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Health Care Reform Fees—Special Rules for HRAs

To cover the cost of some of its reforms, the Affordable Care Act (ACA) imposes a number of fees on health insurance issuers and sponsors of self-insured health plans. These fees include:

- Patient-Centered Outcomes Research Institute fees (PCORI fees); and
- Reinsurance fees.

Both of these fees are calculated based on the average number of covered lives under the plan. For employers that maintain multiple self-insured arrangements, such as a health reimbursement arrangement (HRA) in addition to major medical coverage, this could have resulted in having to pay each fee twice for each covered life, effectively doubling the amount of these fees. To avoid this result, the Internal Revenue Service (IRS) developed special rules for applying PCORI fees and reinsurance fees to HRAs.

PCORI FEES FOR HRAS

The ACA established a private, nonprofit corporation called the Patient-Centered Outcomes Research Institute (Institute) to conduct comparative clinical effectiveness research. The ACA requires health insurance issuers and sponsors of self-insured health plans to pay fees to help finance the Institute's research. These fees are widely known as **PCORI fees**, although they may also be called PCOR fees or comparative effectiveness research (CER) fees.

PCORI fees apply for plan years ending on or after **Oct. 1, 2012,** and before **Oct. 1, 2019**. For calendar year plans, the research fees will be effective for the 2012 through 2018 plan years.

Plan Year	Fee Amount
Plan years ending before Oct. 1, 2013	$1 per covered life
Plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014	$2 per covered life
Plan years ending on or after Oct. 1, 2014	$2 per covered life, as adjusted for increases in the projected per capita amount of National Health Expenditures

On Dec. 5, 2012, the IRS issued final regulations that address how PCORI fees apply to HRAs. Although the IRS did not provide an overall exemption from the research fees for HRAs, they outline two special rules for plan sponsors that provide an HRA.

Under these special rules, if a plan sponsor does not establish or maintain an applicable self-insured health plan other than an HRA, the plan sponsor may treat each participant's HRA as covering a single life. Therefore, the plan sponsor is not required to include as covered lives any spouse, dependent or other beneficiary of the individual participant in the HRA.

In addition, an HRA is *not* subject to a separate research fee if the plan sponsor also maintains another **self-insured plan** providing major medical coverage, as long as the HRA and the plan have the same plan year. This allows the plan sponsor to treat the HRA and the major medical plan as one applicable self-insured health plan for purposes of calculating the research fee. This special rule applies *only if* the HRA and the self-insured plan:

- Are established and maintained the **same plan sponsor**; and
- Have the **same plan year**.

In this case, the plan sponsor will be required to pay the PCORI fee only once with respect to each life covered under the HRA and the other plan, because the same life covered under each arrangement would count as only one covered life under the plan for purposes of calculating the fee.

However, a plan sponsor may not treat an HRA and a **fully-insured group health plan** as a single plan for purposes of calculating the PCORI fee. In this case, the plan sponsor of the HRA and the issuer of the insured plan will *both be subject to the research fees*, even though the HRA and insured group health plan are maintained by the same plan sponsor. This means that there may be two fee payments for the same lives.

REINSURANCE FEES FOR HRAS

The ACA established a risk-spreading program, called the **transitional reinsurance program**, to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014 through 2016) when individuals with higher-cost medical needs gain insurance coverage. The ACA requires health insurance issuers and plan sponsors of self-insured group health plans to pay fees to support the reinsurance program.

On March 23, 2012, the Department of Health and Human Services (HHS) issued a final rule to implement the ACA's standards for reinsurance, risk corridors and risk adjustment programs. On March 1, 2013, HHS released an additional final rule to provide additional guidance on the operation of ACA's risk-spreading programs.

On March 11, 2014, HHS published its 2015 Notice of Benefit and Payment Parameters Final Rule, which includes standards relating to the ACA's risk-spreading programs. The final rule contains the 2015 reinsurance contribution rate, includes an exception for certain self-insured, self-administered plans and implements a two-installment collection schedule for the reinsurance fees.

