SecureOne Benefit Administrators, Inc.

N E W S A L E R T! - REVIEW

January 2013

PPACA NEWS
NEW FEES!!

The Patient Protection and Affordable Care Act (PPACA) will be imposing a new Patient Centered Outcomes Research Institute (PCORI) fee. This fee is for research of clinical effectiveness, risks, and benefits of medical treatments procedures, drugs services. PCORI will distribute funding for the research that will advance the quality and the promotion of evidence based medicine. This information will hopefully assist individuals and their health care providers in making informed decisions about cost effective and quality care.

Insurance carriers and self-funded health care plans are required to assist in the funding. The first year of the fee is $1 per covered life per year. The second year the fee adjusts to $2 per covered life and then after the third year and beyond, it's based upon a index to National Health Expenditures thereafter until it ends in 2019.

WHO PAYS THE FEE?

Insurance carriers for individual or group insurance and self-insured plan sponsors (employers) are responsible for paying the fee. The fee is treated like an excise tax by the IRS. A Federal tax return (Form 720) reporting liability for the fee must be filed by July 31 of the calendar year immediately following the last day of the plan year.

STARTING DATES!!

For policy or plan years ending after September 30, 2012, issuers (Insurance Carriers) and Employers sponsoring certain group health plans (self-funded) must pay a fee of $1 per covered life per year. The fee adjusts to $2 per covered life for policy or plans ending October 1, 2013 through September 30, 2014. For policy or plan years ending after September 30, 2014, the dollar amount in effect for such policies or plan years shall be adjusted by the Secretary of Treasury based on the percentage increase in the projected per capita amount of National Health Expenditures. This will not apply to policy or plan years ending after September 30, 2019.

Exclusions

- Any Stop-Loss or indemnity reinsurance policy.
- Any group plans issued to an employer where the facts and circumstances support that the group policy was designed to cover employees working and residing outside the United States.
- Any prepaid health coverage arrangement, which means an arrangement under which the providers receive fixed payments or premiums as consideration for their agreement to provide health coverage.
- Any insurance policy or plan if substantially all of it's coverage is for "Excepted Benefits". Often Separate policies cover only dental and vision benefits this makes their "Excepted Benefits" under HIPAA. Benefits must meet two requirements for coverage to be "Excepted" if they are not covered by a separate contract.
    A. Employee must make a separate election for the coverages.
    B. Employees must make separate employee contributions for the coverage.
- FSA Plans
- Medicaid & Medicare
- SCHIP
- Federally Recognized Indian Health Services

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PPACA News cont.

Exclusions cont.

- EAP; disease management programs and wellness programs are excluded if they do not provide significant medical care or treatment benefits.
- HRA—Health Reimbursement Arrangement—If the underlying plan is fully insured, the insurance carrier is responsible for the fees. The plan sponsor (employer) is responsible for the self-insured portion of the "HRA". If both the "HRA" and underlying plan are both self-insured, the arrangement can be treated as a single self-insured plan provided they both have the same plan year.

HOW DO YOU CALCULATE THE FEE?

The plan year dates determine the fees!

Policy or plan year ending AFTER September 30, 2012.	$1.00
Between October 1, 2013 and October 1, 2014	$2.00
After October 1, 2014 and before October 1, 2019	$2.00 plus the projected increase to the per capita amount of the National Health Expenditures.

Need to determine the average coverage lives? The Federal Government have given us options to calculate.

A. Insurance Carriers:

1. Actual Count
2. Snap Shot
3. NAIC Member Months
4. State Form Method

The insurance carrier understands the requirements so employers with fully insured plans should not worry!

B. Self Funded

We have three (3) methods:

1. Actual Count—This method requires the plan sponsor (employer) to count the actual number of individuals on each day of the plan year and divide the number by 365 or 366 as applicable.
2. Snapshot—Two method options:
   a. Plan sponsors (employer) can count the actual number of covered individuals on at least one day in each quarter. The covered lives in the snapshot days are then added together and divided by four (4).
   b. Plan sponsors (employer) can count the actual number of employees enrolled for single coverage on one day in each quarter. The plan must add to that day's single count, the number of employees enrolled for non-single coverage, multiply by 2.35. This sum of numbers for each quarter should be divided by four.

PPACA News cont.

Self-Funded Calculation cont.

3. Form 5500 – This method uses the number reported by the plan sponsor (employer) annual form 5500. If a plan offers simple coverage, the plan sponsor can add the participants as of the first day of the plan year to the number of participants on the last day of the plan year. This sum should be divided by two (2) to determine the average covered lives. However, the 5500 form does not distinguish between single and multi-person enrollment categories. If the plan offers family coverage, then the 5500 calculation changes. The plan sponsor will need to add the number of participants at the beginning of the plan year to the number of participants at the end of the plan year. The sum of these two (2) numbers equals the average covered lives for fee purposes. Plan sponsors (employers) must be consistent in the calculation each year until the end.

Special Counting Rules for Multiple Self-Funded Plans

Under the proposed rule, if the plan sponsor of a self-funded plan has more than one self-funded plan (e.g. One for medical and another for pharmacy) it may treat them as a single self-funded plan for purposes of this fee to avoid double counting of the members. This special counting rule only applies to self-funded plans in the proposed rule.

Where Must the Fee Go?

Insurance Carriers and Plan Sponsors (employers) must file a form 720, the quarterly Federal Excise Tax Returns to report and pay the annual fees. Employers not filing a Form 720 today must file it annually to report the fees. Employers need to consult with their tax advisor with questions about filing of the excise tax returns.

The fees are due on the 31st of July of the calendar year following the plan year they are assessed.

SecureOne; keeping our clients informed on the "PPACA" front.

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