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REFORM Update

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Health care reform requires health insurance carriers and certain self-funded health plans to pay a new fee in 2013. The new fee will be used to fund comparative research studies. It is sometimes referred to as the Patient-Centered Outcomes Research (PCOR) fee. Sometimes it is referred to as the Comparative Effectiveness Research (CER) fee.

Last year's initial proposed guidance was discussed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2012/Reform_Update_44.pdf. In December 2012, the IRS released final regulations regarding the CER fee.

This *Reform Update* summarizes the final CER fee guidance and explains a few minor proposed changes.

Parties and Plans the Fees Affect

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

The final regulations clarify situations where an employer may have a plan with both insured and self-funded components. In these cases, the fee is handled separately. As with health reimbursement arrangements (HRAs), the insurance carrier pays the fee on covered lives for the insured component. The employer pays the fee on the self-funded component. For employers that supplement a fully-insured medical plan with a self-funded HRA, both the insurance carrier and the employer pay the fees.

The fees apply specifically to comprehensive health benefit plans. The following plans are explicitly excluded:

- Any insurance policy or plan if substantially all of its coverage is for "excepted benefits" under HIPAA. Often dental and vision coverage is considered excepted under HIPAA, because the benefits are limited. For this coverage to be considered "excepted", it must be offered under separate policies or contracts. But if a separate contract does not cover the benefits, the plans must meet two requirements for the coverage to be "excepted:"
    - Employees must elect the coverage separately.
    - Employees must pay for the coverage separately.
- Any group policy designed to cover employees working and residing outside the United States. For many employers, this will include their international benefit plans.
- Any stop loss or indemnity reinsurance policy
- Any pre-paid health coverage arrangement

The final regulations stress the following:

- Employers and insurance carriers 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 an underlying insurance plan provides the benefits, the carrier pays the fee. If the plan is self-funded, the plan sponsor pays the fee.
- EAPs, disease-management programs and wellness programs are excluded if they do not provide significant medical care or treatment benefits. It is rare for these plans to provide "significant" benefits.

The final regulations continue to provide relief for employers that may use more than one vendor to deliver their health benefits. If a plan sponsor has more than one arrangement providing self-funded health coverage, it may be possible to treat both arrangements as a single self-funded health plan. To count as one plan for CER fees, the plans ***must be self-funded*** and have the ***same plan year***.

For example, let's say Employer D sponsors three different plans that provide certain benefits to employees. Plan 501 is a self-funded health plan that runs on a calendar-year. Plan 502 is a self-funded HRA that reimburses specific medical expenses that Plan 501 doesn't pay. This plan is also self-funded and runs on a calendar year. Plan 503 is a self-funded dental and vision plan. Plans 501 and 502 will be subject to the CER fees. However, since both plans are self-funded and both run on a calendar year, they are treated as one plan for CER fee purposes. Plan 503 is not subject to the fee because it is "excepted" under HIPAA.

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 payment.

Calculating the Fees

CER fees involve two variables. First, the fee increases over the seven-years that it remains in effect. A plan year's end date determines the fee amount:

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 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.

The new final regulations slightly modify the counting methods for self-funded plan sponsors. Plan sponsors can choose from any of the three methods discussed below. The final regulations also offer examples of the counting methods.

Actual Count

This method allows the plan sponsor to count the actual number of covered individuals on each day of the plan year. The sponsor then divides the total by the number of days in the year (365 or 366).

Employer A sponsors a self-funded medical plan that runs on a calendar-year. The employer adds the number of covered lives on each day of the 2012 plan year, for a total of 3,285,000. Since 2012 had 366 days, the total is divided by 366. The average covered lives for 2012 is 8,975. The fee for 2012 is $1 multiplied by 8,975. It is due by July 31, 2013.

Snapshot

The snapshot method involves looking at the number of covered lives at specific times during the year. The final regulations have modified this method.

Plan sponsors should count the actual number of covered individuals on at least one day of one month from each quarter during the plan year. Employers can pick more than one day a month. If they decide to count on two days for one quarter, they must do the same for the other quarters. The covered lives on the snapshot days are then added together and divided by the number of days when lives were counted. Employers must be consistent when they select days from each quarter. The dates they choose for the count month in the last three quarters of the plan year must be within three days of the dates they choose for the snapshot count in the first quarter. All days counted must fall within the employer's plan year. Both the 30th and 31st of the month are treated as the last day of the month.

This may seem confusing, but it is actually simple. Assume an employer has a calendar-year plan and will use the snapshot method. The employer designates the last day of the third month of the quarter as count days. The count days can be March 30 or 31, June 30, September 30 and December 30 or 31.

