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As Feds Begin Reform Frenzy, Learn How New Fees And W-2 Rules Implicate COBRA

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June 1, 2012 — The federal agencies responsible for implementing health reform are going into overdrive in issuing new guidance now that the law is here to stay. So it's important that employers get fully up to speed on their obligations. However, some might not understand the extent to which reform affects COBRA administration, particularly two regulations issued in November.

So we'll discuss how the new rules, which address fees relating to group health coverage, apply to your COBRA practices. We'll also provide a recap of another reform provision with COBRA implications — the Form W-2 health coverage reporting requirement — which takes effect in January 2013.

Fees for the Patient-Centered Outcomes Research Institute

In December 2012, the IRS issued final regulations relating to the payment of fees by insurers and sponsors of group health plans to fund the Patient-Centered Outcomes Research Institute (77 Fed. Reg. 72721). The reform law established the PCORI to conduct research to evaluate the effectiveness of medical treatments, procedures and other items or strategies that treat, manage, diagnose, or prevent illness or injury. To fund the PCORI, the law imposes annual, per-person fees on issuers of certain health insurance policies and plan sponsors of certain self-insured health plans that provide accident or health coverage.

Confusion About COBRA

After proposed regulations were issued earlier in 2012, there was confusion on whether the fees applied to federal COBRA coverage and similar continuation coverage under other federal and state laws. In the final regulations, the IRS clarified that the PCORI fees apply to COBRA and other continuation coverage provided under insurance policies and self-insured health plans are subject to the fees.

As a result of this clarification, insurers and plan sponsors must count COBRA qualified beneficiaries and individuals receiving similar continuation of coverage when determining the average number of lives covered by a policy or plan, as explained below. This will increase the amount of the PCORI fees that insurers and plan sponsors must pay.

Overview of PCORI Fees

- The fees apply to policy or plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. Thus, insurers and plan sponsors must pay the fee for seven years.
- The PCORI fees will be due by July 31 of the calendar year following the last day of the policy or plan year. Accordingly, for policy or plan years ending between Oct. 1, 2012, and Dec. 31, 2012, the first PCORI fee is due on July 31, 2013.
- The PCORI fee is equal to $1 multiplied by the average number of lives covered by the policy or plan for the first policy or plan year and $2 multiplied by the average number of lives covered by the policy or plan for the second policy or plan year.
- The fee amount will be increased after the second year, but the increased amount has not yet been determined.

Employers Need to Coordinate Data

In many cases, employers may not, on their own, be aware of the number of covered qualified beneficiaries without input from a COBRA third-party administrator. Therefore, employers should review their administrative systems to make sure they coordinate the data for covered life counts at the right time among all their service providers.

How the PCORI Fees Are Determined

The final PCORI fee regulations establish a variety of methods by which health insurers and group health plan sponsors may determine the average number of lives covered by the policy or plan for the relevant year.

Counting Methods for Insurance Policies

Insurers may choose from four different methods to determine the average number of lives covered:

- **Actual count method:**Calculate the sum of lives covered for each day of the policy year and then divide that sum by the number of days in the year.
- **Snapshot method:** Calculate the sum of the lives covered on a date during the first, second or third month of each quarter of the policy year (or an equal number of additional dates in each quarter). Then divide that number by the number of days on which a count was made.
- **Member months method:** Determine the average number of lives covered based on the "member months" reported on the National Association of Insurance Commissioners Supplemental Health Care Exhibit (Exhibit) divided by 12.
- **State form method:** An insurer that is not required to file the exhibit may use data in any equivalent form filed with the applicable state, if that state form reports covered lives in the way as member months are reported on the exhibit.

Counting Methods for Self-insured Plans

Plan sponsors may choose from three different methods to determine the average number of lives covered by the plans:

- **Actual count method:** Calculate the sum of the lives covered for each day in the plan year and then divide that sum by the number of days in the year.

- **Snapshot method:** Calculate the sum of the lives covered on a date during the first, second or third month of each quarter of the plan year (or an equal number of additional dates in each quarter) and then divide that number by the number of days on which a count was made.
- **Form 5500 method:** Determine the average number of covered lives for a plan year based on the number of participants reported on Form 5500 for that plan year.

