General Board
Pension and Health Benefits

Caring For Those Who Serve

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Health Care Reform: New Fees for Employer Health Plans (PCORI Fee, Reinsurance Fee)

Recent guidance from the Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) addresses two new fees under the Patient Protection and Affordable Care Act (PPACA or ACA) that group health plan sponsors and health insurers will soon face. Final rules from the IRS explain the fees to support federal comparative effectiveness research, and new proposed rules from HHS address the fees to fund a transitional reinsurance program for the ACA's health insurance exchanges (Exchanges). Many plan sponsors will begin paying comparative effectiveness research fees in summer 2013 and reinsurance fees in 2014. Although rules governing the two fees are similar, some significant differences will complicate plan sponsors' compliance. To budget and plan for these fees, group health plan sponsors should identify their plans' covered lives, which will trigger the fees.

The fees apply to fully-insured and self-insured plans. However, because the insurance company is responsible for paying the fees on fully-insured plans, this summary focuses on the fees as applied to self-insured employer-sponsored health plans, such as HealthFlex and many other United Methodist annual conference plans.

- The General Board will pay these fees with respect to *HealthFlex active and Medicare Companion plans*.
- Annual conference and employer plan sponsors of the *Extend Health program* for retired participants will have to pay the fees for retired participants (and spouses) that have health reimbursement arrangements (HRAs) through Extend Health.
- The annual conference (e.g., its board of pensions or council on finance and administration) as plan sponsor will have to pay the fees with respect to *self-funded annual conference health plans*.
- The insurance company issuing the underlying policies will pay the fees with respect to *fully insured annual conference health plans*.

Comparative Effectiveness Research Fee (PCORI Fee)

The IRS issued a **final rule** on December 6, 2012 governing the annual fees that will help finance comparative effectiveness research conducted through the Patient-Centered Outcomes Research Institute (PCORI). PCORI is a private, nonprofit corporation established under the ACA to fund research on the clinical effectiveness of medical treatments, procedures and drugs. PCORI aims to expand access to evidence-based medical information for patients, clinicians and payers.

The PCORI Fee applies for each plan year that ends on or after October 1, 2012, and before October 1, 2019. The PCORI expires after October 2019. For calendar-year plans (HealthFlex and most annual conference health plans), the first PCORI Fee covers the 2012 plan year (the year ended December 31, 2012) and must be paid by **July 31, 2013**. This first-year PCORI Fee will be $1 multiplied by a plan's average number of covered lives. The final rule closely follows the proposed rule released in 2012, described **here**, with some changes and clarifications.

For the plan year ending between October 1 and December 31, 2013 (December 31, 2013 for most calendar-year plans), the PCORI Fee increases to *$2 per covered life*. For plan years ending after October 1, 2013 but before October 1, 2019, the PCORI Fee will rise with health care inflation.

Fees for Self-Insured Health Plans

Under Internal Revenue Code (Code) §4376, plan sponsors of "applicable self-insured health plans" are responsible for paying the PCORI Fee. In general, an applicable self-insured health plan is a plan that provides health or accident coverage, any portion of which is provided other than through an insurance policy. **For the PCORI Fee, this definition includes retiree-only plans.**

The final regulations ***do not exempt*** health reimbursement arrangements (HRAs) and health flexible spending accounts (FSAs). In fact, HRAs and FSAs may be subject to PCORI Fees in their own right (in addition to PCORI Fees related to the plan sponsor's group health plan) under certain circumstances. **Please note**:

- *Multiple self-insured arrangements* established and maintained by the same plan sponsor and having the same plan year *are subject to a single PCORI Fee*.
- An HRA that is integrated with a *self-insured health plan* providing major medical coverage *will not incur a separate PCORI fee* if the HRA and plan are established or maintained by the same plan sponsor.
- An HRA that is integrated with a *fully-insured group health plan* is treated as an applicable self-insured health plan and *is subject to the PCORI Fee*. Additionally, the insurer of the group insurance policy *is subject to the PCORI Fee separately*.
- A health care FSA is not subject to the PCORI Fee if it meets the requirements of an "excepted benefit" under Code §9832(c). A health FSA is an excepted benefit if: (1) the maximum benefit that is available to a participant in any given year is not more than twice his or her contribution (or, if greater, his or her contribution plus $500); and (2) major medical coverage is made available that same year.
- The PCORI Fee does not apply if substantially all of the coverage is for excepted benefits under Code §9832(c) (for example, certain limited-scope dental and vision benefits).
- Employee assistance programs (EAPs) and wellness programs *are not subject to the PCORI Fee* if they do not provide "significant benefits relating to medical care."

