Comparative Effectiveness Fee and Other Recent Developments/
Guidance for Health Care Reform

This document summarizes recent guidance on the Patient Protection and Affordable Care Act (PPACA or ACA, i.e., federal health care reform) and the potential impact on church health plans. The following PPACA provisions are addressed:

- Comparative effectiveness fees,
- Automatic enrollment,
- Employer mandate,
- Waiting periods for coverage, and
- Supreme Court arguments.

Comparative Effectiveness Fees

On April 17, 2012, the Internal Revenue Service (IRS) issued proposed regulations regarding fees imposed under PPACA on certain health insurers and plan sponsors of self-insured health plans. These fees will finance the Patient-Centered Outcomes Research Institute (PCORI), a private, nonprofit corporation established under the PPACA to fund research on the clinical effectiveness of medical treatments, procedures and certain drugs. PCORI research aims to broaden access to evidence-based medical information for patients, clinicians, payers and others.

For the first plan year ending on or after October 1, 2012 (ending between October 1, 2012 and September 30, 2013, but December 31, 2012 for most calendar-year annual conference plans), insurers and self-funded plan sponsors will contribute $1 multiplied by the average number of covered lives under a policy or plan. For the plan year ending between October 1 and December 31, 2013 (December 31, 2013 for most calendar-year plans), the multiplier increases to $2 per covered life. For plan years ending after October 1, 2013 but before October 1, 2019, this fee may rise with health care inflation.

Comparative effectiveness fees for the first plan year (e.g., the plan year ending December 31, 2012 for most annual conference plans, including HealthFlex) must be paid by July 31, 2013. Comparative effectiveness fees will be paid to the IRS.

Fees for Self-Insured Health Plans

Under Internal Revenue Code (Code) §4376, plan sponsors of “applicable self-insured health plans” are responsible for paying the comparative effectiveness fees. In general, an applicable self-insured health plan is a plan that provides health or accident coverage, any portion of which is provided other than through an insurance policy. This definition includes retiree-only plans.
The proposed regulations do not exclude health reimbursement arrangements (HRAs) and health flexible spending accounts (FSAs). In fact, HRAs and FSAs may be subject to their own comparative effectiveness fees (in addition to fees related to the health plan) under certain circumstances. Please note:

- **Multiple self-insured arrangements** established and maintained by the same plan sponsor and having the same plan year are subject to a single comparative effectiveness fee.
- An HRA that is integrated with a self-insured health plan providing major medical coverage will not incur a separate fee specific to the HRA if the HRA and plan are established or maintained by the same plan sponsor.
- An HRA that is integrated with a fully-insured group health plan (notwithstanding that the HRA and insured plan are maintained by the same plan sponsor) is treated as an applicable self-insured health plan and is subject to the fee for self-insured plans. Additionally, the insurer of the group insurance policy is subject to the fee for health insurers.
- A health care FSA is not an applicable self-insured health plan if it meets the requirements of an excepted benefit under Code §9832(c). Health care FSAs that do not meet the excepted benefit requirements under Code §9832(c) will be subject to the fee for self-insured plans. However, FSAs under this latter circumstance will not be subject to a separate fee specific to the FSA if the plan sponsor has other self-funded health plans.
- Employee assistance programs (EAPs) and wellness programs are not subject to the fee if they do not provide “significant benefits relating to medical care.”

The fees do not apply if substantially all of the coverage is for excepted benefits under Code §9832(c) (for example, certain limited-scope dental and vision benefits).

**Calculating the Average Number of Lives**

Self-insured plan sponsors may use any of the following methods to calculate the average number of lives covered and applicable to the comparative effectiveness fee(s):

- **Actual count method**: Plan sponsor calculates the sum of the lives covered for each day of the plan year and divides the sum by the number of days in the plan year (typically 365).
- **Snapshot method**: Plan sponsor adds the total number of lives covered on one selected date in each quarter of the plan year, or an equal number of dates for each quarter, and divides the total lives by the number of dates on which a count was made.
- **Form 5500 method**: Plan sponsor uses a formula that includes the number of participants actually reported on the Form 5500 for the plan year.

Plan sponsors must use only one method in each year, but are not required to use the same method from year to year. For plan years already in progress, i.e., 2012, a plan sponsor may use any reasonable method to determine the average number of lives. Church plans, such as HealthFlex and other annual conference health plans, do not submit a Form 5500, so that method of counting would not apply.

