured arrangement for prescription drug benefits, and both arrangements have the same plan year, they would be treated as a single applicable self-insured plan and thus subject to a single fee. Similarly, a self-insured high-deductible health plan (HDHP) integrated with an HRA would be treated as a single applicable self-insured plan and also subject to a single fee. However, if the HDHP is insured, the health insurer would be assessed the fee with respect to the HDHP and the plan sponsor would be assessed the fee with respect to the HRA.

INSIGHT

Plan sponsors had been concerned that they could be subject to multiple fees. The rule limiting the application of the fee in plans with multiple self-insured arrangements is thus a very favorable development for plan sponsors.

Determining the Number of Covered Lives

The proposed regulations provide plan sponsors with three alternatives for determining the average number of lives covered for a plan year. The same approach does not have to be used each year, nor does the same approach have to be used for each plan.

Actual Count Method: The average number of lives covered under the plan for a plan year is determined by taking the sum of the number of lives covered under the plan for each day of the plan year and then dividing it by the number of days in the plan year.

Snapshot Method: The average number of lives covered under the plan for a plan year is determined by totaling the number of lives covered by the plan on one date during each quarter and then dividing that sum by four. Under this method the plan sponsor has two alternatives for counting lives:

- Snapshot Factor Method: The number of participants with self-only coverage plus 2.35 times the number of participants with coverage other than self-only.
- Snapshot Count Method: The actual number of lives covered on each date.

A plan sponsor could elect to base the determination on more than one date in quarter, provided an equal number of dates are used. In that event, the denominator would be the total number of dates used.

Form 5500 Method: The average number of lives is determined on the basis of information in ERISA Form 5500 filings. For plans that provide coverage to employees and dependents, the number of lives is the sum of the number of participants on the Form 5500 at the beginning and at the end of the plan year. For plans that only provide self-only coverage, the number of lives is the sum of the number of participants at the beginning and at the end of the plan year, divided by two.

INSIGHT

The Snapshot and Form 5500 methods are particularly practical methods for most plan sponsors to determine the fee, particularly because the actual number of covered dependents does not have to be tracked.

Special rule for health FSAs and HRAs. The proposed regulations provide that if the only applicable self-insured plan maintained by a plan sponsor is a health FSA or HRA subject to the PCORI fee, the plan sponsor may treat each participant's health FSA or HRA as covering a single covered life. Thus,

even though the health FSA or HRA may be used to reimburse expenses incurred by spouses or dependents, it does not have to be counted in determining the fee.

Who Is the Plan Sponsor?

The proposed regulations state that the following entities are considered to be the plan sponsor for purposes of reporting and paying the fee:

- The employer, in the case of a single-employer plan
- The employee organization, in the case of a plan established or maintained by that organization
- In the case of a multiemployer plan, MEWA or VEBA, the association, committee, joint board of trustees, or similar group that represents the parties that establish or maintain the plan
- The cooperative or association that establishes or maintains a plan by a rural electric cooperative.

The proposed regulations provide that a single plan maintained by more than one employer (even if the employers are related) or by more than one employee organization will be treated as a plan that is maintained by two or more employers or organizations. In that case, the plan sponsor responsible for reporting and paying the PCORI fee will generally be the entity identified as the plan sponsor in the plan documents under which the plan is operated or that is designated in the document. The designation must be made and consented to no later than the deadline for paying the PCORI fee for the plan year, and the entity designated as the plan sponsor must be one of the employers or other entities maintaining the plan. If the plan sponsor is not identified or designated in the plan document, each entity that is maintaining the plan must report and pay the PCORI fee with respect to its own employees or members.

INSIGHT

Related employers that provide coverage to their employees through a single plan may want to designate a plan sponsor if they want to consolidate the filing and pay the PCORI fee.

Transition Rule

Because the fee will apply with respect to plan years that have already begun, the guidance provides a special transition rule. For plan years starting before July 11, 2012 and ending after October 1, 2012, the plan sponsor may determine the average number of covered lives using any reasonable method.

Reporting and Payment

The PCORI fee falls under the excise tax provisions of the Internal Revenue Code. The proposed regulations state that although plan sponsors will file the Form 720 (Quarterly Federal Excise Tax Return Form) to pay and report their PCORI fees, they will only have to do so once each year (instead

of quarterly). The preamble to the proposed regulations states that third parties will not be permitted to report or pay the fees on behalf of plan sponsors.

The proposed regulations provide that plan sponsors must report and pay the PCORI fee for a plan year by July 31 of the calendar year that immediately follows the year in which the plan year ended. Thus, for plans with plan years that began between October 1, 2011 and December 31, 2011, or for calendar-year plans, the first PCORI fees must be paid by July 31, 2013. Plans with plan years that begin after January 1, 2012 but prior to October 1, 2012 will not have to report and pay the PCORI fee until July 31, 2014.

Conclusion

The proposed regulations provide very practical alternatives for determining the number of covered lives for the purpose of determining the PCORI fee. Plan sponsors should review the options available for determining the fee to determine the most effective approach for their plans. The first fees will be due by July 31, 2013 for calendar-year plans.

Buck prepared a Health Care Reform Timeline and Health Care Reform Comparison in Brief that provide an overview of the health care reform requirements, reflecting current guidance.

Buck Can Help

- Determine which employer-sponsored plans are subject to the fee
- Determine the most effective approach to determining the fee