Issue Brief

Health Plan Fees to Fund Research on Patient-Centered Outcomes
Issue Date: February 2013

Background

The Affordable Care Act (ACA) set up a new nonprofit entity, the Patient-Centered Outcomes Research Institute, to fund and support clinical effectiveness research. This research will be partially funded by health insurance companies and sponsors of self-insured health plans.

Employers who sponsor fully insured health plans will not be required to pay the fee directly. The fee will be paid by the health insurance company issuing the insurance policy. However, it can reasonably be assumed that carriers will include the fee when setting the employer's rates.

The plan sponsor, however, is responsible for paying the fee for "applicable self-insured health plans." Employers who sponsor self-funded health plans, including health reimbursement arrangements (HRAs), must pay the fee for each plan or policy year on an annual basis.

Amount of Fees

In general the fee is calculated by multiplying $2.00 per year times the average number of covered lives in the plan. However, for plan or policy years ending before October 1, 2013, the fee is based on $1.00 per covered life. For plan or policy years ending after October 1, 2014, the fee will increase based on the percentage increase in National Health Expenditures as published by the IRS.

The fee is based on the average number of lives covered under the plan. This means not just employees covered under the plan, but covered spouses and dependents as well. See below for details on calculation of the average number of covered lives.

Effective Date and Payment Due Date

Fees are payable for policy and plan or policy years ending after October 1, 2012. The fee sunsets and no longer applies for plan years ending after Sept. 30, 2019. Another way to look at the effective date is that for plans that begin on the first of the month, the first plan or policy year subject to the fee is November 1, 2011 – October 31, 2012.

Fees are reported and paid once a year. Payments for a particular plan or policy year are due by July 31 of the calendar year following the year in which the plan ends. To put it another way, fees for plan or policy years ending during 2012 must be paid by July 31, 2013; fees for plan or policy years ending in 2013 must be paid by July 31, 2014, etc.

For example:

- The sponsor of a plan or policy year beginning 01/01/2012 and ending 12/31/2012 must report and pay the fees for that plan or policy year by 07/31/**2013**.
- The sponsor of a plan or policy year beginning 03/01/2012 and ending 02/28/2013 must report and pay the fee for that plan or policy year by 07/31/**2014**.

Plan sponsors will use the IRS Form 720 (Quarterly Federal Excise Tax Return) to report the fees. As of January 2013, the IRS had not yet released a new version of the Form 720. Even though fees are reported on the quarterly Form 720, plan sponsors need report and pay the fee only once per year for each applicable plan or policy year.

Treatment of Multiple Plans Offered by the Same Plan Sponsor

Multiple Self-funded Plans
If one plan sponsor maintains more than one self-insured health plan (such as a self-funded medical plan with an HRA, or a self-funded Rx plan offered with a medical plan), the arrangements can be treated as a single plan for purposes of the fee as long as the arrangements have the same plan year.

HRAs Offered in Conjunction with Fully Insured Health Plans
IMPORTANT NOTE FOR SPONSORS OF A FULLY INSURED HEALTH PLAN WITH AN HRA - The special treatment for HRAs integrated with a self-funded medical plan described above does not extend to HRAs offered in conjunction with a fully insured plan. An employer who sponsors an HRA with a fully insured medical plan is required to pay the fee with respect to HRA participants.

Determining the Annual Fee

Plan sponsors with self-insured plans may use any of three alternative methods to calculate the fee. Plan sponsors may use only a single method for a particular plan or policy year, but they are not required to use the same method from one plan or policy year to the next.

Actual Count Method
A sponsor may determine the average number of lives covered for the plan or policy year by calculating the sum of the lives covered for each day of the plan or policy year and dividing that sum by the number of days in the plan or policy year.

Snapshot Method
A plan sponsor may determine the average number of lives covered for the plan or policy year by adding the totals of lives covered on a particular date during each quarter of the plan or policy year, or an equal number of dates for each quarter, and dividing the total by the number of dates on which a count was made.

The regulations do not require that a specific date be used for each month or quarter, but do require that similar dates be used each month (for example - the 15th day of the second month of each quarter).

In addition, there are two methods within the snapshot method to count family members.

- The “snapshot count method” requires the plan to count the actual number of lives, including dependents, covered on the designated date.
- The “snapshot factor method” allows the plan to count the number of participants with self-only coverage on the designated date, plus the number of participants with coverage other than self-only coverage (i.e. family coverage) on the designated date multiplied by 2.35.

Form 5500 Method
A sponsor may determine the average number of lives covered for the plan or policy year based on a formula that includes the number of participants actually reported on the Form 5500. A plan sponsor may use this method only if the Form 5500 is filed no later than the due date for the fee.

If a plan offers single and family coverage, the total number of lives is determined by simply adding the total participant counts at the beginning and end of the plan or policy year. Under the 5500 method the term “participant” means only covered employees and principal subscribers such as COBRA participants. Participant in this context generally does not include covered spouses and dependents.

Note that since a plan adds the number of participants on the first and last day of the plan or policy year, using the 5500 method has the effect of assuming approximately 2 covered lives per participant contract.

Special Rules for Calculating the Fee When an HRA Is Offered

For HRA coverage each participant can be treated as a single life, regardless of how many other individuals (e.g., spouse, dependents, and other beneficiaries) are actually covered by the HRA plan. This means that the plan sponsor is not required to include dependents as "lives" under an HRA, and is only required to count the employee.

HRAs integrated with insured coverage.
If a plan sponsor has other fully insured coverage, the plan sponsor generally must pay the fee with respect to the average number of lives covered by the HRA. The HRA's covered lives will be determined using the one life per participant rule. Note that the plan sponsor's health insurance carrier will also be responsible to pay the fee based on the participants in the fully insured plan.

HRAs integrated with self-funded 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 counted only once. The individuals covered by both plans are counted using the counting method chosen for the regular medical plan (so the one life per participant HRA 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.

Other Miscellaneous Rules

The DOL has indicated that these fees generally are not permissible plan expenses under ERISA, since they are imposed on the plan sponsor and not the plan. This means that plan assets should not be used to pay the fee; fees should be paid from the general assets of the sponsor.

Other Types of Plans and Benefits that Are Subject to the Fees

- Governmental entities are also subject to the fees, unless they qualify as an "exempt governmental program."
- Retiree-only plans are not required to comply with certain health care reform provisions but are subject to these fees.

Other Types of Plans and Benefits not Subject to the Fees

- The fees do not apply to an employee assistance program (EAP), disease-management program, or wellness program if such program does not provide "significant" benefits in the nature of medical care or treatment.
- The fees do not apply excepted benefits under Code § 9832(c). Excepted benefits include, among others, most health FSAs (if an employer makes an employer contribution to employee FSA accounts the plan may not qualify as an excepted benefit), limited-scope dental and vision coverage, and certain supplemental coverage.
- Stop-loss and reinsurance policies are not subject to the fees.

More Information

The IRS final regulations regarding this fee can be found at http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf.