Health Reform

Final Regulations Issued on Research Fee

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The Affordable Care Act created a new fee on health plans to fund the Patient-Centered Outcomes Research Institute. The Institute was established to fund the research of the clinical effectiveness of medical treatments, procedures and drugs. The fee applies to all group health plans, including retiree-only plans, self-insured plans, HRAs and some health FSAs. The fee equals $1 in the first year ($2 in the next year, then adjusted for inflation) multiplied by the average number of lives insured under a group health plan policy and is paid by insurance carriers for insured plans and by employers for self-insured plans. The proposed regulations issued in April 2012 provide three methods to determine the average number of lives: actual count, snapshot and Form 5500. Carriers and plan sponsors must report and pay the fee annually (Form 720 Quarterly Federal Excise Tax Return) no later than July 31 of the year following the last day of the policy or plan year (for year ending December 31, 2012, must be filed by July 31, 2013).

The IRS has issued final regulations, effective December 6, 2012. Although the final regulations do not make substantial changes to the proposed regulations, they include several changes and clarifications as discussed below.

Policies subject to the fee

As stated above, the fee and reporting requirement apply to all group health plans. The proposed regulations provide an exception for the following:

- 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

The final regulations add an exception to the above policies for any policy to the extent that it provides an employee assistance program, disease management program, or wellness program, if the program does not provide significant benefits in the nature of medical care or treatment.

Retiree-Only Coverage

The IRS reiterated that policies and plans subject to the fee include retiree-only plans.

Continuation Coverage

The final regulations clarify that continuation coverage must be taken into account in determining the fee. "Continuation coverage" includes COBRA or similar continuation coverage under other federal law or under state law.

Multiple Arrangements

The proposed regulations permit employers to aggregate all self-insured plans having the same plan year for the purpose of paying the fee. The final regulations confirm that if the same plan sponsor maintains multiple self-insured arrangements (e.g., major medical coverage and an HRA), the arrangements can be treated as a single plan if they have the same plan year. Commenters asked the IRS to allow fully insured and self-insured arrangements with a common plan sponsor to be treated as one plan, but the preamble explains that the statutory structure prohibits this type of integration. However, an applicable self-insured health plan that provides accident and health coverage through fully-insured options and self-insured options may determine the fee by disregarding the lives that are covered solely under the fully-insured options.

Snapshot Method

The proposed regulations define the snapshot method as 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 and required that the date or dates for each quarter must be the same (e.g., the first day of the quarter). The final regulations provide more flexibility while restricting plan sponsors from picking the most advantageous dates. The final regulations require a plan sponsor that uses the snapshot method to determine the counts used based on a date during the first, second, or third month of each quarter (or more dates in each quarter if an equal number of dates is used for each quarter). Each date used for the second, third, and fourth quarters must be within 3 days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy year or plan year. If a plan sponsor uses multiple dates for the first quarter, the plan sponsor must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within 3 days of such corresponding dates, and all dates used must fall within the same policy year or plan year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or 31 are used as snapshot dates for a calendar year plan, June 30 is the corresponding date for the second quarter). Thus, for example, if a plan sponsor uses the snapshot method to determine the average number of lives covered under an applicable self-insured health plan with a calendar year plan year and uses Monday, January 7, 2013 as the counting date for the first quarter, the plan sponsor may use any date beginning with Thursday, April 4, 2013, and ending with Wednesday, April 10, 2013 as the counting date for the second quarter (because all of those days are within three days of April 7, 2013, the date that corresponds to the January 7, 2013 counting date for the first quarter).

Form 5500 Method

The proposed regulations provide that Forms 5500 can be used to determine the average number of lives by using the number of participants actually reported on the Form 5500 for the plan year. The final regulations confirm that a sponsor using the Form 5500 method for calculating lives with an extension for filing Form 5500 does not get an extended due date to report and pay the fee.

Third parties

The final regulations confirm that parties other than the plan sponsor such as third party administrators cannot report or pay the fee.

International plans

The term "specified health insurance policy" includes only an accident and health insurance policy that is issued with respect to an individual residing in the United States. The fee applies to individuals on a temporary U.S. Visa who live in the U.S. The fee does not apply to a self-insured health plan if the facts and circumstances show that it was designed specifically to cover primarily employees who are working and residing outside of the United States.