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Health Care Reform Update: Many Self-Insured Plans Subject to New Annual Fees This Year

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New regulations have been issued under the Patient Protection and Affordable Care Act ("PPACA") implementing annual fees and reporting requirements on self-insured health plans and indirectly on fully insured plans. The Internal Revenue Service ("IRS") has finalized regulations on annual fees imposed on sponsors of self-insured plans and issuers of health insurance policies to fund the Patient-Centered Outcomes Research Trust Fund. The fee for 2013 is $1 per covered life, which must be reported and paid by July 31, 2013 for calendar-year plans. The Department of Health and Human Services ("HHS") has issued proposed regulations that would impose additional fees on self-insured plans and health insurance issuers to fund the Transitional Reinsurance Program. HHS estimates that the initial annual contribution rate, for 2014, will be $63 per covered life.

Patient-Centered Outcomes Research Institute Fee

Background

PPACA established the Patient-Centered Outcomes Research Institute ("PCORI") to synthesize and disseminate research relating to the comparative clinical effectiveness of various medical treatments. PCORI is to be funded in part by fees ("PCORI fees") assessed on sponsors of self-insured health plans and issuers of health insurance policies.

PCORI fees are tied to the federal fiscal year, and they apply to plan years ending on or after October 1, 2012 and before October 1, 2019. The fee is equal to $2 ($1 for plan years ending before October 1, 2013), multiplied by the average number of employees and dependents covered by the plan ("covered lives"). For plan years ending on or after October 1, 2014, the fee is indexed to increases in projected per capita national health expenditures.

Who Pays the Fee?

PCORI fees are payable by sponsors of self-insured health plans and issuers of health insurance policies. For this purpose, the plan sponsor is generally the employer, disregarding controlled group rules. If multiple employers participate in the same plan, the fee is allocated among each employer, unless the sponsor is identified in the plan document. The regulations permit employers to amend their plans to designate one employer as the plan sponsor for PCORI fee purposes, provided that the designation is made in writing, and the designated sponsor has given its written consent, before the PCORI fee for the plan year is due. Although the PCORI fee for fully insured plans is initially imposed on the insurance issuer, the regulations do not restrict issuers from passing the fees to plan sponsors and participants in the form of higher premiums.

Plans Subject to the Fee

PCORI fees are generally imposed on all self-insured health plans and health insurance policies, including plans and policies providing coverage only to retirees, continuation coverage under COBRA, most health reimbursement arrangements ("HRAs"), and health flexible spending accounts ("FSAs") provided in lieu of other group health coverage or funded primarily with employer contributions or flex credits.

The following arrangements are not subject to the PCORI fee:

- Benefits excepted from the Health Insurance Portability and Accountability Act ("HIPAA"), such as limited-scope dental and vision plans and health FSAs funded primarily by employee salary reduction contributions (if other group health coverage is made available);
- Employee assistance, disease management, and wellness programs that do not provide significant benefits in the nature of medical care or treatment;
- Certain governmental programs, such as Medicare (including Medicare Advantage plans), Medicaid and the Children's Health Insurance Program ("CHIP"); and
- Expatriate plans that primarily cover employees working and residing outside the United States.

Determining the Number of Covered Lives

For the initial payment, sponsors of self-insured plans may use any reasonable method to determine the average number of lives covered for the plan year. For future payments, the regulations offer three optional counting methods:

- the "actual count method," which counts covered lives on each day of the plan year;
- the "snapshot method," which counts covered lives (or derives an estimate of covered lives based on a count of covered participants) on a designated day or period each quarter of the plan year; or
- the "Form 5500 method," which derives an estimate of covered lives based on the number of participants recorded on the annual report filed by the plan administrator on Form 5500.

The Form 5500 method may be used only if the plan administrator has filed the Form 5500 for the plan year prior to the July 31 payment date, which coincides with the due date for the Form 5500 filing (without

extensions). Plan sponsors are permitted to assume one covered life for each employee participating in an HRA or health FSA (and, therefore, to disregard any dependents) if the sponsor does not maintain a self-insured plan other than the HRA or health FSA, or if the employee does not participate in the other, integrated plan. Self-insured plans are not required to use the same counting method each year or use the same approach for each plan. Other counting options are available for issuers with respect to fully insured plans.

Treatment of Multiple Self-Insured Arrangements

For purposes of counting covered lives, the regulations permit multiple self-insured arrangements to be treated as a single self-insured health plan if they are established and maintained by the same plan sponsor and have the same plan year. For example, if a plan sponsor has a self-insured major medical plan whose expenses may be paid out of an HRA and both arrangements have the same plan year, they would be treated as a single self-insured plan. Therefore, participants and dependents covered by both arrangements would only be counted once. However, a fully insured plan may not be integrated with a self-insured plan. Therefore, if an employee participates in a fully insured major medical plan and an HRA, the issuer must take the employee and his or her dependents into account in determining the PCORI fee attributable to the plan, and the sponsor must also take the employee and his or her dependents into account in determining the PCORI fee attributable to the HRA, even if both arrangements are maintained by the same sponsor.

