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REFORM Update

Issue Forty-Four June 2012

June 11, 2012

The health care reform legislation contained provisions to promote research to evaluate and compare health outcomes. This research will include the evaluation of clinical effectiveness, risks, and benefits of medical treatments, procedures, drugs and services. One key initiative launched the establishment of a private, non-profit corporation called the Patient-Centered Outcomes Research Institute (PCORI). PCORI will distribute funding for research that will advance the quality and promotion of evidence-based medicine. They will disseminate the research findings in an understandable manner. This information will assist individuals and their health care providers in making informed decisions about cost-effective and quality care.

Health care reform specifically prohibits the Secretary of Health and Human Services from using research findings to determine coverage, reimbursement, or incentive programs without allowing public comment. Also, the Secretary cannot deny coverage for items or services based solely on comparative clinical effectiveness research findings.

Insurance carriers and self-funded health plan fees will partially fund the PCORI studies. Some call this fee the PCORI fee, while others refer to it as the Comparative Effectiveness Research (CER) fee.

The IRS recently released rules for paying CER fees. The fees are effective as of the first plan year that ends after September 30, 2012. For calendar year plans, this means the fees apply to the plan year beginning January 1, 2012. The fees will expire and will not apply to plan years ending after October 1, 2019.

The guidance clarifies a number of issues relating to assessing and paying CER fees.

Parties and Plans Affected by the Fees

The organization responsible for paying the fees differs depending on whether the plan is fully-insured or self-funded. For fully-insured plans, the fee is assessed against the insurance carrier. For self-funded plans, the fee is assessed against the plan sponsor. In many cases, the employer is the plan sponsor.

The fees apply specifically to health insurance; the following plans are explicitly excluded:

- Any insurance policy or plan if substantially all of its coverage is for “excepted benefits.” Often, separate policies cover only dental and vision benefits, which makes them “excepted benefits” under HIPAA. Benefits must meet two requirements for the coverage to be “excepted” if they are not covered by a separate contract:
  - Employees must make a separate election for the coverage.
  - Employees must make a separate employee contribution for the coverage.

- Any group policy issued to an employer where the facts and circumstances support that the group policy was designed to cover employees working and residing outside the United States. For many employers, this will include their international benefit plan.
- Any stop loss or indemnity reinsurance policy.
- Any prepaid health coverage arrangement, which means an arrangement under which providers receive fixed payments or premiums as consideration for their agreement to provide or arrange for providing health coverage. Examples include any hospital or medical services policy or a health maintenance organization contract.

The regulations answer some employers' questions regarding certain plans:

- The regulations **do not** exclude retiree-only health plans. Employers and insurance carriers will need to include retirees when they calculate average covered lives.
- VEBA-funded plans are subject to the fees. The VEBA trust is simply the funding vehicle for benefits. If benefits are provided through an underlying insurance plan, the carrier is responsible for the fee. **However, if the plan is self-funded, the plan sponsor is responsible for the fee.**
- EAPs, disease-management programs and wellness programs are excluded if they do not provide significant medical care or treatment benefits. For most employers, such programs will be excluded from the fee.
- The regulations clarify CER fees for health reimbursement arrangements (HRAs). If the underlying health plan is fully insured, then the insurance carrier pays the CER fees associated with the insured plan. The plan sponsor is responsible for paying the CER fees for individuals covered by the self-funded HRA portion of the plan.

  An exception may apply if the underlying health plan and the HRA are both self-funded. If a plan sponsor has more than one arrangement providing self-funded accident or health coverage, the arrangements can be treated as a single self-insured health plan provided they both have the same plan year. For example, if an employer has an HRA paired with an underlying self-funded medical plan, and both plans have the same plan year, they are treated as a single plan for calculating the fee. But most employers offering HRAs have a fully-insured underlying health plan. In essence, these plans will pay the CER fee twice, with the carrier paying for the insured plan and the employer paying for the self-funded HRA plan.
- The guidance also clarifies how plan sponsors should handle carve-out situations. Employers sometimes carve out benefits like pharmacy or mental health. The exception noted above may apply. If a plan sponsor has more than one arrangement that provides self-insured accident or health coverage, the sponsor can treat both arrangements as a single self-insured health plan provided they both have the same plan year. To count as one plan for the purpose of CER fees, the plans must be self-funded and have the same plan year.

IRS controlled group rules do not apply to CER fees. If more than one employer maintains a plan, each employer will generally be responsible for filing and paying its portion of the fees. Employers can avoid this situation by designating a specific employer as the plan sponsor in the plan document, or by designating an employer as the plan sponsor for purposes of the CER fee rules.

