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IRS Releases Final Regulations on Comparative Effectiveness Research Fee to Fund PCORI; Guidance on Transitional Reinsurance Fee

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On December 5, 2012, the Internal Revenue Service ("IRS") released final regulations regarding the payment of fees by insurers and plan sponsors of group health plans to fund the Patient-Centered Outcomes Research Institute (the "Institute" or "PCORI"). The Institute was established by the Patient Protection and Affordable Care Act ("ACA") 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. In order to fund the Institute, ACA imposes annual per-participant fees on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans, as further described in our client alert on the proposed regulations. The final regulations generally adopt the provisions of the proposed regulations with some changes, as discussed below.

In addition, the Department of Health and Human Services ("HHS") recently released proposed rules that provide guidance on several programs, including the Transitional Reinsurance Program, which becomes effective in 2014. While a fulsome discussion of the Transitional Reinsurance Program is beyond the scope of this alert, there is one item of particular interest to plan sponsors of self-insured group health plans. HHS estimates that the fee under the Transitional Reinsurance Program for 2014 will be $5.25 per member per month, which is $63 annually for each participant (i.e., $63 annually for each covered employee, spouse and dependent). HHS will require contributing entities (generally insurers and third party administrators) to submit enrollment information by November 15, 2014, and will notify them within a month of any contributions due, which must be paid within 30 days of such notification.

Effective Date

The final regulations maintain the rules in the proposed regulations that the fees generally apply to policy and plan years ending on or after October 1, 2012 and before October 1, 2019. For calendar year plans, the final regulations and the requirement to pay fees begins with the 2012 plan year. The final regulations retain the proposed rule that all plan sponsors and issuers report and pay the PCORI fee no later than July 31 of the calendar year following the last day of the policy or plan year. Based on this rule, the first PCORI fees will be due on July 31, 2013 for plan or policy years that end on or after October 1, 2012. The final regulations maintain the rules in the proposed regulations providing transitional relief to plan sponsors and issuers for purposes of counting lives during the 2012 year.

Final Regulations

The following items were changed, modified or clarified by the final regulations:

Plans or Policies Subject to the Fees. In response to a number of comments regarding what policies or plans constitute either a "specified health insurance policy" or an "applicable self-insured health plan" subject to the fees, the final regulations:

1. Provide that the definition of a "specified health insurance policy" does not include any insurance policy than provides for an employee assistance, disease management or wellness program if the program does not provide significant medical benefits. The purpose of this change was to incorporate the same exception that applied for these types of programs offered on a self-insured basis to those that are required by state law to be insured arrangements.
2. Clarify that continuation coverage offered under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar federal or state laws must be taken into account for purposes of the fees, unless this coverage is otherwise excluded.

Calculating the Fees. The final regulations include a number of modifications or clarifications to the rules regarding what individuals must be counted in the case of multiple arrangements. The final regulations:

1. Permit an applicable self-insured health plan that provides accident/health coverage through fully-insured options and self-insured options to disregard the individuals covered solely under the fully-insured options for purposes of the fees. Of course, the disregarded individuals would still be counted by the issuer in

determining fees due for the applicable insurance policy.

2. Clarify that, although individuals covered by a health reimbursement arrangement (HRA) and another self-insured plans maintained by the same employer with the same plan year do not need to be counted twice for purposes of the fees, plan sponsors may not treat an HRA and a fully-insured plan as a single plan or arrangement for purpose of the fees.
3. Include examples of how the fees apply to HRAs and health flexible spending acccounts ("FSAs"), including when these arrangements are offered in connection with coverage under a separate self-insured or fully-insured plan.

Non-US Residents. Under the proposed regulations, the term "specified health insurance policy" does not include any group policy issued to an employer if the group policy was designed and issued specifically to cover employees working and residing in the United States. The final regulations extend this exception to self-insured group plans that cover employees working and residing outside the United States.

Counting Participants. Under the proposed regulations, issuers and plan sponsors were permitted to use a number of alternative methods for counting the average number of individuals (or "lives") in the year for purposes of calculating the applicable fee. One of these methods, the "snapshot method" requires issuers or plan sponsors to calculate the sum of lives covered on one date in each quarter of the year (or an equal number of dates in each quarter) and then divide that number by the number of days on which a count was made. In response to comments, the final regulations require an issuer or plan sponsor that uses the snapshot method to use dates in the second, third and fourth quarters that are within three days of the date in that quarter that correspond to the date used for the first quarter. The final regulations also specify that all dates used must fall within the same policy or plan year.

Plan Sponsor Expense. Consistent with the statutory provisions, the preamble to the final regulations emphasizes that the fees for individuals covered by an applicable self-insured health plan must be paid by the plan sponsor. The preamble also refers to the Department of Labor position that, except in limited situations, the fees may not be paid from assets of the plan (i.e., they are not a plan expense).

Please contact your Proskauer lawyer or any member of our Health Care Reform Task Force should you have questions regarding the above.

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