Calculating the Average Number of Lives

The PCORI Fee is based on the average number of covered lives (employees, spouses and dependents) during the plan year. Only individuals residing in the U.S. must be counted. If the address on file for the primary covered individual is outside the U.S., the plan sponsor may presume that the spouse and dependents also reside outside the U.S. Self-insured plan sponsors may use any of the following methods to calculate their covered lives subject to the PCORI Fee:

- **Actual count method**: Plan sponsor calculates the sum of the covered lives for each day of the plan year and divides the sum by the number of days in the plan year (i.e., 365).
- **Snapshot method (factor or count methods)**: Plan sponsor adds the total number of covered lives on one selected date in each quarter of the plan year, or an equal number of dates for each quarter, and divides the total covered lives by the number of dates on which a count was made. Each date used during the second, third and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all quarterly dates must fall within the same plan year. To count covered lives on a designated date, the plan sponsor uses either the snapshot factor method or the snapshot count method.
  - ***Snapshot Factor method***: The number of covered lives is equal to the sum of the number of primary plan participants with self-only coverage on that date, plus the number of primary participants with other than self-only coverage (e.g., participant plus spouse or family coverage) multiplied by **2.35**. (This is the method for those not wishing to count dependents separately.)
  - ***Snapshot Count method***: The number of covered lives is the actual number of covered lives (primary participants and all covered dependents) on the designated date.

- ***Form 5500* method**: Plan sponsor uses a formula that includes the number of participants actually reported on the *Form 5500* for the plan year. (**Please note**: Church plans, such as HealthFlex and other annual conference health plans, generally do not submit a *Form 5500*, so that method of counting would not apply.

Plan sponsors must use only one method in each year, but are not required to use the same method from year to year.

PCORI Fees will apply to coverage provided through COBRA or state-based continuation laws (unless the type of coverage is otherwise exempt as described above). Church plans are not subject to COBRA, but church plans usually provide some sort of continuation coverage. Given the breadth of applicability of the PCORI Fee, church plan sponsors should count participants with "continuation coverage" as covered lives.

The regulation provides a special rule for health FSAs and HRAs. Under the special rule, if a plan sponsor does not establish or maintain an applicable self-insured health plan other than a health FSA or HRA, the plan sponsor may treat each participant's health FSA or HRA as covering a single life (not counting spouses or dependents). Under this scenario, plan sponsors of Extend Health HRAs will only have to count a single life for each separate HRA for purposes of the PCORI Fee (i.e., not counting spouses or dependents of each HRA-participant).

Paying the Fees to the IRS

For fully-insured annual conference plans, insurers will file reports and pay the PCORI Fees. However, plan sponsors of self-insured (self-funded) plans must do these tasks themselves and *cannot delegate this work to third parties or vendors*. Plan sponsors must submit IRS ***Form 720*** "Quarterly Federal Excise Tax Return" to report the PCORI Fees and make annual payments. On June 4, *Form 720* was revised to reflect the PCORI Fee. Revised instructions for *Form 720* are **here**. Late filing of the *Form 720* or late payment of the PCORI Fee will result in penalties (fines), which may be waived or abated if the plan sponsor has reasonable cause and the failure was not due to willful neglect.

For HealthFlex plan sponsors, with respect to the active participant and Medicare companion plans, the General Board of Pension and Health Benefits (General Board)—as trustee of the multiple employer plan—will manage administration of the PCORI Fees. However, the General Board *will not* handle administration of the PCORI Fees for HRAs managed through Extend Health for plan sponsors that have adopted the Extend Health program for their retired participants—instead; the PCORI Fees for HRAs may require affected plan sponsors to submit *Form 720* and PCORI Fees themselves.

