Comparative Advantages?

The comparative effectiveness fee

What is the amount of the PPACA health coverage fee to fund comparative effectiveness research, and for what years does it apply?

PPACA section 6301 amended Title XI of the Social Security Act to establish the Patient Centered Outcomes Research Institute (Institute), which is generally tasked with conducting research to evaluate and compare the clinical effectiveness, risks, and benefits of various medical treatments, services, procedures, drugs, and other strategies that treat, manage, diagnose, or prevent illness or injury. PPACA also amended the Internal Revenue Code (Code) to create the Patient-Centered Outcomes Research Trust Fund (Trust Fund) (new Code § 9511) to fund the Institute and new annual fees payable by health insurers and sponsors of self-insured health plans to help fund the Trust Fund (new Code §§ 4375-4377). These fees are effective for policy or plan years ending after September 30, 2012, and generally apply for each policy or plan year from 2012 through 2018 (for calendar-year plans).

On June 9, 2011, the IRS released Notice 2011-35 (the Notice), which requests comments on the implementation of the fee. The Notice provides some insight regarding the fee's amount and effective date, possible mechanics of calculating and paying the fee, and possible safe harbors that the IRS ultimately may adopt in proposed regulations. The Notice states that the IRS will be issuing proposed regulations regarding the fee and will consider comments received by September 6, 2011, in response to the Notice.

For the first year the fee is assessed (i.e., 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 (e.g., employee plus spouse and dependents). For the second assessment year (i.e., 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. In later years, the fee is indexed according to the increase in per capita national health expenditures as determined by the Department of Health and Human Services.

The Notice requests comments regarding "reasonable methods" an insurer may use to determine the average number of lives covered under a policy. It describes a current reporting obligation of insurers—the Supplemental Health Care Exhibit developed by the National Association of Insurance Commissioners

 Illustration by Ellen Weinstein

(Exhibit)—and suggests that the IRS may develop a safe harbor under which the IRS will not challenge an insurer's calculation of the fee based on the number of lives reported in the Exhibit. The Notice requests comments on this possible safe harbor as well as other reasonable methods that insurers may use to determine the average number of lives covered under the policy.

The Notice also requests comments on "reasonable methods" a sponsor of a self-insured plan may use to determine the average number of lives covered under an applicable self-insured plan, and whether guidance should provide a safe harbor that would permit sponsors 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).

In addition, the Notice requests comments regarding whether each insurer and plan sponsor subject to the fee 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 insurer or plan sponsor. It also requests comments regarding the need for definitions of "policy year" or "plan year" for purposes of the fee, and whether transition rules may be needed for the first policy or plan year in which the fee is effective (e.g., to determine the average number of lives covered for such first year).

What types of health insurance policies and self-insured health plans are subject to the PPACA health coverage fee to fund comparative effectiveness research?

The fees payable by health insurers and sponsors of self-funded health plans are to be imposed on "specified health insurance policies" and "applicable self-insured health plans," respectively. 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 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 accounts (FSAs) that meet certain requirements). The issuer of the specified health insurance policy is required to pay the fee.

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 also must be established or maintained (1) by 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.

The Notice describes the circumstances under which an FSA is considered an excepted benefit under Code § 9832(c).

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These Q&As first appeared on www.plansponsor.com in July 2011. As health-care law is evolving rapidly, there may be further developments since the initial publication.

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