**Insured Plans**

Under the proposed regulations, a “specified health insurance policy” subject to the comparative effectiveness fee is any accident or health insurance policy issued with respect to individuals living in the United States. This term does not include stop-loss or indemnity reinsurance policies. Health insurers may use any one of four methods, including the snapshot, actual count or Form 5500 methods described above. Insurers must use the same method for all policies reported on a single return. If some benefits under an annual conference plan are fully-insured, (for example, if mental health benefits are carved out and fully-insured or one benefit option under the plan is a fully-insured HMO), this may mean the insurer will pay the fee for covered participants and pass that cost on to the annual conference or other plan sponsor.
Paying the Fees to the IRS
For fully-insured annual conference plans, insurers will file reports and pay the fees for insured policies. However, self-insured plan sponsors must do these tasks themselves and cannot delegate this work to third parties or vendors. Plan sponsors must submit IRS Form 720 to report the fees and make annual payments. Form 720 has yet to be updated to reflect the comparative effectiveness fees.

For HealthFlex plan sponsors, generally HealthFlex will manage the administration of these fees. However, HealthFlex will not handle administration of the fees for HRAs managed through Extend Health—instead; these fees may require independent fee submissions by plan sponsors.

FAQs on Automatic Enrollment, Employer Mandate and Waiting Periods
On February 9, 2012, the DOL issued Technical Release 2012-01; and the IRS and the Department of Health and Human Services (HHS) issued substantially identical versions of this guidance (see IRS Notice 2012-17 and HHS FAQs), providing answers to frequently asked questions from employers, plans and insurers on PPACA provisions governing:

- Automatic Enrollment in health plans under the Fair Labor Standards Act (FLSA);
- Employer shared responsibility, i.e., the Employer Mandate, under Code Section 4980H; and
- The prohibition on Waiting Periods of more than 90 days.

Automatic Enrollment
The PPACA requires employers with at least 200 full-time employees (i.e., “large employers”) to automatically enroll new full-time employees in a health plan and re-enroll those already enrolled in coverage. Automatically enrolled employees will be permitted to opt out of coverage. The original PPACA language was ambiguous about the effective date for Automatic Enrollment, and the DOL indicated in earlier guidance that the effective date would be January 1, 2014.

However, the new FAQs state that the federal government’s guidance on Automatic Enrollment will not be ready to take effect by 2014. Until the DOL issues final regulations under the FLSA, employers are not required to comply with Automatic Enrollment. Large employers in annual conference plans (and other large employer United Methodist plan sponsors) will not have to comply with Automatic Enrollment until 2015 or later.

Waiting Periods
The PPACA prohibits a health plan from imposing a Waiting Period of more than 90 days, effective January 1, 2014. The FAQs indicate that forthcoming regulations will specify that the 90-day rule will apply only to employees who are otherwise eligible for coverage under the employer’s plan design. Nothing in the rule will require an employer to treat any particular employee as eligible for coverage; therefore, an employer may continue to exclude, for example, part-time employees or seasonal employees. The Waiting Period rule merely requires that, with respect to employees whom the employer considers to be in an eligible class, the plan cannot make them wait more than 90 days (after becoming eligible) for their coverage to begin.

Although the 90-day rule does not require coverage of any particular employee, the Automatic Enrollment rule appears to do so for all full-time employees (FTEs) of large employers. The Departments are considering approaches for coordinating the Waiting Period and Automatic Enrollment rules. The Waiting Period rule also coordinates with the Employer Mandate (described below). The FAQs provide that an employer will not be subject to the Employer Mandate, with respect to a new FTE, during the first three months (90 days) of his or her employment; i.e., the employer has a “free pass” for those first three months.

Employer Mandate
Beginning in 2014, the PPACA requires employers with 50 or more full-time equivalent employees to offer health coverage to their FTEs (generally, those averaging at least 30 hours per week). If the coverage does not have a “minimum value,” (meaning it covers at least 60% of health costs) or if the employee-only premium is not considered
“affordable,” (meaning it exceeds 9.5% of the employee’s income), the employer will be subject to a penalty if the affected employee obtains federally-subsidized health coverage in a health insurance exchange (Exchange).

The IRS intends to issue guidance allowing employers to use a “look-back and stability period safe harbor” rule of up to 12 months to determine whether an employee is an FTE for purposes of Code §4980H. Whether a newly hired employee qualifies as an FTE will likely depend on whether:

- At the time of hire the employee is reasonably expected to work an average of 30 or more hours per week annually; and
- The employee’s first three months at work are reasonably viewed as representative of the average hours the employee is expected to work annually.

The Departments have not yet defined precisely how robust the employer-provided coverage must be to satisfy “minimum value.” However, with regard what is “affordable” coverage, earlier guidance suggests that employee-only coverage will be considered “affordable,” for purposes of the Employer Mandate, if the employee is not asked to pay more than 9.5% of his or her salary, based on W-2 (taxable) wages. The FAQs confirm that federal officials intend to retain this safe harbor for employers. There remains no obligation for employers to subsidize dependent coverage.

