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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 the **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.

This ACA Overview summarizes the special rules for applying the PCORI fees and reinsurance fees to HRA coverage.

LINKS AND RESOURCES

- On Dec. 5, 2012, the IRS issued final regulations that address how PCORI fees apply to HRAs.
- On March 23, 2012, HHS issued a final rule implementing the ACA's reinsurance program. On March 1, 2013, HHS released a separate final rule providing additional guidance. On March 11, 2014, HHS published its 2015 Notice of Benefit and Payment Parameters, which made changes to reinsurance fees for 2015.

HIGHLIGHTS

PCORI FEES

- PCORI fees apply to health insurers and self-insured plan sponsors.
- These fees are widely known as PCORI fees, although they may also be called PCOR fees or comparative effectiveness research (CER) fees.
- The fee applies to policy or plan years ending on or after **Oct. 1, 2012, and before Oct. 1, 2019**.

REINSURANCE FEES

- Reinsurance fees generally apply to health insurance issuers and self-insured plan sponsors in 2014–2016.
- These fees are calculated based on a national contribution rate announced by HHS each year.
- For 2016, the annual contribution rate is $27 per enrollee per year, or $2.25 per month.

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PCORI FEES FOR HRAS

The ACA established a private, nonprofit corporation called the Patient-Centered Outcomes Research 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, and before Oct. 1, 2015	$2.08 per covered life
Plan years ending on or after Oct. 1, 2015, and before Oct. 1, 2016	$2.17 per covered life
Plan years ending on or after Oct. 1, 2016, and before Oct. 1, 2017	$2.26 per covered life
Plan years ending on or after Oct. 1, 2017, and before Oct. 1, 2019	Adjusted for increases in the projected per capita amount of National Health Expenditures

In the PCORI fee final regulations, the IRS did not provide an overall exemption for HRAs. However, they outline two special rules for plan sponsors that provide an HRA. Under these special rules:

- First, 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 PCORI 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 PCORI fee. This special rule applies *only if* the HRA and the self-insured plan: (1) are established and maintained the **same plan sponsor**; and (2) 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,

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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 PCORI fees*, even though the HRA and insured group health plan are maintained by the same plan sponsor. Thus, there may be two fee payments for the same lives.

TYPE OF HRA	SPECIAL RULE
Stand-alone HRA	If the plan sponsor has no other applicable self-insured health plans, the sponsor must pay the PCORI fee based on the average number of lives covered by the HRA, counting only one life per participant.
HRA offered with insured coverage	If a plan sponsor has other fully insured coverage, the plan sponsor generally must pay the PCORI fee for the average number of lives covered by the HRA—counting only one life per participant—in addition to the PCORI fees that will be paid for the insured plan by the insurer. However, the plan sponsor may disregard the lives covered solely under the fully insured option when counting the number of lives for HRA purposes.
HRA offered with self-insured coverage	If the same plan sponsor has another applicable self-insured health plan with the same plan year, then each person covered by both plans is only counted once. The individuals covered by both plans are counted using the counting method for the other plan (so the one life per participant rule does not apply to them). If the HRA covers anyone who is not also covered under the other plan, the sponsor must pay the fee for those individuals, using the one life per participant rule.

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.

Amount and Calculation of Fees

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

- For 2014, the annual contribution rate was **$63 per enrollee** per year, or $5.25 per month.
- For 2015, the annual contribution rate was **$44 per enrollee** per year, about $3.67 per month.
- For 2016, the annual contribution rate was **$27 per enrollee** per year, or $2.25 per month.

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An issuer's or plan sponsor's reinsurance fee is 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.

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.

- The reinsurance contribution amounts for reinsurance payments and administrative expenses are collected earlier in the calendar year following the applicable benefit year.
- The reinsurance contribution amounts for payments to the Treasury are collected in the last quarter of the calendar year following the applicable benefit year.

For the 2016 benefit year, the $27 annual per capita contribution rate is allocated $21.60 towards reinsurance payments and administrative expenses, and $5.40 towards payments to the Treasury. These amounts are payable in January 2017 and late in the fourth quarter of 2017, respectively.

The following tables outline key deadlines for the 2016 benefit year:

TO MAKE A TWO-PART CONTRIBUTION (FIRST AND SECOND COLLECTION):		
Date	**Activity**	**Contribution Amount**
No later than Nov. 15, 2016	Submit the contribution form and **schedule payment** of the first collection, then duplicate the form ***and*** **schedule payment** of the second collection	
No later than Jan. 17, 2017	Remit first contribution amount	$21.60 per covered life
No later than Nov. 15, 2017	Remit second contribution amount	$5.40 per covered life
	Total:	**$27.00 per covered life**

TO MAKE A FULL CONTRIBUTION IN ONE PAYMENT (COMBINED COLLECTION):		
Date	**Activity**	**Contribution Amount**
No later than Nov. 15, 2016	Submit the contribution form and **schedule payment**	
No later than Jan. 17, 2017	Pay full contribution amount	$27 per covered life
	Total:	**$27.00 per covered life**

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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.

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) generally are not permitted.

On Sept. 13, 2013, the IRS and the DOL issued technical guidance in IRS Notice 2013-54 and DOL Technical Release 2013-03 on how the ACA's reforms apply to HRAs. 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 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.

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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 (MV);
- Employees with the HRA are actually enrolled in a group health plan that provides MV, 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 MV group coverage, regardless of whether the employer sponsors the non-HRA MV 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 MV 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.

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.

Please see the following page for a fee comparison chart.

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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 • **$2.08 per covered life** for plan years ending on or after Oct. 1, 2014, and before Oct. 1, 2015 • **$2.17 per covered life** for plan years ending on or after Oct. 1, 2015, and before Oct. 1, 2016 • **$2.26 per covered life** for plan years ending on or after Oct. 1, 2016, and before Oct. 1, 2017 • For plan years ending on or after Oct. 1, 2017, 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** HHS announces the national contribution rate annually. For 2014, the national contribution rate was $5.25 per month ($63 per year). For 2015, the national contribution rate was about $3.67 per month ($44 per year). For 2016, the annual contribution rate was about $3.67 per month ($44 per enrollee 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. **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.	**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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