GROOM LAW GROUP CHARTERED

BENEFITS BRIEF

June 28, 2011 www.groom.com

Authors: Ada Esedebe, Christine L. Keller and Brigen L. Winters

If you have questions, please contact your regular Groom attorney or any of the Health and Wefare attorneys listed below:

Jon W. Breyfogle
jbreyfogle@groom.com
(202) 861-6641

Elizabeth T. Dold
edold@groom.com
(202) 861-5406

Thomas F. Fitzgerald
tfitzgerald@groom.com
(202) 861-6617

Anubhav Gogna
agogna@groom.com
(202) 861-2602

Cheryl Risley Hughes
chughes@groom.com
(202) 861-0167

Christine L. Keller
ckeller@groom.com
(202) 861-9371

Tamara S. Killion
tkillion@groom.com
(202) 861-6328

Mark C. Nielsen
mnielsen@groom.com
(202) 861-5429

William F. Sweetnam, Jr.
bsweetnam@groom.com
(202) 861-5427

Christy A. Tinnes
ctinnes@groom.com
(202) 861-6603

Brigen L. Winters
bwinters@groom.com
(202) 861-6618

IRS Releases Notice 2011-35 and Requests Comments on Health Coverage Fee to Fund Patient-Centered Outcomes Research Institute

On June 9, 2011, the Internal Revenue Service ("IRS") released Notice 2011-35 ("Notice") requesting comments on the implementation of a fee that is payable each year from 2012 through 2018 (for calendar year plans) by issuers of health insurance policies and plan sponsors of self-insured health plans to fund the Patient-Centered Outcomes Research Institute. The fee (which some have referred to as the "comparative effectiveness fee") is established as a federal tax under the Internal Revenue Code and was a surprise to many when enacted by section 6301 of the Patient Protection and Affordable Care Act ("PPACA") (adding sections 9511, 4375, 4376, and 4377 to the Internal Revenue Code ("Code")). This Notice is the first information that the IRS has provided regarding the fee, and provides some insight regarding the effective date, possible mechanics of calculating and paying the fee, and possible safe harbors and other exceptions that the IRS may ultimately adopt. The Notice states that the IRS will be issuing proposed regulations setting forth rules in published guidance regarding the fee, and that the IRS will consider comments received in response to this Notice in drafting those proposed regulations. Comments are due by September 6, 2011.

Below, we provide key information about the fee and the comments that the IRS has requested.

Background

The Patient-Centered Outcomes Research Institute ("Institute") was established by PPACA through an amendment to Title XI of the Social Security Act to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions. The Institute is tasked with conducting research to evaluate and compare the clinical effectiveness, risks and benefits of medical treatments, services, procedures, drugs or other items or strategies that treat, manage, diagnose or prevent illness or injury. The Institute is funded by the Patient-Centered Outcomes Research Trust Fund ("Trust Fund") (new Code § 9511). The Trust Fund, in turn, will be funded in part by annual fees payable by issuers of health insurance policies (new Code § 4375) and sponsors of self-insured health plans (new Code § 4376). These fees will be imposed on "specified health insurance policies" and "applicable self-insured health plans," respectively.

GROOM LAW GROUP CHARTERED

Amount of Fee and Effective Date

The applicable fee is imposed on each specified health insurance policy or applicable self-insured health plan for each policy or plan year ending after September 30, 2012, but not policy or plan years ending after September 30, 2019. For calendar year policies and plans, this means that the fee will apply for policy or plan years 2012 through 2018.

For the first assessment year (policy and plan years ending after September 30, 2012 and before October 1, 2013), the fee is one dollar multiplied by the average number of covered lives (i.e., employee plus spouse and dependents). For the second assessment year (policy and plan years ending after September 30, 2013 and before October 1, 2014), the fee increases to two dollars multiplied by the average number of covered lives. Starting in the third assessment year (i.e., the first policy or plan year ending after September 30, 2014) and continuing until the fee expires, the fee is indexed according to the increase in per capita national health expenditures as determined by the Department of Health and Human Services. This fee must be paid by the issuer of the policy or the sponsor of the self-funded health plan.

Specified Health Insurance Policies

Code § 4375 and the Notice broadly define "specified health insurance policy" as any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States. The term also includes an arrangement under which fixed payments or premiums are received as consideration for a person's agreement to provide or arrange for the provision of accident or health coverage to U.S. residents, regardless of how such coverage is provided or arranged to be provided. (The Notice does not explain the types of arrangements that this language may cover.) The term does not, however, include any insurance if substantially all of its coverage is for excepted benefits as described in Code § 9832(c) (e.g., stand-alone dental and vision, specified disease or illness, hospital indemnity, accident, long-term care coverage, or health flexible spending arrangements that meet certain requirements). The issuer of the specified health insurance policy is required to pay the fee. For this purpose, the issuer is either the insurance company that issues the policy, or the person that receives fixed payments or premiums as consideration for providing or arranging for the provision of accident or health coverage.