Some annual conferences may have more trouble satisfying this requirement, particularly those with lower-paid clergy. Moreover, some annual conference may leave cost-sharing determinations (the portion of premium paid by individual clergy) to charge conferences and local churches, which may lead to even less control over this provision.

With respect to determining who is an FTE for Employer Mandate purposes, the IRS has suggested it will allow employers to average an employee’s hours over a look-back period of up to 12 months, to determine if the employee averaged at least 30 hours per week over the period. If the employee’s average work hours fall below 30 hours per week, he or she would not be considered an FTE for Employer Mandate purposes for an ensuing “stability period” that would run at least as long as the look-back period, i.e., up to 12 months.

If a new employee is expected to work at least 30 hours per week annually, and averages at least 30 hours per week during his or her first three months of employment, the employee will be considered an FTE for a stability period of three months after the initial three months of work. Beginning with the fourth month, the employer will be required to offer health coverage to the employee.

The FAQs suggest some flexibility regarding seasonal and part-time employees. If it is not clear how many hours per week an employee is likely to average, the employer may wait until the employee has worked three months. If the employee averages at least 30 hours per week over those three months, and the hours worked are reasonably representative of the hours the employee is expected to average on an annual basis, then the employee is considered an FTE for an ensuing stability period of at least three months. If such an employee does not average at least 30 hours per week over his or her first three months, the employee is considered part-time and the employer has no Employer Mandate obligation to provide health coverage for the employee for those three months or the ensuing three months. If the employee averages 30 hours per week over the first three months but those hours are not representative of the hours the employee is expected to work on an annual basis, then the employer may wait through a second three-month measurement period to determine whether the employee is an FTE.

Though the Employer Mandate is less likely to affect annual conference plan sponsors, some conference offices may have 50 or more full-time equivalent employees, particularly if they are closely affiliated with foundations, camps and other conference agencies.

Supreme Court Arguments

The Supreme Court heard oral arguments about the PPACA March 26–28, 2012. The challenges focus on whether Congress has the power under Article I of the Constitution (the Commerce Clause) to enforce the minimum coverage provision (the “individual mandate”). The Supreme Court also heard arguments about
whether the penalty for lacking minimum coverage is a tax that is covered by the Anti-Injunction Act (AIA). The AIA is a law that prohibits federal courts from hearing cases that seek to stop the federal government from collecting a tax. The Court also heard arguments about whether Congress violated basic principles of federalism when it added new conditions on the PPACA’s expansion of Medicaid. Additionally, the Court heard arguments regarding to what extent (if any) the individual mandate can be severed from the remainder of the PPACA, if the mandate is found unconstitutional. This is an important distinction. If the individual mandate is ruled unconstitutional, severing the individual mandate from the remainder of PPACA would allow implementation of other PPACA provisions, whereas not severing the mandate would in effect overturn the PPACA in its entirety.

The Supreme Court will likely issue an opinion in the case toward the end of its term (late June). The Supreme Court Justices did not appear to be persuaded by arguments that the penalty under the individual mandate is a tax, which suggests that the Court will not feel constrained by the AIA and will decide the merits of the challenge. Several of the Justices appeared from their questions to be quite skeptical of the individual mandate. In prior decisions, the Court has made clear that health insurance is an industry that affects interstate commerce. Therefore, the critical question in this case is whether Congress can require individuals who would choose to self-insure their health risks (i.e., people who choose to stay out of the health insurance market) to purchase health insurance in order to assure that costs are not shifted to those who do carry insurance. A few of the Justices who many consider to be critical “swing votes” appeared to worry that upholding the mandate would remove all limits to the federal government’s Commerce Clause power.

On the question of severability, the Justices appeared to struggle. Some appeared ready to strike the entire PPACA, while others seemed more reluctant to reject the health care reform legislation in its entirety. A few Justices displayed different views of that argument in their own successive questions. The complexity of the severability issue is perhaps giving some of the Justices a bit more pause about striking the mandate. The Court may try to find a middle ground if it strikes the mandate by eliminating a few provisions that are very closely tied to the mandate, including the prohibitions on medical underwriting and pre-existing condition exclusions and the community rating of premiums.

However, any final determination will not be known until the Supreme Court issues its opinion in this case, which is expected in late June. The General Board of Pension and Health Benefits (General Board) will provide an update at that time.

More Information

You can read more about health care reform on the General Board’s health care reform webpage. Please send your questions to healthcarereform@gbophb.org. General information about health care reform is available from the federal government at www.healthcare.gov.

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