Employers then have two choices. First, they could simply count all covered lives on the designated count days. If they count covered lives once each quarter, they divide the total by four. Second, they

can use the factor count method. To use this method, they add the number of single electors on the count day to the family electors multiplied by 2.35. Following are examples of each option.

Actual Count Method
Employer B has a calendar-year plan and selects four count days. The count days will be in the first month of each quarter. The employer records the following covered lives:

Count Day	Covered Lives
January 4, 2012	2,000
April 5, 2012	2,100
July 5, 2012	2,050
October 4, 2012	2,050

The average number of covered lives for 2012 is 2,050 [(2,000 + 2,100 + 2,050 + 2,050) / 4]. The fee for 2012 is $1 multiplied by 2,050. It is due by July 31, 2013.

Factor Count Method
Assume the same facts and plan information as in the previous example, but the employer uses the factor count method instead:

Count Day	Single Electors	Other than Single Electors
January 4, 2012	600	800
April 5, 2012	608	800
July 5, 2012	610	809
October 4, 2012	610	809
Total	2,428	3,218

The average number of covered lives for 2012 is 2,497 [2,428 + (3218 x 2.35) /4)]. The fee for 2012 is $1 x 2,497. It is due by July 31, 2013.

Form 5500

A plan sponsor may determine average covered lives by using the participants reported on the Form 5500. Employers may use this method as long as they file Form 5500 on time. They cannot use this method if they apply for a filing extension.

If the employer offers just self-only coverage, the employer should add the number of total participants at both the beginning and end of the plan year, and then divide that total by two.

Employers covering employees and their families can still use the Form 5500 method. The employer would simply add the number of participants at the beginning of the plan year to the number of participants at the end of the plan year. This total will be the average covered lives for CER fees.

The regulations offer several examples. In one, the employer has a calendar-year ERISA plan year. The employer must submit Form 5500 for the 2012 plan year by July 31, 2013. This employer's health plan covers both employees and their dependents. The employer reports 4,000 plan participants at the beginning of the plan year and 4,200 plan participants on the last day of the plan year. The average number of covered lives for 2012 is 8,200 (4,000 + 4,200). The fee for 2012 is $1 x 8,200. It is due by July 31, 2013.

The regulations offer another helpful example. Assume the employer's ERISA plan has two medical plan options. The first plan is self-funded, while the second plan is fully insured. The employer's 2012 plan year Form 5500 indicates 4,000 participants on the first day of the plan year and 4,200 on the last day of the plan year. Some of those participants are covered under the fully insured plan option, for which the insurance carrier is paying the CER fee. Therefore, the employer can remove these participants before calculating average covered lives. In this example, as of the first day of the plan year, the fully insured plan covers 3,000 participants. As of the last day of the plan year the fully insured plan covers 2,900 participants.

The employer will determine covered lives by looking only at participants the self-funded medical plan covers. Therefore, covered lives as of the first day of the plan year will be 1,000. Covered lives as of the last day of plan year will be 1,300. The average number of covered lives for 2012 is 2,300 (1,000 + 1,300). The fee for 2012 is $1 x 2,300. It is due by July 31, 2013.

Plan sponsors must consistently use the same method to calculate average covered lives during the year. They can change the calculation method they use annually, but not mid-year. Employers must also include anyone COBRA covers when they count covered lives to determine CER fees.

If an FSA or HRA must pay the CER fee, the plan sponsor need only assume that each participant has single coverage. Medical FSAs are subject to the CER fee only if they are not considered "excepted benefits" under HIPAA. For CER fees, only employees are counted, not family members who are eligible for tax-free benefits under these plans.

The final regulations maintain the special rule included in the proposed regulations. Because employers have so little lead time, 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 count 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 will pay the fee for insured plans. Employers with self-funded plans need to pay the CER fee for only their self-funded plan options. Plan sponsors must file a Form 720 to report covered lives. At the point the Form 720 is filed, the CER fee must be paid. However, the Form 720 has not yet been amended to account for 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, assume an employer has a calendar-year plan ending on 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, the employer would also need to report and pay the CER fees by July 31, 2013. If a plan year ends on January 31, 2013, the CER fees will be due by July 31, 2014.

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

These final regulations do not differ significantly from the proposed regulations. However, the examples will help employers to understand the various counting options.

Employers with self-funded medical plans should begin evaluating the various counting methods and choose the method that fits best with their recordkeeping procedures.

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.