Fees for the Transitional Reinsurance Program

The reform law established a Transitional Reinsurance Program to help states help stabilize premiums for coverage in the individual market from 2014 through 2016.

Also in December 2012, the U.S. Department of Health and Human Services issued proposed regulations (77 Fed. Reg. 73118) that:

- provide a methodology for calculating the specified dollar amount of the fee, which HHS estimates to be $63 per covered life for 2014;
- establish how health insurers and self-funded plan sponsors may determine the average number of covered lives, which will form the basis for the annual fee amount;
- require insurers and TPAs to submit enrollment information by Nov. 15, 2014, and that they will be notified within a month of the fees due, which they then must pay within 30 days; and
- clarify that self-insured group health plans are liable for the fees, but recognize that TPAs may pay the fees on their behalf in many instances.

Overview of the Transitional Reinsurance Program

- It is anticipated that under health reform, unhealthy individuals who previously did not have health coverage will purchase individual policies through health insurance exchanges. Covering these individuals likely will be very expensive, and the Transitional Reinsurance Program will limit insurance companies' costs for the first three years that coverage is provided.
- The program will be funded by fees paid by health insurers and self-insured group health plans.
- Similar to the PCORI fees, the program fees will be determined by multiplying a specified dollar amount by the number of lives covered by the insurance policy or group health plan.

The Importance of the Counting Method

The counting methods to be used by insurers and self-insured group health plan sponsors generally follow the PCORI fee counting methods. However, some adjustments allow for the timing differences in the fees (the PCORI fees are paid on a policy/plan year basis, while the Transitional Reinsurance Program fees are paid on a calendar year basis).

How the Counting Method Affects COBRA

The proposed rules do not explicitly state that individuals receiving COBRA and similar continuation coverage must be counted when determining the number of covered lives. However, the counting methods are essentially the same as for the PCORI fees, which do count individuals receiving COBRA and similar continuation coverage. Therefore, it is expected that such individuals covered under policies and plans subject to the program fee will be included in calculating that fee amount.

As with the PCORI fees, this will result in higher fees for health insurers and self-insured plan sponsors. This further points to the importance of reviewing administrative systems to ensure that data on covered lives are properly coordinated.

Form W-2 Reporting

In early 2012, we provided a detailed summary of the IRS guidance on reporting the cost of group health coverage on employees' Form W-2s. Employers must report the cost of 2012 coverage on W-2s they issue in January 2013. Due to the imminence of this requirement, here's a reminder about two rules that most affect COBRA coverage:

1. One rule applies to employees who terminate employment in the middle of a calendar year and receive group health coverage from the employer after their termination (such as, for example, COBRA coverage). For these individuals, an employer can choose whether to include the months of COBRA or other post-termination coverage in the aggregate cost reported on the Form W-2s. Note that the employer must follow the same method for all employees who are in this situation for a calendar year.
2. The other rule is a confirmation that the reporting requirement does not expand the individuals to whom an employer must provide a Form W-2.

Example. A retiree or other former employee receiving no compensation from the employer (and thus not required to receive a Form W-2) does not have to receive a Form W-2 just because he or she gets health coverage from his or her former employer.

Consequently, the cost of COBRA coverage extending beyond the year of an employee's termination is not reported on Form W-2, unless the former employee is receiving severance or other cash payments from the former employer that otherwise requires the employer to provide the former employee with a Form W-2 for that year.

Exceptions Apply

Remember that not all group health plans subject to COBRA are subject to the reporting requirement. Specifically, dental and vision group health plans and health reimbursement arrangements are subject to COBRA. However, the reporting requirement does not apply to HRA coverage at all, and only applies to dental and vision coverage if that coverage is not "HIPAA-excepted." Many dental and vision plans are HIPAA-excepted and thus will not be subject to the requirement.

Conversely, health flexible spending arrangements are subject to COBRA and are subject to the reporting requirement, but only if the amount available under the health FSA for the year exceeds the employee's salary reduction election for the year. For example, if the only contributions to a health care FSA are employee pre-tax contributions, then the requirement does not apply.

Moving Forward

The broad, sweeping reform law will significantly change health care in our country over the next decade. Very few, if any, facets of health care will be left untouched. As demonstrate by the PCORI and reinsurance program fees and the Form W-2 reporting requirement, COBRA coverage also has not escaped the law's reach.

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