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Employment, Labor & Benefits Advisory

JUNE 11, 2012

Treasury Department and IRS Issue Proposed Rule Implementing Comparative Effectiveness Research Fees for Insured and Self-insured Health Plans

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The Patient Protection and Affordable Care Act includes provisions intended to promote "comparative effectiveness research" (CER) — i.e., the direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harms. To fund CER, the Act establishes a new nonprofit organization called the Patient-Centered Outcomes Research Institute (PCORI). Funding for PCORI is provided through fees paid by health insurance issuers and group health plans into a newly created Patient-Centered Outcomes Research Trust Fund (the Trust). The requirements imposed on health insurance issuers and group health plans to pay CER fees are found in the following provisions of the Internal Revenue Code as added by the Act:

- Code § 4375 imposes a fee on "specified health insurance policies," which means and includes "any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States." A specified health insurance policy does not, however, include any insurance if substantially all of its coverage is of HIPAA-excepted benefits. The fee is based on the average number of covered lives under the policy, which includes employees, spouses, dependents, and beneficiaries.
- Code § 4376 imposes a fee on a plan sponsor of an "applicable self-insured health plan." An applicable self-insured health plan is "any plan for providing accident or health coverage if any portion of the coverage is provided other than through an insurance policy, and the plan is established or maintained" by a plan sponsor. A "plan sponsor" for this purpose is the employer in the case of a plan established or maintained by a single employer, or the employee organization in the case of a plan established or maintained by an employee organization. Special rules apply to multiple employer welfare arrangements (MEWAs) and voluntary employees' beneficiary associations (VEBAs), under which the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.
- Code § 4377 includes definitions and special rules that apply for purposes of Code §§ 4375 and 4376. It also provides a limited exemption for certain governmental programs, including Medicare, Medicaid, the Children's Health Insurance Program, and programs providing medical care (other than through insurance policies) to members of the military and their families. Thus, governmental entities falling outside these exemptions must pay CER fees.

CER fees apply to policy and plan years ending after September 30, 2012 and before September 30, 2019. For calendar year policies and plans, the fee applies from 2012 through and including 2018. In the case of a group health plan, the fee is $2 ($1 for plan years ending before October 1, 2013) multiplied by the average number of lives covered under the plan. The dollar amounts of the fee are adjusted, starting in 2014 or 2015 (depending on

the plan year), by the percentage increase in the projected per capita amount of National Health Expenditures published by the Department of Health and Human Services before the beginning of the fiscal year.

On April 17, 2012, the Treasury Department and the Internal Revenue Service issued a notice of proposed rulemaking (the NPRM) that sets out proposals for calculating and paying CER fees by fully insured and self-funded group health plans. The NPRM also includes a request for comments and provides notice of public hearing.

Obligations Imposed on Specified Health Insurance Policies

The NPRM establishes a general rule under which a "specified health insurance policy" is liable for a fee imposed for policy years ending on or after October 1, 2012, and before October 1, 2019. The term "specified health insurance policy" is defined broadly to mean and include "any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States[,]" including certain prepaid health coverage arrangements (e.g., HMOs), but excluding HIPAA excepted benefits, i.e., stand-alone dental or vision plans, long-term care plans, coverage for a specific disease or illness offered as a separate policy, on-site medical clinics, coverage of accident and/or disability insurance, and workers' compensation and automobile payment insurance. Also excluded are plans covering expatriate employees, and stop-loss coverage for self-funded plans. The amount of the CER fee for a policy year is equal to the product of the average number of lives covered under the policy for the policy year and the "applicable dollar amount." To determine the average number of lives covered under a specified health insurance policy during a policy year, the NPRM proposes to permit an issuer to use one of the following four methods —

1. ***The actual count method***

   An issuer may determine the average number of lives covered under a policy for a policy year by adding the total number of lives covered for each day of the policy year and dividing that total by the number of days in the policy year.

2. ***The snapshot method***

   An issuer may determine the average number of lives covered under a policy for a policy year by adding the totals of lives covered on one date in each quarter of the policy year, or more dates if an equal number of dates is used for each quarter, and dividing that total by the number of dates on which a count was made.

3. ***The member months method***

   An issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months (an amount that equals the sum of the totals of lives covered on pre-specified days in each month of the reporting period) reported on the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit filed for that calendar year. Under this method, the average number of lives covered under the policies in effect for the calendar year equals the member months divided by 12.

4. ***The state form method***

   An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that is filed with the issuer's state of domicile, provided that the form reports the number of lives covered in the same manner as member months are reported on the NAIC Supplemental Health Care Exhibit.

Under a proposed "consistency" rule, issuers must use the same method of calculating the average number of lives covered under a policy consistently for the duration of the year.

The "applicable dollar amount" is:

- For policy years ending on or after October 1, 2012, and before October 1, 2013 — $1; and
- For policy years ending on or after October 1, 2013, and before October 1, 2014 — $2.

