BlueCross BlueShield of Wyoming
An independent licensee of the Blue Cross and Blue Shield Association

Patient Centered Outcomes Research Trust Fund Fee Self Funded Groups Notice of Proposed Rulemaking

The IRS issued its notice of proposed rulemaking on April 12, 2012 regarding the Patient Centered Outcomes Research Institute fee. This fee is levied as a part of the Patient Protection and Affordable Care Act to fund comparative effectiveness research that will evaluate and compare health outcomes and the clinical effectiveness, risks and benefits of two or more medical treatments and/or services. This fee is a per member per year (pmpy) fee and is applicable to self insured plans.

The reporting and payment of the fee is the responsibility of the plan sponsor. The guidance allows for specific methods in which to count members, which are discussed later in this bulletin. Blue Cross Blue Shield of Wyoming may issue further bulletins on this topic as additional guidance becomes available. A summary of the current provisions follows:

Applicable Dollar Amount (26 C.F.R. §46.4376-1 (c)(vii))

- Plan years ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is $1.
- Plan years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2.
- Any plan year ending in any fiscal year beginning on or after October 1, 2014, the applicable dollar amount is equal to the sum of –
    - The applicable dollar amount for plan years ending in the previous fiscal year; plus
    - The amount equal to the product of –
        - The applicable dollar amount for plan years ending in the previous fiscal year; and
        - The percentage 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.

Applicable Self-Insured Health Plan (26 C.F.R. § 46.4376-1(b)(1))

- Generally, an applicable self-insured health plan subject to the fee is a plan that is established or maintained by a plan sponsor for the benefit of employees, former employees, members, former members, or other eligible individuals to provide health coverage, any portion of which is provided other than through an insurance policy, and that meets certain other conditions
    - Retiree-only plans are subject to the fee.

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- Exemptions from the fee:
    - Excepted benefits. *See 26 U.S.C. §9832(c) for the definition of excepted benefits.*
    - An employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.

Calculating the Number of Covered Lives

The proposed rule gives three methods of calculating the number of covered lives, with some variations on those methods (26 C.F.R. § 46.4376-1(c)(2)(iii)-(v)):

- Actual count method: Calculate the sum of the lives covered for each day of the plan year and divide that sum by the number of days in the plan year.
- Snapshot methods: Add the totals of lives covered on one date in each quarter, or an equal number of dates for each quarter, and divide the total by the number of dates on which a count was made.
    - Snapshot count method: The number of lives covered on a date may be determined as equal to the sum of the actual number of lives covered on these dates.
    - Snapshot factor method: The number of lives covered on a date may be determined as equal to the sum of (1) the number of participants with self-only coverage on that date, plus (2) the product of the number of participants with coverage other than self-only coverage on the date multiplied by a dependent factor of 2.35.
- Form 5500 methods: Based on a formula that includes the number of participants actually reported on the Form 5500 for the applicable self-insured health plan for the plan year.
    - Plan providing only self-only coverage: Treat the average number of covered lives under the plan for a plan year as the sum of the total participants at the beginning and the end of the plan year, in each case as reported on the Form 5500, divided by two.
    - Plan providing other than self-only coverage: Form 5500 does not identify whether the coverage is self-only or family (or some other non-self-only coverage). Therefore, the number of participants reported on the Form 5500 generally is converted to covered lives by multiplying the number of participants on each date by a factor of 2.0. A plan sponsor may simply add the number of participants reported for the beginning of the plan year to the number reported for the end of the plan year to determine the average number of covered lives for the plan year.

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These methods must be used in certain ways:

- Consistency: A plan sponsor must apply a single method in determining the average number of lives covered under the plan for the entire plan year.

- Changes in method: However, a plan sponsor is not required to use the same method from one plan year to the next.

- The guidance does not indicate a preference among methods.

A transition rule is also used for plan and policy years that end on or after October 1, 2012, but began before May 12, 2012: a plan sponsor may determine the average number of lives covered under the plan for the plan year using any reasonable method.

- Treatment of tax-favored arrangements:

    - Archer MSAs and health savings accounts are not insurance or self-insured plans, so they are not subject to the fee. *See* Rule Preamble, footnote 2.

    - Health reimbursement arrangements: HRAs integrated into a group health plan providing major medical coverage established by the same plan sponsor are not subject to a separate fee. However, the preamble states that an insurer that issues a health insurance policy paid for through the HRA also has to pay a fee.

    - Health FSAs: A health FSA that that covers excepted benefits under 26 U.S.C. §9832(c) is excluded from the definition of an "applicable self-insured health plan" and is not subject to the fee. However, a health FSA that does not fit within this exception is subject to the fee.

    - Assume one covered life per employee: Health FSAs and HRAs subject to the fee may assume one covered life per employee.

Tax Return Filing; Collection and Enforcement

Plan sponsors of self-insured plans must report and pay the fee only once a year on Form 720. The form must be filed by July 31, beginning in 2013, of the calendar year immediately following the last day of the plan year. Thus, for example, a return that reports liability for the fee for the year ending on December 31, 2012, must be filed by July 31, 2013. As another example, a return that reports liability for the fee imposed for the plan year ending on

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January 31, 2013, must be filed by July 31, 2014. The preamble to the rule states that Form 720 may be filed electronically. (26.C.F.R. §§ 40.6011(a)-1(c), 40.6071(a)-1(c))

The preamble to the rule further states that the collection and enforcement procedures applicable to other taxes generally apply to the fee.

Reliance on the Proposed Rule

The preamble to the proposed rule states that insurers and plan sponsors may rely on the proposed rule for guidance pending the issuance of final regulations, which will be effective as of the date the proposed rule is published in the *Federal Register.*

The preamble also says that if future guidance is more restrictive than the guidance in the proposed regulations, the future guidance will be applied without retroactive effect.