Amount and Calculation of Fees

The reinsurance program's fees are based on a national contribution rate, which HHS announces annually.

- For 2014, HHS announced a national contribution rate of $5.25 per month ($63 per year).
- For 2015, the annual contribution rate will be $44 per enrollee per year, about $3.67 per month.

HHS plans to establish the uniform reinsurance contribution rate for the 2016 benefit year in the HHS notice of benefit and payment parameters for 2016.

The national contribution rate is calculated by dividing the sum of three statutory components (the reinsurance payment pool, the U.S. Treasury contribution and administrative costs) by the estimated number of enrollees in plans that must make reinsurance contributions.

An issuer's or plan sponsor's reinsurance fee will be calculated by multiplying the number of covered lives (employees and their dependents) during the benefit year for all of the entity's plans and coverage that must pay contributions, by the national contribution rate for the benefit year. Thus, the annual contribution in 2014 for a group health plan with 150 covered lives would be $9,450 per year (150 x $63 = $9,450).

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Collection Schedule

In the 2015 Notice of Benefit and Payment Parameters Final Rule, HHS modified the collection schedule for the reinsurance program so that the fees will be paid in two installments—one at the beginning of the calendar year following the applicable benefit year, and one at the end of that calendar year. According to HHS, this two-installment policy was designed to alleviate the upfront burden of the reinsurance contribution, allowing contributing entities additional time to make the payment.

The reinsurance contribution amounts for reinsurance payments and for administrative expenses will be collected earlier in the calendar year following the applicable benefit year, while the reinsurance contribution amounts for payments to the U.S. Treasury will be collected in the last quarter of the calendar year following the applicable benefit year.

For the 2014 benefit year, of the $63 annual per capita contribution rate, $52.50 will be allocated towards reinsurance payments and administrative expenses, and $10.50 towards payments to the U.S. Treasury. Therefore, if a contributing entity submits its enrollment count to HHS by Nov. 15, 2014:

- A reinsurance contribution payment of $52.50 per covered life will be invoiced in December 2014, and payable in January 2015; and
- Another reinsurance contribution payment of $10.50 per covered life will be invoiced in the fourth quarter of 2015, and payable late in the fourth quarter of 2015.

For the 2015 benefit year, the $44 annual per capita contribution rate will be allocated $33 towards reinsurance payments and administrative expenses, and $11 towards payments to the U.S. Treasury. These amounts will similarly be payable in January 2016 and late in the fourth quarter of 2016, respectively.

Exception for Self-insured, Self-administered Group Health Plans

In the 2015 Notice of Benefit and Payment Parameters Final Rule, HHS modified the definition of "contributing entity" for the 2015 and 2016 benefit years to **exempt certain self-insured, self-administered group health plans** from the reinsurance contribution requirement. For 2015 and 2016, self-insured group health plans that do not use a third party administrator in connection with the core administrative functions of claims processing or adjudication (including the management of appeals) or plan enrollment are not required to pay reinsurance fees.

However, to avoid disruption for plans and issuers, this exception does not apply for the 2014 benefit year. For 2014, a contributing entity means:

- A health insurance issuer; or
- A self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage), **regardless of whether the plan uses a third party administrator**.

Exception for Integrated HRAs

HRAs that are integrated with major medical coverage are excluded from reinsurance fees. This applies regardless of whether the major medical coverage is self-insured or fully-insured. Reinsurance fees are required for the group health plan providing major medical coverage. HHS did not provide guidance on when an HRA is considered integrated with major medical coverage for purposes of the reinsurance fee exception. However, other federal agencies have provided guidance on integrated HRAs.

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Effective for plan years beginning on or after Jan. 1, 2014, an HRA must be integrated with another group health plan to satisfy certain ACA market reforms, such as the annual dollar limit prohibition. Thus, effective for 2014 plan years, stand-alone HRAs (other than retiree-only HRAs and limited-scope dental or vision HRAs) will not be permitted.

