Leavitt Group
Benefit Trends

HEALTH CARE REFORM – SPECIAL EDITION

IRS Issues Proposed Regulations on Health Plan Fees to Fund Patient-Centered Outcomes Research Trust

LEGISLATIVE BRIEF

April 23, 2012

The IRS issued proposed regulations April 12, 2012 regarding the research effectiveness fee that will be imposed on health plans and health insurance issuers to fund the Patient-Centered Outcomes Research Institute (PCORI) that was established by the Affordable Care Act (ACA). The PCORI is a new independent, non-profit research institute that will provide objective information on prevention and on the effectiveness of various medical treatment options.

Quick Summary on the Research Effectiveness Fee:

What	An annual fee of $1/enrollee (based on the average number of employees, spouses and dependents enrolled) will be assessed on all fully insured and self-funded health plans, for plan years ending after September 30, 2012 and before September 30, 2013. The fee will increase to $2/enrollee after the first year, and thereafter will be indexed for inflation. No fee will be imposed for plan years ending after September 30, 2019.
When	The fee is effective January 1, 2012 for calendar-year policies & plans. The fee applies for 2012-2018 calendar years.
Who	Insured health plans and individual policies and self-funded health plans (both grandfathered & non-grandfathered) must pay the research effectiveness fee. The fee is paid by the carrier for insured plans and policies, and by the plan sponsor for self-funded plans. The fee does not apply to stand-alone dental and vision plans or to HFSAs that are "excepted" benefits. Additional list below of other health coverage not subject to fee.
Why	The fee will support the non-profit Patient-Centered Outcomes Research Institute, which will study and report on the effectiveness of various medical treatments.
How	The fee will be due annually, using Tax Form 720. It must be reported and paid by July 31 of the calendar year immediately following the end of the plan or policy year. The fee will be assessed, collected and enforced under the Tax Code, same as other taxes.

Quick Summary of the Main Points in the Proposed Regulations

1 Which health plans and policies are subject to the fees and which are not?

- *Subject to the fee:* The fee applies to plans that provide accident or health coverage primarily for individuals living in the U.S.
- *Not Subject to the fee:* The fee does not apply to the following plans or policies:
  - » Limited-scope dental and vision benefits that are "excepted benefits" under IRC section 9832(c). These are either insured benefits that are under a separate contract from insured medical benefits, or are benefits that medical plan participants can elect *not* to receive, and if they elect *to* receive them they must pay an additional amount for the dental or vision coverage.
  - » Health FSAs that are "excepted benefits" under IRC section 9832(c). These are HFSAs under which the maximum benefit for the year does not exceed two times the participant's salary reduction election for the year, or, if greater, the participant's salary reduction election plus $500; and the employee has other regular medical coverage (that is not an excepted benefit) available under a group health plan of the employer for that year.
  - » Employee assistance programs, disease management programs or wellness programs that do not provide significant medical benefits.
  - » HRA that is bundled with a self-insured major medical plan (e.g., PPO or HDHP) is not subject to a separate fee. But HRA that is bundled with an insured major medical plan is subject to a separate fee (calculated by including only employees--not dependents- in the total participant count).
  - » Expatriate policies
  - » Stop-loss or indemnity reinsurance policies

2 How much is the fee and how will it be calculated?

The fee calculation is:

The average number of covered lives under the plan or policy during the year	**X**	The applicable fee amount for the year (e.g., $1 for 2012 plan year)

The applicable fee amount is:

- $1 for plan years ending on or after October 1, 2012 and before October 1, 2013.
- $2 for plan years ending on or after October 1, 2013 and before October 1, 2014.
- For subsequent plan years ending before October 1, 2019, the fee will be adjusted for projected increases in national health expenditures.
- The fee is scheduled to sunset for plan or policy years ending after on or after October 1, 2019.

3 By what methods may the plan or issuer calculate the average number of covered lives?

For insured plans, health insurance issuers may select from the following four calculation methods:

- Actual count method
  - » Total number of lives covered for each day of the policy year, divided by the total number of days in the policy year.

- Snapshot method
  - » Total number of lives covered on one or more dates in each quarter, divided by the total number of dates on which the count was made.
- Member months method
  - » As calculated on an NAIC Exhibit filed for the calendar year
- State form method
  - » As calculated on a required state insurance reporting form, for issuer that is not required to file NAIC annual financial statements

For self-insured plans, plan sponsors may select from three calculation methods.

- Actual count method – same as above but for plan year rather than policy year
- Snapshot method – same as above but for plan year rather than policy year
- Form 5500 method
  - » This number is derived from the number of total participants reported on the Form 5500.

There are special rules for calculating the average number of covered lives for the first and last years for which the fee is assessed.

4 How and when will the fee be paid?

The fees will be paid annually with Tax Form 720 (even though this form is otherwise used for quarterly filings of Federal taxes) and generally will be due by July 31 of the calendar year immediately following the last day of the policy or plan year.