IRS Issues Proposed Rules on ACA Research Fees for Health Plans

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The IRS has issued proposed rules addressing the comparative effectiveness research fees imposed by the Affordable Care Act (ACA) on health insurance carriers and plan sponsors of self-insured health plans. The IRS is taking comments on the proposed rules for 90 days and is expected to issue final regulations shortly thereafter.

Background

The ACA creates a nonprofit corporation, the Patient-Centered Outcomes Research Institute, to conduct and promote clinical effectiveness research. The Institute will be funded by a Patient-Centered Outcomes Research Trust Fund. The Trust Fund will be funded in part by fees to be paid by issuers of health insurance policies and sponsors of self-insured health plans.

The ACA imposes fees on "specified health insurance policies" and "applicable self-insured health plans" based on the average number of lives covered under the policy or plan. The fees are effective for plan years ending after September 30, 2012. Thus, for employer sponsored plans that begin on the first day of the month, the first plan year subject to the fees will be plan years beginning November 1, 2011 (which will end October 31, 2012). The fee no longer applies for plan years ending after September 30, 2019.

The fee equals to $1.00 (one dollar) per year, multiplied by the average number of lives covered under the plan for plan years ending before October 1, 2013, and $2.00 (two dollars) per year for plan years ending after that date. Beginning in 2014 the fee will be adjusted based on a formula that takes into account the increase in national health care expenditures. Covered employees, spouses, and dependents will be included in the total number of covered lives.

IRS Guidance

The IRS previously issued a request for comments regarding the fees in IRS Notice 2011-35 released in June 2011. The proposed rules address a number of outstanding issues included in the request for comments.

Who pays the fee?

For fully-insured plans the fee will be paid by the health insurance carrier (referred to as the issuer in the regulations). For self-insured plans, the fee must be paid by the plan sponsor (generally the employer in the case of a single-employer plan).

The IRS had requested comments regarding the possibility of allowing third parties, such as the employer claims administrator, to pay the fee on behalf of a self-funded employer. Unfortunately, the IRS has decided that the fee for self-funded plans must be paid directly by the plan sponsor/employer.

Plans subject to the fee

The fee applies to "specified health insurance policy" including self-funded plans, which is defined as any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States. The fee does not apply to plans that are treated as excepted benefits under HIPAA (i.e. limited scope dental and vision plans).

- The effect of the fee on a Health Reimbursement Arrangement (HRA) will depend on if the HRA is integrated with a self-funded or fully-insured health plan.
    - Under the proposed rule, multiple self insured arrangements maintained by the same employer with the same plan year are subject to a single fee. Thus, a health reimbursement arrangement (HRA) is not subject to a separate fee as long as the HRA is integrated with a self-insured health plan.
    - However, an HRA offered in conjunction with a fully-insured health plan will be considered a self-funded plan and will be subject to the fee. This means that if you have an HRA with a fully-insured health plan, the carrier will pay the fee for the health plan, but the separate fee imposed

on the HRA is the responsibility of the plan sponsor/employer.

- No fee will apply to a Health Flexible Spending Account (HFSA) that satisfies the HIPAA definition of an "excepted benefit".
- An employee assistance program, disease management program, or wellness program will generally not be considered a plan subject to the fee as long as the plan does not provide significant medical care benefits.

Calculating and paying the fee

The fee will be based on the average number of lives covered under the policy or plan. To determine the average number of lives covered under a self-funded health plan during a plan year, a plan sponsor must use one of the following methods:

- The actual count method
    - The average number of lives covered under a plan for a plan year is determined by adding the totals of lives covered for each day of the plan year and dividing that total by the number of days in the plan year.
- The snapshot dates method
    - A plan sponsor may determine the average number of lives covered under a plan by adding the totals of lives covered on one date in each quarter (or more dates if an equal number of dates are used for each quarter) and dividing that total by the number of dates on which a count was made.
    - For this purpose, the date for each quarter must be the same (for example, the first day of the quarter, the last day of the quarter, the first day of each month, etc.).
- The 5500 method
    - A plan sponsor may determine the average number of lives covered under a plan for a plan year based on the number of reportable participants on the plan's 5500.
    - If the plan covers individuals other than the employee (e.g. spouses and dependents) as most employer plans do, the average number of lives covered under the plan equals the sum of total participants reported in the 5500 covered at the beginning plus the number at the end of the plan year.
    - This methodology was created to address the fact that the fee includes spouses and dependents covered by the plan but those spouses and dependents are not included in the count of participants on the 5500. Adding the number of 5500 "employee" participants at the beginning of the year to the number at the end of the year to determine the participant count essentially estimates that there are approximately 2 "covered individuals" to every participant reported on the 5500.

Plan sponsors of self-funded plans will report and pay the fees once a year on IRS Form 720, which will be due by July 31 of each year. The Form 720 will cover plan years that end during the preceding calendar year. For example, an employer with a plan year ending December 31st, 2012 will need to report and pay the fee by July 31, 2013, while an employer with a plan year ending January 31, 2013 will not need to report and pay the fee until July 31, 2014.

Summary

Obviously employers who sponsor only fully-insured plans have little to do since the insurance carrier is responsible for paying the fee. Assumedly, the fee will be reflected in the premiums paid by the employer to the carrier. Note however that employers who sponsor a fully-insured health plan, but also offer an HRA, will need to report and pay the fee for the HRA plan.

Employers who sponsor self-funded health plans have some work to do. They must first determine which method they plan to use to calculate the fee. It is also possible that different allowable methods will result in different fee amounts due, so employers may want to calculate the fee each way to determine the lowest amount due.

A copy of the IRS guidance which includes examples of the different types of participant calculation methods can be found at http://www.irs.gov/pub/irs-drop/n-11-35.pdf.