Transitional Reinsurance Program Fee

HHS has issued a **proposed rule** for the annual fees that will help fund a transitional reinsurance program (Reinsurance Fees) for the health plans participating in the Exchanges. The Reinsurance Fees are designed to stabilize individual health insurance premiums in 2014-2016—the first three years that Exchanges will be operational. The program is temporary and will help mitigate premium increases in the individual market resulting from individuals with high health care costs purchasing insurance in the new Exchanges. ***HHS estimates that the 2014 fee will be $63 annually per covered life in a group health plan.***

Amount and Time for Payment

HHS has determined that it needs to collect $12.02 billion in 2014, $8.02 billion in 2015 and $5.02 billion in 2016 to sufficiently fund the reinsurance program in the Exchanges. HHS determines the Reinsurance Fee by taking these annual aggregate amounts and dividing by the number of enrollees in health plans nationwide. For 2014, HHS estimates that the national per capita rate for the Reinsurance Fee will be $5.25 monthly ($63 annually); however, the final 2014 rate may differ based on final regulations from HHS later this year. This means that a plan sponsor will have to pay an estimated $63 multiplied by the average number of covered lives during the first year of the Reinsurance Fee.

For 2014, each contributing entity (each self-insured plan as defined below) must report its number of enrollees to HHS no later than **November 15, 2014**. HHS will notify the plan sponsor within 30 days (but not later than December 15, 2014) of the Reinsurance Fees to be paid. *A plan sponsor will have to pay the amount within 30 days of HHS notification*. As a result, the first Reinsurance Fee is likely to be paid in January 2015. HHS has not yet released a process for annual reporting and payment of Reinsurance Fees.

Plans Subject to Reinsurance Fees

In general, a "contributing entity" is a health insurance issuer or a self-insured group health plan that provides major medical coverage.

- If a group health plan is fully insured, the Reinsurance Fee is paid by the insurance company.
- If the group health plan is self-insured, the Reinsurance Fee is owed by the plan. Unlike the PCORI Fee described above, it is anticipated that the third-party administrator (TPA) of a self-insured health plan will remit the Reinsurance Fee on the plan's behalf. But regardless of who actually sends the payment to HHS, the additional cost will be borne by plan sponsors and ultimately plan participants in self-insured plans.

The Reinsurance Fee applies only with respect to health coverage that is major medical coverage (not limited scope coverage) or that is not subject to Section 2711 of the Public Health Service Act (PHSA), which defines the prohibition on annual limits. An HRA that is integrated with a group health plan providing medical coverage is excluded from the Reinsurance Fee, but the group health plan with which it is integrated *will* be subject to the Reinsurance Fee.

The following arrangements are ***excluded*** from the Reinsurance Fee because they do not provide "major medical coverage":

- Health flexible spending accounts (FSAs) (due to the $2,500 limit)
- Employee assistance programs (EAPs)
- Disease management programs
- Stand-alone vision and dental plans
- Stand-alone prescription drug plans
- Wellness programs
- Health savings accounts (HSAs)
- Stop-loss and indemnity reinsurance policies
- HRAs that are integrated with a group health plan

There is no express exception to the Reinsurance Fee for retiree-only major medical plans. However, unlike the PCORI Fee, health plans will not be subject to the Reinsurance Fee with respect to any enrollees for which Medicare is the ***primary payer***. This means that the Reinsurance Fee excludes individuals whose employer plan pays ***secondary*** to Medicare under the Medicare Secondary Payer (MSP) rules.

- Early retirees (prior to age 65) as well as actively working employees over age 65 will generally trigger Reinsurance Fees.
- Medicare-covered retirees age 65 and older, Medicare-covered long-term disabled individuals, and active employees over age 65 but for whom HHS has approved the "small employer exception" under the MSP rules will *not* generally trigger a Reinsurance Fee.
- It appears that an HRA that covers employees or retirees for whom Medicare is secondary and that is not integrated with a group health plan would be subject to the Reinsurance Fee. Under this interpretation, it appears that plan sponsors in HealthFlex's Extend Health program will *not* have to pay Reinsurance Fees for covered retirees because Medicare is the primary payer for these participants.
- It also appears that coverage provided through COBRA and other continuation coverage is subject to Reinsurance Fees.
- If a plan sponsor maintains two or more self-funded plans that collectively provide major medical coverage for the same covered lives, then the plans shall be treated as a single self-funded plan.

