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employee benefits lawflash

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Internal Revenue Service Issues Guidance on New Research Fee

Proposed regulations provide detail on who must pay the new patient-centered outcomes research fee, the amount of the fee, and how the fee is to be calculated and reported.

On April 17, the Internal Revenue Service (IRS) issued proposed regulations on the patient-centered outcomes research fee created by the Patient Protection and Affordable Care Act (PPACA). The fee, which starts at $1 per covered life beginning in 2012 and is scheduled to phase out in six years, will be used to fund the research of the Patient-Centered Outcomes Research Institute (PCORI) created by PPACA. The PCORI's publicly available research is intended to assist healthcare consumers, payors, and providers in making informed decisions about the most effective forms of healthcare and benefits coverage.

What is the fee?

To provide funding for the PCORI's research, PPACA added two new sections to the Internal Revenue Code (Code) to assess fees on health insurers and self-insured health plan sponsors. Code Section 4376 applies to sponsors of "applicable self-insured health plans" and assesses an annual fee of $1 per covered life for plan years ending on or before October 30, 2013, and $2 per covered life each plan year thereafter. Code Section 4375 assesses the same fee to issuers of "specified health insurance policies." This LawFlash will focus on **self-insured** health plans.

For plan years beginning on or after October 1, 2014, the amount of the fee will be adjusted annually to account for increases in healthcare spending. The fee increase will be based on the percentage increase in the projected per-capita national health expenditures published by the U.S. Secretary of Health and Human Services.

Who must pay the fee?

The fee is assessed on health insurers and plan sponsors of self-insured health plans. Employers that sponsor insured health plans can expect the plans' insurers to pass this new fee back to their customers.

What "applicable self-insured health plans" are subject to the fee?

The proposed regulations apply to applicable self-insured health plans and include medical and prescription drug plans, health reimbursement arrangements, and some healthcare flexible spending accounts. Surprisingly, the proposed regulations do not exclude retiree-only health plans from reach of the tax.

Excluded Plans

The proposed regulations exempt most "excepted benefits" under the Health Insurance Portability and Accountability Act (HIPAA) from the fee. Excepted benefits include stand-alone dental-only, vision-only, and most health flexible spending account plans. Also excluded are employee assistance programs, disease management programs, and wellness programs unless they provide "significant benefits in the nature of medical care or treatment." While the proposed regulations do not define "significant benefits," absent additional guidance, it does not appear likely that regulators intend the fee to reach these types of benefits. The proposed regulations also

exclude health savings accounts (HSAs) but not high-deductible health plans that may be associated with HSAs.

Multiple Plans

If a plan sponsor offers two or more self-insured health plans and all plans have the same plan year, they will be counted as a single health plan for purposes of calculating the fee. For example, a plan sponsor may offer a self-insured major medical plan, a prescription drug plan, an integrated health reimbursement arrangement, and a dental plan. In such an arrangement, the same participant covered under one or more of the plans would count as one "covered life," not two. A less favorable result will be encountered, however, if an employer offers employees an insured high-deductible health plan (for which the insurer must pay the fee) and a related self-insured health reimbursement arrangement (for which the plan sponsor must pay the fee). In such a case, two fees must be paid.

How is the fee calculated?

The fee is equal to the product of $2 (or $1 for plan year 2012) multiplied by the average number of lives covered under the self-insured health plan or insurance policy. "Lives covered" include employees, spouses, and dependents. The proposed regulations provide separate permissible calculation methods to determine the average number of lives covered—one set for plan sponsors of self-insured health plans and one set for health insurers.

Plan sponsors of self-insured health plans must use one of the following three methods to determine average number of lives covered.

- **Actual Count Method.** The plan sponsor may calculate the sum of the lives covered on each day of the plan year and divide the total by the actual number of days in the plan year to determine the average number of lives covered.
- **Snapshot Count Method.** The plan sponsor may sum the totals of lives covered on any one date in each quarter of the plan year or an equal number of dates in each quarter and divide the total by the number of dates on which the count was made to determine the average number of lives covered. The proposed regulations also provide two methods for determining the number of lives covered on the date(s) chosen—the snapshot count method and the snapshot factor method.
- **Form 5500 Method.** The plan sponsor may use the participant numbers reported on the plan's Form 5500 filing for that plan year to determine the average number of lives covered. The proposed regulations direct plan sponsors to add together the total number of participants at the beginning of the plan year as reported on the Form 5500 and the total number of participants at the end of the plan year as reported on the Form 5500. If the plan offers only self-only coverage, the sum is divided by 2 to arrive at the average number of lives covered. The sum is not divided if the plan offers coverage to dependents.

  The Form 5500 method is problematic for plan sponsors of wrap health and welfare plans who file one Form 5500 for all health and welfare benefits. The beginning and end of plan year participant totals on the Form 5500 for wrap plans typically reflect the number of participants in the component health and welfare plan with highest number of participants. For example, 100% of employees may participate in an employee assistance plan component of a wrap plan while only 65% of employees participate in the medical and prescription drug plan component. For this reason, the Form 5500 method may have limited value for many employers.

Issuers of health insurance policies may employ the actual count or snapshot count methods described above. In addition, health insurers have the option of using a member-months method or state-form method described in the proposed regulations.

How is the fee paid?

Plan sponsors are required to report the fee on Form 720, Quarterly Federal Excise Tax Return. Form 720 is currently being revised to reflect the new fee and will be due by July 31 of the calendar year immediately following

the last day of the plan year. For plan years ending on or before December 31, 2012, the fee must be reported and paid by July 31, 2013.

Comments may be submitted to the IRS before the proposed regulations are adopted as final regulations later this year. A public hearing has been scheduled for August 8, 2012.

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