For any policy years ending in any fiscal year beginning on or after October 1, 2014, the applicable dollar amount

is further adjusted based on the increase in the projected per capita amount of the National Health Expenditures most recently released by the Department of Health and Human Services before the beginning of the fiscal year. For 2012 and 2019 (the first and last years of the CER fee requirements under the Act), the amount of the fee is prorated to conform data reporting periods to the periods covered by the Act.

Obligations Imposed on Self-funded Plans

The NPRM establishes rules under which an "applicable self-insured health plan" is liable for a CER fee for plans with plan years ending on or after October 1, 2012, and before October 1, 2019. An applicable self-insured health plan is defined to mean and include "a plan that provides for accident or health coverage … if any portion of the coverage is provided other than through an insurance policy" and the plan is established or maintained (1) by one or more employers, (2) by one or more employee organizations, (3) jointly by one or more employers and one or more employee organizations, (4) by a VEBA, (5) by an organization described in Code § 501(c)(6) (e.g., business leagues, chambers of commerce), or (6) by a MEWA. An applicable self-insured health plan does not, however, include HIPAA excepted benefits, nor does it include:

- Medical flexible spending arrangements (FSAs), if the employer offers other health plan coverage to employees, and the maximum annual benefit of the FSA is not more than two times the participant's salary reduction election for the year;
- Health savings accounts (HSAs);
- Self-funded employee assistance programs (EAPs) (i.e., wellness programs and disease management programs that do not provide significant benefits in the nature of medical care or treatment);
- Stop-loss insurance policies and reinsurance policies; and
- Expatriate plans (i.e., plans that cover workers outside the United States).

The amount of the CER fee for a plan year is equal to the product of the "average number of lives covered under the plan for the plan year" and the "applicable dollar amount" determined in the manner described above. For the purpose of determining the average number of lives covered under an applicable self-insured health plan during a plan year, the Notice provides the following options:

1. ***The actual count method***

   A plan sponsor may determine the average number of lives covered under a plan for a plan year by adding the totals of lives covered for each day of the plan year and dividing that total by the number of days in the plan year.

2. ***The snapshot dates method***

   A plan sponsor may determine the average number of lives covered under a plan for a plan year by adding the totals of lives covered on one date in each quarter, or more dates if an equal number of dates are used for each quarter, and dividing that total by the number of dates on which a count was made. For this purpose, the date or dates for each quarter must be the same (for example, the first day of the quarter, the last day of the quarter, the first day of each month, etc.).

3. ***The Form 5500 method***

   A plan sponsor may determine the average number of lives covered under a plan for a plan year based on the number of reportable participants for the Form 5500 filed for the applicable self-insured health plan for that plan year. If the plan does not offer family coverage, this amount is divided by 2.

The Notice imposes a separate consistency rule on self-funded plans under which a plan sponsor must use the same method of calculating the average number of lives covered under the plan consistently for the duration of the plan year. But a plan sponsor may use a different method from one plan year to the next. The NPRM includes a special rule for a plan sponsor that maintains multiple self-insured plans with the same plan year under which the plan sponsor is permitted to treat the plans as a single plan and pay a single fee. Thus, a self-funded plan that is paired with a medical expense reimbursement plan (MERP) or health reimbursement arrangement (HRA) may be treated as one self-insured plan subject to a single fee provided that both plans share the same plan year. But if

the MERP or HRA is paired or integrated with a fully-insured group health plan, each plan would be subject to a separate CER fee.

Special Rules for Governmental Plans

The fees imposed by Code §§ 4375 and 4376 generally apply to group health plans, whether fully-insured or self-funded, of governmental employers. The NPRM fleshes out the following statutory exceptions, under which the CER fee rules do not apply to any covered life under an "exempt governmental program." The term "exempt governmental program" includes the following:

- The insurance program established under title XVIII of the Social Security Act (i.e., Medicare);
- The medical assistance program established by title XIX or XXI of the Social Security Act (i.e., Medicaid and the Children's Health Insurance Program);
- A program established by federal law for providing medical care (other than through insurance policies) to individuals (or their spouses and dependents) by reason of such individuals being (or having been) members of the Armed Forces of the United States; and
- A program established by federal law for providing medical care (other than through insurance policies) to members of Indian tribes.

Paying the CER Fee

The CER fees are reported and paid using IRS Form 720, which is due by July 31 for all plan years ending in the preceding calendar year. This is a modification of existing rules for the reporting and paying of excise taxes, which generally call for quarterly filing. The NPRM amends this rule so that issuers and plan sponsors will report and pay the §§ 4375 and 4376 fees only once a year on Form 720, which will be due by July 31 of each year. For self-insured plans, the employer sponsoring the plan is responsible for paying the fee. The insurance company is responsible for insured plans, and the board of trustees is responsible for multiemployer (union) plans.

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