On Sept. 13, 2013, the IRS and the Department of Labor (DOL) issued technical guidance on how the ACA's reforms apply to HRAs. This guidance is contained in IRS Notice 2013-54 and DOL Technical Release 2013-03. This guidance provides two integration methods for HRAs. Under both methods, integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor, the same plan document or governing instruments or file a single Form 5500, if applicable.

Method One—Limiting HRA Reimbursements, Minimum Value Not Required

An HRA is integrated with group health coverage if the following conditions are satisfied:

- The employer offers a group health plan (other than the HRA) to employees that does not consist solely of excepted benefits;
- Employees with the HRA are actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage);
- The HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse);
- Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA; and
- The HRA is limited to reimbursement of one or more of the following—copayments, coinsurance, deductibles and premiums under non-HRA group coverage, as well as medical care that does not constitute essential health benefits.

Method Two—Minimum Value Required, No Limit on Reimbursements

Alternatively, an HRA that is not limited with respect to reimbursements as described above is integrated with group health coverage if the following conditions are satisfied:

- The employer offers a group health plan to employees that provides minimum value under the ACA;
- Employees with the HRA are actually enrolled in a group health plan that provides minimum value, regardless of whether the employer sponsors the plan (non-HRA group coverage);
- The HRA is available only to employees who are enrolled in non-HRA minimum value group coverage, regardless of whether the employer sponsors the non-HRA minimum value group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA minimum value group coverage, such as a plan maintained by the employer of the employee's spouse); and
- Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

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EXCEPTED BENEFITS

Coverage that consists solely of "excepted benefits" under HIPAA is not subject to the PCORI or reinsurance fees. This includes, for example, stand-alone dental and vision plans, accident-only coverage, disability income coverage, liability insurance, workers' compensation coverage, credit-only insurance or coverage for on-site medical clinics. Thus, plan sponsors of HRAs will not be required to pay PCORI fees or reinsurance fees if substantially all of the coverage is considered excepted benefits.

FEE COMPARISON CHART

	PCORI FEES	REINSURANCE FEES
Applies To	Health insurance issuers and sponsors of self-insured health plans	Health insurance issuers and sponsors of self-insured group health plans
Effective Date	Plan years ending on or after **Oct. 1, 2012,** and before **Oct. 1, 2019**. For calendar year plans, fees will be effective for the 2012 through 2018 plan years. The first possible payments were due **July 31, 2013**.	Calendar years 2014 through 2016
Amount	Calculated as follows: • **$1 per covered life** for plan years ending before Oct. 1, 2013 • **$2 per covered life** for plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014 • For plan years ending on or after Oct. 1, 2014, the fee amount will grow based on increases in the projected per capita amount of National Health Expenditures	Calculated for each issuer or plan sponsor using the following formula: Average Number of Covered Lives X National Contribution Rate Reinsurance Fee The national contribution rate will be announced by HHS annually. For 2014, the national contribution rate is **$5.25 per month ($63 per year)**. For 2015, the national contribution rate is about $3.67 per month ($44 per year).
Special Rule for HRAs	**If the only applicable self-insured plan offered by the employer is an HRA**: The plan sponsor may treat each participant's HRA as covering a single life (and will not have to count spouses or dependents). **HRA Integrated with Self-insured Plan**: The HRA is *not* subject to a separate research fee, as long as the HRA and the plan: • Are established and maintained by the same plan sponsor; and • Have the same plan year.	**HRAs Integrated with Major Medical Coverage**: Excluded from reinsurance fees, regardless of whether the major medical coverage is self-insured or fully-insured.

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	HRA Integrated with Fully-insured Plan: The plan sponsor of the HRA and the issuer of the insured plan will *both* be subject to the research fees, even though the HRA and insured group health plan are maintained by the same plan sponsor.	

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