# Health Reform:

## New Research Fee Required for Group Health Plans

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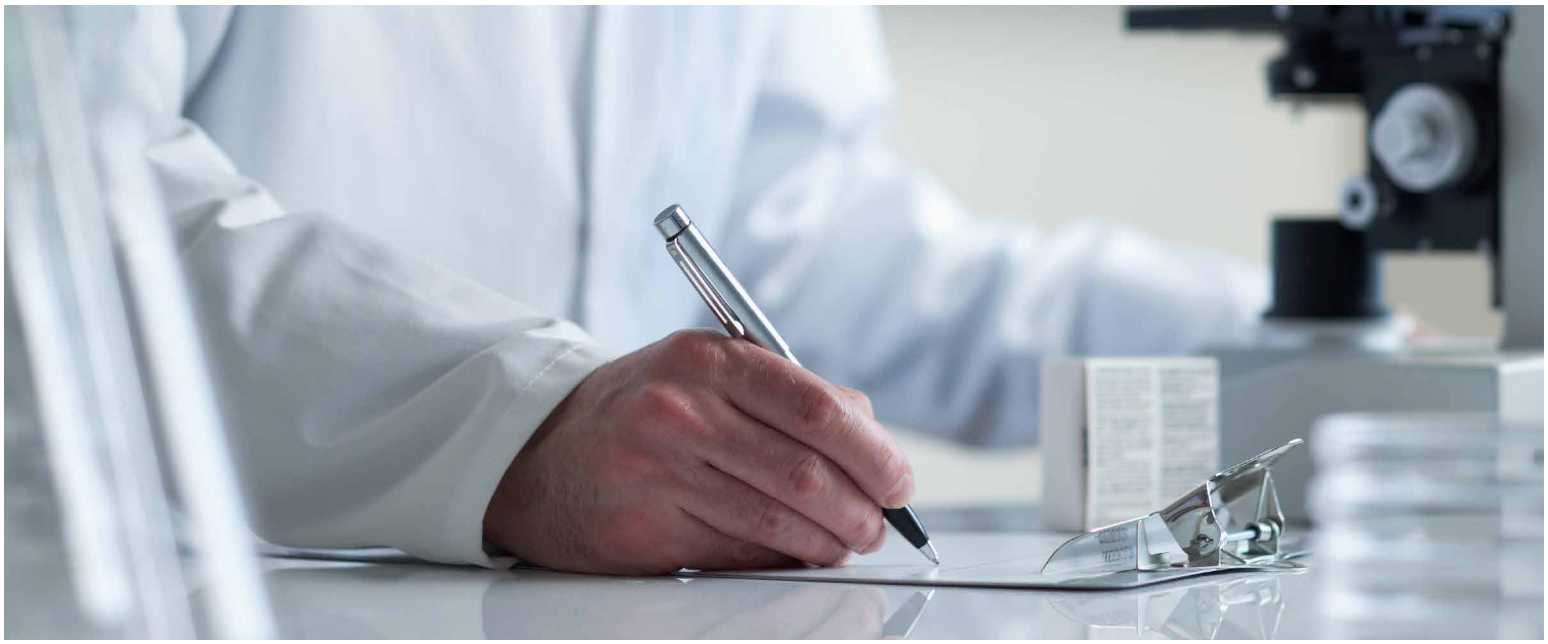

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The Affordable Care Act created a new fee on health plans to fund a new nonprofit corporation. The Patient-Centered Outcomes Research Institute was established to fund research of the clinical effectiveness of medical treatments, procedures and drugs. To fund this Institute, the ACA imposes a fee on both insured and self-insured health plans for the seven-year period from 2012 through 2019. Highlights from the IRS' proposed regulations providing rules on this new fee can be found below. Although the proposed regulations address similar requirements for both insurers and employer-sponsored plans, this article focuses mainly on the requirements for employer-sponsored self-insured group health plans.

