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First Comparative Effectiveness Fee Due July 2013

The Internal Revenue Service (IRS) has released a proposed regulation explaining a new fee (the patient-centered outcomes research fee or comparative effectiveness fee) that must be paid by both insured and self-insured health plans under the federal healthcare reform law. For calendar-year self-insured plans, the first payment will be due by July 31, 2013, for the 2012 plan year.

Background: As established under healthcare reform, the new temporary fee will fund the Patient-Centered Outcomes Research Institute (PCORI) which will conduct research to evaluate and compare the clinical effectiveness, risks and benefits of medical treatments, services, procedures, drugs or other items or strategies that treat, manage, diagnose or prevent illness or injury. The publicly available research results are expected to assist patients, payers, providers and the public by better informing their decisions about the most effective medical treatments, services, procedures, and drugs.

Amount of the Fee: For 2012 (for plan years and policy years ending before October 1, 2013), insurers and self-insured plans will pay $1 per year multiplied by the average number of covered lives under the plan (employees, spouses and dependents). Starting in 2013, the fee is $2 per year. For plan years and policy years ending on or after October 1, 2014, the $2 fee will be indexed based on increases in the projected per capita amount of National Health Expenditures.

Year of Determination: The fee applies to self-insured plan years and insured policy years ending on or after October 1, 2012, and before October 1, 2019. For calendar-year self-insured plans and calendar-year insurance policies, this means the fee will apply to the 2012 year (the first plan/policy year ending on or after October 1, 2012) and remain in effect through 2018 (the last plan/policy year ending before October 1, 2019). Non-calendar-year health plans that begin during November or December will have earlier effective dates.

Payers: For insured plans, the fee will be paid by the health insurer. For single-employer self-insured plans, the sponsoring employer will pay the fee. For self-insured plans that are not single-employer plans, the fee is to be paid by the Taft-Hartley multi-employer fund, the VEBA, the MEWA, the rural electric cooperative or the rural telephone cooperative association that sponsors the self-insured coverage. Insurers and self-insured plans will use IRS Form 720 to report and pay the fee once each year, by July 31, for the prior year (Form 720 has yet to be updated to reflect the fee). Thus, for calendar-year plans, the first payment will be due by July 31, 2013, for the 2012 plan year or policy year.

Affected Plans: The fees apply to insured and self-funded group health plans for active or former employees, and under certain circumstances, HRAs and health FSAs may be subject to the fee (a group health plan used with such arrangements is subject to the fee). Many plans are exempt, including "excepted benefits," such as stand-alone dental or vision plans; HSAs, employee assistance plans (EAPs), wellness and disease management programs that don't offer "significant benefits in the nature of medical care or treatment;" most expatriate plans; and stop-loss insurance. Retiree-only plans are not exempt, and governmental entities are also generally not exempt from the fee. There is an exception for exempt governmental programs, including Medicare, Medicaid, SCHIP and any program established by federal law for providing medical care (other than through insurance policies) to members of the armed forces, veterans or members of Indian tribes.

Number of Covered Lives: To determine "the average number of lives covered under the plan for the plan year," self-insured plan sponsors can generally use any reasonable method in the first plan year (2012) and will choose from three alternative methods in later years, including an actual count method, a "snapshot" method, and a Form 5500 method (examples of each method are provided in the guidance). A plan sponsor may apply a single method in determining the average number of lives covered under the plan for the entire plan year. However, a plan sponsor is not required to use the same method from one plan year to the next.

The Obama administration continues to issue regulations implementing healthcare reform according to the original timetable set out under the 2010 law, with the assumption that healthcare reform will survive the Supreme Court challenge and this year's election cycle. Accordingly, employers are advised to continue to monitor healthcare reform developments.

Should you have questions about this or any aspect of federal health insurance reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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