Counting Number of Lives

The proposed rule provides alternative methods to determine the average number of enrollees (including dependents), also referred to as covered lives. The methods permitted for the Reinsurance Fee resemble the methods used to determine the PCORI Fee described above. However, unlike the PCORI Fee, covered lives that have Medicare as their primary coverage are excluded from these counts. The number of covered lives must be determined by using one of three methods (which are *similar but slightly different* than the methods permitted for the PCORI Fee). Acceptable methods for counting covered lives for the PCORI Fee include:

- **Actual Count Method**. Add the total number of lives covered each day of the first nine (9) months of the *calendar year* and divide by the number of days during that nine-month period.
- **Snapshot Method**. Add the total lives covered (using the snapshot factor or snapshot count method described above) on any date during the same corresponding month in each of the first three quarters of the *calendar year* and divide that total by the number of dates on which a count was made (i.e., divide by 3).
- ***Form 5500* Method**. Use the most recently filed *Form 5500* (e.g., the 2013 *Form 5500*, which is filed in October 2014).

In most cases, plan sponsors of church plans should use either the actual count or snapshot count method, as they generally do not submit *Form 5500* [unless the church plan elected under Code §410(d) to become subject to the Employee Retirement Income Security Act (ERISA)].

Supplemental State Programs

States are permitted to establish a supplemental reinsurance program in addition to the federal program. If a state establishes a supplemental program, it may charge additional fees to fully insured plans. However, the ACA does not provide authority for a state to assess self-insured plans.

Who Pays these Fees?

"Plan sponsors" of self-insured group health plans are liable for reporting and paying the PCORI Fee and the Reinsurance Fee. Health insurers must pay for fully-insured coverage. The IRS has a rule for identifying the "plan sponsor" of a self-insured health plan for the PCORI Fee, and HHS has adopted that rule with respect to the Reinsurance Fee. The entity treated as plan sponsor in these common scenarios is:

1. *The "employer"* in the case of a plan maintained by a single-employer, e.g., a large local church sponsoring and maintaining its own plan for church lay employees.
2. *The employee organization* in the case of a plan established or maintained by an employee organization.
3. *The joint board of trustees of a multiemployer plan*, mainly relating to collectively-bargained union plans.
4. *The controlling committee of a multiple employer welfare arrangement (MEWA)*. MEWAs are fully-insured arrangements that resemble annual conference plans and HealthFlex in many ways.
5. *The trustee* in the case of a voluntary employees' beneficiary association (VEBA). Some church plans are maintained as VEBAs.

In the case of a plan not described above, the plan sponsor is the entity identified or designated by the terms of the document under which the plan operates.

For United Methodist Church self-funded annual conference health plans, it appears from this guidance that the "plan sponsor" for the purposes of these fees will be the annual conference board of pensions that administers and maintains the plan.

For HealthFlex, the General Board will be the responsible payer of the Reinsurance Fees and PCORI Fees, except to the extent either of the fees may apply to the HRAs maintained under the Extend Health program for retired participants of adopting annual conferences.

The Department of Labor (DOL) has advised that the Reinsurance Fee is a plan-related expense that may be paid with plan assets for plans subject to ERISA. Although ERISA does not apply to church plans, this guidance

nonetheless suggests that the Reinsurance Fees for church plans are also permissible plan expenses that may be paid with plan assets. The DOL has indicated that the PCORI Fee is generally *not* a permitted plan expense for ERISA plans; it should be paid directly by the plan sponsor. However, the DOL has opined that in situations where the plan sponsor is a multiple employer plan trustee, board or committee that exists primarily to administer the plan, the PCORI Fee may be considered a permissible plan expense.

Questions and Information

If you have questions or would like additional information, please send your inquiries to **healthcarereform@gbophb.org**. General information about health care reform is available from the federal government at **www.healthcare.gov**.