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PCORI Fee to be Paid by Self-Insured Plans

The agencies have finalized rules implementing a new fee on health insurance policies and self-insured health plans to fund the Patient-Centered Outcomes Research Institute (PCORI) Trust Fund. The Affordable Care Act established PCORI to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing comparative clinical effectiveness research. The PCORI 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.

Calculating the Fee: The new rules confirm most of the rules from the April 2012 proposed regulations (see our recent Update), but do offer some useful clarifications and additional guidance on calculating the new fee. The fees are applicable to plan or policy years ending on or after October 1, 2012 and before October 1, 2019. Thus, plan sponsors and insurers with calendar year plans or policies will be required to pay the fee for 2012 by July 31, 2013. Because the fee is imposed on the plan administrator (instead of the plan), paying the fee generally does not constitute a permissible expense of the plan for a single employer plan for purposes of Title I of ERISA. The fee is $1 in the case of years ending before October 1, 2013 (and $2 in the second year) multiplied by the average number of lives covered under the plan (employees, spouses and dependents). For years ending on or after October 1, 2014, the $2 fee is increased based on increases in the projected per capita amount of National Health Expenditures.

Payers: Insurers will pay the fee on behalf of fully insured plans (but can be expected to pass on the cost in premiums). For self-insured plans, the plan sponsors are required to 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 “Quarterly Federal Excise Tax Return” 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. Third party administrators are not permitted to report or pay fees on behalf of plan sponsors (however they can assist with fee filings). Plan sponsors can file Form 720 electronically, but to do so, they must submit Form 720 through an approved transmitter software developer (see all http://www.irs.gov/uac/720-e-file). If plan sponsors wish to file electronically, they will incur service fees for online submission.

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 (for a plan year beginning before July 11, 2012 and ending on or after October 1, 2012) and can choose from several methods in later years to determine the average number of lives: actual count, snapshot and Form 5500 methods (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.

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, Archer MSAs, 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.

The rules clarify the following:

- COBRA coverage must be taken into account in determining the fee.
- Two or more arrangements established or maintained by the same plan sponsor that provide health coverage (other than an insurance policy) and that have the same plan year may be treated as a single applicable self-insured plan for purposes of calculating the fee (e.g., a self-insured major medical plan and a separate self-insured arrangement for prescription drug benefits could be treated as one applicable self-insured plan so that the same covered life covered under each arrangement would count as only one covered life for purposes of calculating the fee.)
- An applicable self-insured health plan that provides coverage through fully-insured options and self-insured options may determine the fee by disregarding the lives that are covered solely by the fully-insured options.
- A plan's number of covered lives includes those residing in the United States (regardless of citizenship), including U.S. territories (residence is determined based on the most recent address on file for the primary insured and can treat any spouse, dependents, or other beneficiaries covered under the same plan as having the same address).
- The term "applicable self-insured health plan" does not include a self-insured plan (if facts and circumstances show) was designed specifically to primarily cover employees who are working and residing outside the United States.

HRAs and FSAs: As noted above, there is no broad exclusion for HRAs or health FSAs. However, certain HRAs and FSAs may be able to escape this requirement if they are considered to be excepted benefits. In general:

- As the annual value typically exceeds $500, HRAs generally will not be considered excepted benefits.
- HRAs are not subject to separate fees, provided they are integrated with another self-

insured plan that provides major medical coverage sponsored by the same plan sponsor.

- HRAs that are integrated with an insured group health plan are subject to separate fees, even if the same plan sponsor sponsors both plans.
- Health FSAs are not subject to fees, provided they are “excepted benefits” under HIPAA as is usually the case (i.e., the employer does not make a contribution towards the FSA, the employee has other coverage available under the employer’s group health plan, and that other coverage is not limited to “excepted benefits.”)
- For health FSAs or HRAs that are subject to fees, plan sponsors can assume one covered life for each employee with an HRA and for each employee with a health FSA that is not an excepted benefit.

The Obama administration continues to issue regulations implementing healthcare reform according to the original timetable set out under the 2010 law. 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.