Applicable Self-Insured Health Plan

Code § 4376 and the Notice broadly define "applicable self-insured health plan" as any plan for providing accident or health coverage (not including excepted benefits as described in Code § 9832(c)) if any portion of the coverage is provided other than through an insurance policy. The plan must also be established or maintained by (1) one or more employers for the benefit of their employees or former employees, (2) by one or more employee organizations for the benefit of their members or former members, (3) jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees, (4) by a voluntary employees' beneficiary association, (5) by any organization as described in Code § 501(c)(6), or (6) in the case of a plan not previously described, by a multiple employer welfare arrangement, a rural electric cooperative, or a rural telephone cooperative association. The "plan sponsor" of the applicable self-insured health plan is required to pay the fee. For this purpose, plan sponsor is defined as the employer (for a single employer plan), the employee organization (for a plan established or maintained by an employee organization), or the association, committee, joint board of trustees, cooperative, or association, as applicable.

Request for Comments on Specified Health Insurance Policies and Applicable Self-Insured Health Plans

The IRS and Treasury anticipate proposing regulations on the fees imposed on specified health insurance policies and applicable self-insured health plans. To inform the development of the proposed regulations, the Notice requests comments on the following topics:

- **Average Number of Lives under a Specified Health Insurance Policy:** The Notice describes a current reporting obligation of issuers -- the Supplemental Health Care Exhibit developed by the National Assocation of Insurance Commissioners ("Exhibit") -- and suggests that the IRS may develop a safe harbor under which the IRS will not challenge an issuer's calculation of the fee based on the number of lives reported in the Exhibit. The Notice requests comments on this possible safe harbor (including circumstances in which the Exhibit may not serve as a reliable basis for calculating the fee) as well as other reasonable methods that insurers may use to determine the average number of lives covered under the policy. The Notice cautions that any alternative to the safe harbor may require an issuer to account for any differences between the numbers computed under the alternative method and the data reported on the Exhibit.

- **Average Number of Lives under a Self-Insured Health Plan:** The Notice requests comments on reasonable methods to determine the average number of lives covered under an applicable self-insured plan. In addition, the Notice requests comments on whether future guidance should include a safe harbor that would allow self-insured health plans to compute the average number of lives covered based on a formula to account for the number of dependents instead of requiring that the actual dependents covered under the plan be counted.

- **Exclusion of Certain FSAs:** The Notice describes the circumstances under which a health Flexible Spending Arrangement ("FSA") is considered an excepted benefit under Code § 9832(c) (i.e., where other group health plan coverage that is not limited to excepted benefits is made available to participants, and where the maximum benefit payable to any eligible participant cannot exceed two times the participant's salary reduction election (or, if greater, $500 plus the amount of the salary reduction election)). With respect to health FSAs that do not satisfy these requirements, the Notice invites comments on whether additional exceptions should be created.

- **Possible Exclusion for Certain HRAs:** The Notice suggests that the IRS may be willing to create exceptions for certain types of Health Reimbursement Arrangements ("HRAs"), and requests comments on the types of HRAs that should be excluded. Factors the IRS may consider in determining whether to create HRA exceptions are whether there is a limitation on annual contributions and whether other employer-sponsored health coverage is available.

- **Administration of Fees:** The Notice requests comments concerning whether each issuer and plan sponsor should be required to report and pay fees annually as opposed to quarterly, and whether reporting and payment should occur on the same calendar date regardless of the policy year or plan year of any individual issuer or plan sponsor.

- **Transition Rules:** The Notice requests comments regarding whether transition rules may be needed for the first policy or plan year in which the fee is effective, including whether information needed to determine the average number of lives covered would be unavailable for the first year for which the fee is in effect.

- **Definitions:** The Notice requests comments concerning the need for definitions of "policy year" or "plan year" for purposes of the fee.

- **Guidance Regarding U.S. Residency/Expatriates:** The Notice requests comments on whether there are circumstances under which the insurer or plan sponsor may not know whether a covered individual resides in the United States for purposes of determining whether the fee applies and, if so, how those circumstances should be addressed. The Notice also requests comments on whether guidance is needed on the application of the fee to plans covering expatriates.

- **Single Employer:** The Notice requests comments on whether future guidance should permit all employers that are treated as a single employer under Code § 414 to be treated as a single employer for purposes of the fee on self-inusured health plans.

- **Third-Party Administrators:** With respect to the fee on self-insured health plans, the Notice requests comments concerning whether a third-party administrator may act on behalf of the plan sponsor in complying with fee requirements.

Conclusion

The Notice makes clear that the IRS is aware that these new fee requirements will impose not only a financial burden on issuers and plan sponsors, but administrative burdens as well. However, it appears that the IRS is receptive to reducing administrative burdens where possible, and allowing issuers and plan sponsors to use existing data and safe harbors to determine the average number of covered lives. It also appears that the IRS may be open to creating exceptions for certain types of arrangements such as health FSAs and HRAs. Commentators should therefore consider advocating for exceptions and providing specific comments that the IRS can use to develop rules that will lessen the administrative burden of calculating and paying this fee.