Payment and Reporting of Fees

Plan sponsors must report the number of covered lives and pay the PCORI fee on IRS Form 720, "Federal Excise Tax Return," by July 31 of the calendar year immediately following the end of the plan year. Thus, for calendar-year plans, the first report and fees must be filed by July 31, 2013. Because the PCORI fee is imposed on sponsors and issuers, rather than on the plans themselves, the Department of Labor has advised that the PCORI fee generally does not constitute an expense that may be paid from plan assets.

Transitional Reinsurance Program Contribution

Background

The Transitional Reinsurance Program ("TRP") is one of three programs established under PPACA to stabilize health insurance premiums after the individual health insurance mandate becomes effective in 2014. The TRP does so by collecting payments from self-funded health plans and health insurance issuers, which will be used to offset a portion of high-cost medical claims that arise in the individual market in the first three years of the mandate's operation. By statute, the aggregate national contributions for reinsurance payments are $12 billion for 2014, $8 billion for 2015 and $5 billion for 2016. HHS estimates that the TRP contribution rate for 2014 will be $5.25 per covered life per month, or $63 per covered life annually.

Who Makes the Contribution?

The plan trust is ultimately responsible for any TRP contributions assessed on self-insured group health plans, although the plans may direct third-party administrators to transfer the contributions to HHS on the plan's behalf. A self-insured group health plan without a third-party administrator must remit its TRP contributions to HHS directly. Health insurance issuers are responsible for any TRP contributions assessed on fully insured plans, although the regulations do not restrict issuers from passing the fees to plan sponsors and participants in the form of higher premiums.

Contributing Entities and Excluded Entities

Contributions are required with respect to "commercial books of business" for "major medical products," including major medical coverage extended to retirees. In the proposed regulations, HHS provides that the following plans do not meet this standard, and therefore are not subject to TRP contributions:

- Benefits excepted from HIPAA, such as limited-scope dental and vision plans;
- Health FSAs, health savings accounts and HRAs integrated with group health plans;
- Employee assistance, disease management, and wellness programs, to the extent that they provide only benefits ancillary to major medical coverage;
- Certain governmental programs, such as Medicare (including Medicare Advantage plans), Medicaid and CHIP, and private coverage that is secondary to Medicare; and
- Expatriate plans that primarily cover employees working and residing outside the United States.

Determining the Number of Covered Lives

The counting methods available to determine the number of covered lives for the TRP contribution are similar to those used to determine the covered lives for the PCORI fee. Self-insured plans may use the actual count method, the snapshot method or the Form 5500 method, and fully insured plans may use the other methods available to them under the PCORI regulations. However, the counting methods used to determine the TRP contribution differ from those of the PCORI fee in the following ways:

- For the actual count and snapshot methods, covered lives are counted only for the first nine months of the applicable calendar year, in order to meet the November 15 reporting deadline;
- For the Form 5500 method, the plan may use the number of participants recorded on the Form 5500 for the preceding plan year, not the current plan year;
- Covered lives are measured over the calendar year, rather than the plan year; and
- Self-insured and fully insured health plans maintained by the same plan sponsor are treated as a single plan, to avoid double-counting employees and dependents covered by both plans. The plan sponsor (as determined under the PCORI regulations) is responsible for paying the TRP fee for the combined arrangement.

Contributing entities are allowed to use a different counting method for the TRP contribution than the method used for the PCORI fee.

Collection of TRP Contributions

HHS intends to collect the TRP contributions on an annual basis from plans and policies in all states, including states that elect to operate their own reinsurance programs. Contributing entities must submit data reflecting the average number of covered lives to HHS by November 15 of calendar years 2014, 2015 and 2016. HHS will then calculate the final rates and assess the liability of each plan and issuer. This amount will be billed within 15 days of submission of the annual enrollment count or by December 15, whichever is later. The assessment is expected to be due 30 days after receipt (approximately, January 15). The Department of Labor has advised that TRP contributions would generally be payable from plan assets. If paid by the sponsor, the IRS has issued guidance that the contributions would be deductible as an ordinary and necessary business expense.

Actions to be Taken

In preparation for compliance with the PCORI fee and TRP contribution requirements, plan sponsors are encouraged to take the following actions:

- Review the options available for determining the PCORI fee and TRP contribution amounts, and elect a counting method to be used, beginning with the data for the 2012 plan year;
- If more than one employer participates in the health insurance plan, amend the plan before July 31, 2013 (for calendar-year plans) to specify the plan sponsor for PCORI and TRP purposes;
- Calculate expected costs, in coordination with insurers and third-party administrators, and take such costs into account in setting participant premiums; and
- Put into place procedures for reporting covered lives to the IRS by July 31, 2013 (for calendar-year plans) and to HHS by November 15, 2014 and making PCORI payments by July 31, 2013 (for calendar-year plans) and TRP payments by January 15, 2015.

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