Calculating the Fees

Two variables apply to calculating CER fees. First, the fee increases over the seven-year period that it remains in effect. The plan year end date determines the fee:

Plan Year End	Annual Fee Per Covered Life
Before October 1, 2013	$1
Between October 1, 2013 and October 1, 2014	$2
After October 1, 2014 and before October 1, 2019	$2 increased by the projected increase to the per capita amount of the National Health Expenditures

Second, the plan needs to determine average covered lives. The government offers several ways to calculate this average. The options differ based on whether the insurance carrier or the plan sponsor is paying the fee.

Insurance carriers can use any of the following four methods:

1. Actual count
2. Snapshot
3. Members months
4. State form

Insurance carriers understand the details of these methods and will choose the option that makes sense for them. They must consistently use the same method to calculate the average covered lives under a policy throughout the year.

Self-funded plan sponsors can use any of the following three methods:

1. **Actual Count** – This method requires the plan sponsor to count the actual number of covered individuals on each day of the plan year and to divide that number by 365 or 366, as applicable.
2. **Snapshot** – This method has two allowable approaches:
    a. Plan sponsors can count the actual number of covered individuals on at least one day in each quarter. The covered lives on the snapshot days are then added together and divided by four.

b. Plan sponsors can count the actual number of employees enrolled for single coverage on one day in each quarter. The plan must add to that day's single count, the number of employees enrolled for non-single coverage, multiplied by 2.35. The sum of these numbers for each quarter should then be divided by four. This method allows a multiplier for plan sponsors that do not have a good method for keeping track of all covered lives (specifically dependents).

3. **Form 5500** – This method uses the numbers reported on the plan sponsor's annual Form 5500. If a plan offers only single coverage, the plan sponsor can add the participants as of the first day of the plan year to the number of participants on the last day of the plan year. This sum should then be divided by two to determine the average covered lives. However, the Form 5500 does not distinguish between single and multi-person enrollment categories. If the plan offers family coverage, then the Form 5500 calculation changes. The plan sponsor will need to add the number of participants reported on the Form 5500 at the beginning of the plan year to the number of participants at the end of the plan year. The sum of these two numbers equals the average covered lives for CER fee purposes.

Plan sponsors must also be consistent in the method they use to calculate average covered lives during the year.

If an FSA or HRA is subject to the CER fee, the plan sponsor need only assume that each participant has single coverage. Medical FSAs are only subject to the CER fee if they are not considered "excepted benefits" under HIPAA. If an employer does not provide any funding for a medical FSA, it is considered "excepted". For these plans, the government will count each employee as a covered life, regardless of whether or not the employee's family is eligible for tax-favored benefits from the account.

Because little lead time was provided, a special rule applies to the first year of calculating CER fees for self-funded medical plans. For plan years ending on or after October 1, 2012, and beginning before July 11, 2012, the plan sponsor can use any reasonable method to determine covered lives during the first year. For subsequent years, a plan sponsor will have to use one of the methods previously described.

Paying Fee and Reporting Requirements

Insurance carriers and plan sponsors must file a Form 720, the Quarterly Federal Excise Tax Return, to report and pay the annual CER fees. Because many of the taxes reported on this form relate to transportation expenses, the IRS will modify the form to allow for the reporting of CER fees. In addition, it will amend the instructions for reporting and paying these fees.

Some employers are already filing this form quarterly. Because they only need to pay CER fees annually, these organizations should simply add the CER fees to the required quarter. Employers not filing a Form 720 today must file it annually to report and pay the CER fees.

The CER fees are due on July 31 of the calendar year following the plan year for which they are assessed. For example, let's assume an employer has a calendar-year plan that ends December 31, 2012. The CER fees for that year must be reported on the Form 720 and paid by July 31, 2013. If a

plan year ended on October 31, 2012, that employer would also need to report and pay the CER fees by July 31, 2013.

Employers can file Form 720 electronically. Although the government is **not** requiring electronic filing, it is strongly encouraging it. To submit the Form 720 electronically, an employer must use an approved transmitter software developer. The employer or taxpayer will pay the approved software developer's fee for online submission.

Concluding Thoughts

The government has requested comments on this guidance, specifically on the issue of allowing third parties to act on behalf of plan sponsors in reporting and paying the CER fees. These arrangements were not discussed in the initial guidance. The IRS has scheduled a public hearing regarding CER fees on August 8, 2012.

Employers should begin assessing their situation based on this new information:

- Review your plan options – which of your plans will be subject to the CER fees?
- Evaluate funding status – if your plan is fully insured, the insurance carrier pays the fee. But if any of your plans are self-funded, you should start reviewing potential approaches for calculating average covered lives.
- Review your counting options – your goal will be to automate the count as much as possible. Based on the information available, is one option preferable to the others?

Employers have some time to evaluate options and develop a process for reporting and paying CER fees. These fees are due, at the earliest, on July 31, 2013.