### Who is Subject to the Fee and Who is Required to Pay?

The fee and reporting requirement applies to all group health plans, including retiree-only plans (which are exempt from many other ACA mandates), self-insured medical plans, HRAs and in some limited cases, health FSAs. The proposed regulations clarify that the following benefits are not subject to the fee:

- Excepted benefits, including limited scope dental and vision benefits, accident and disability benefits, workers' compensation benefits, on-site medical clinics, LTC benefits and most health FSAs
- Health Savings Accounts
- Employee assistance, disease management, and wellness programs that do not provide significant medical benefits
- Expatriate plans
- Stop-loss coverage

For fully-insured plans, insurance carriers are responsible for paying the fees; for self-insured plans, plan sponsors must pay (typically the employer). It is important to note that third-party administrators will not be paying this fee on behalf of a self-insured plan. Further, although carriers are responsible for paying the fee for fully-insured plans, the new costs will likely ultimately be passed along in premiums for an insured group health plan.

## How is the Fee Calculated and When Must it be Paid?

The fee is based on the "average number of lives covered under the plan" for the plan year, multiplied by the "applicable dollar amount." Plan sponsors can use one of three methods for determining the average number of lives covered under the plan for the plan year (insurance carriers must use one of four methods). For policy years already in progress, plan sponsors may use any reasonable method to determine the average number of covered lives during the first year that the fee is in effect. Only one method may be used each year, but calculation methods may vary from year to year.

The three methods are as follows:

- Actual Count Method: the actual number of lives covered under the plan for each day of the plan year, divided by the number of days in that plan year.
- Snapshot Method: the actual number of lives covered on one date in each quarter (or more dates if an equal number of dates are used for each quarter), divided by the number of dates on which a count was made. For this purpose, the date or dates for each quarter must be the same (e.g., the first day of the quarter).
- Form 5500 Method: the number of participants actually reported on the Form 5500 for the plan year.

The applicable dollar amount is as follows:

- 1st year (plan years beginning on or after November 1, 2011, but before November 1, 2012): $1
- 2nd year (plan years beginning on or after November 1, 2012, but before November 1, 2013): $2
- Subsequent years (plan years beginning on or after November 1, 2013, but before November 1, 2018): the fee will be indexed to increases in National Health Expenditures.

Although the fee is generally calculated separately for each plan, the proposed regulations ease this rule by allowing an employer to aggregate all self-insured plans having the same plan year. Thus, if an employer sponsors both a self-insured medical plan and a self-insured prescription plan, and the plans have the same plan year, only a single fee must be paid for any individual who is covered under both plans. Similarly, an HRA or FSA that operates on the same plan year as the employer's self-insured major medical plan may also be aggregated with that major medical plan when calculating the number of covered lives. However, if an employer maintains an HRA or FSA and sponsors an insured major medical plan, no aggregation would be allowed. Rather, the insurer would pay the fee for the covered lives attributable to the major medical plan, and the employer would pay the fee for all participants in the HRA or FSA. It should be noted that the employer only has to pay the fee for the actual number of participants in the HRA or FSA, disregarding any dependents whose expenses might be reimbursable from the account.

Plan sponsors are required to file Form 720 "Quarterly Federal Excise Tax Return" annually for purposes of the fee. The return, together with payment, must be filed by July 31 of the calendar year immediately following the last day of the plan year. Thus, a return for the year ending on December 31, 2012 must be filed by July 31, 2013.

## What is the Effective Date and What are the Penalties for Non-Compliance?

The fee applies for plan years ending after September 30, 2012; the requirement expires after September 30, 2019. In other words, for calendar year plans, fees would apply for plan years 2012 through 2018. Penalties may apply for filing a late return, depositing taxes late, paying taxes late, willfully failing to collect and pay tax or file a return, negligence, and fraud. These penalties are in addition to the interest charged on late payments.

## What Action Should Plan Sponsors Take?

Plan sponsors may rely upon the proposed regulations for guidance pending the issuance of final regulations. Plan sponsors should identify all health plans that are subject to this new fee, select a method for calculating each plan's number of covered lives and budget the amount of money needed to pay this new fee.