Fees Under The New Healthcare Reform Act Set To Begin

Insights
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The new healthcare reform law includes a number of new taxes and fees which are rarely mentioned by the law's supporters. On December 5, IRS announced final regulations governing new fees on health insurers and employer sponsors of self-insured health plans, designed to fund the "Patient-Centered Outcomes Research Trust." This Trust finances an "Institute" tasked with "advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings." Got that?

Say What?
Since insurers must pay the fee with respect to insured plans, the following discussion centers on obligations of self-funded plan sponsors. For calendar-year plans, the first payment is due July 31, 2013. Employers sponsoring self-insured plans need to be aware of these issues now since 2012 plan data will be necessary to calculate the fee owing in 2013.

The regulations describe how the new fee is to be calculated and paid by sponsors of self-insured plans for plan years ending on or after October 1, 2012 and before October 1, 2019, when the fee is scheduled to expire. The fee is based on the number of lives covered by the plan, which means the sponsor pays on the basis of participants (including COBRA recipients), as well as covered spouses, dependents and other beneficiaries.

Since the fee affects all plans with plan years ending on and after October 1, 2012, it is required for most plans this year, including all calendar-year plans. For plan years ending ***before*** October 1, 2013 (for most plans, the current plan year), the fee is $1 times the average number of lives covered under the plan.

For plan years ending on and after October 13, 2013, the fee is $2 per average number of lives, and for years ending after October 13, 2014, the fee will increase based on the projected per capita amount of national health expenditures. Fees are due no later than July 31 of the year following the last day of the plan year. For calendar year plans, that means the first fee is due July 31, 2013.

Who's Covered?
A self-insured health plan is defined as any plan that provides accident or health coverage, if any portion of the coverage is provided "other than through an insurance policy." Certain plans fall within an exception to this requirement, including those that provide benefits that are "substantially all 'excepted' benefits." EAPs, disease management or wellness programs that do not provide

all "excepted" benefits," EAPs, disease-management or wellness programs that do not provide significant benefits in the nature of medical care or treatment, and plans designed to cover primarily employees who are working or residing outside of the U.S.

"Excepted benefits" are benefits such as accident-only coverage, workers' compensation, limited-scope dental or vision care, long-term care, coverage for a specific disease, or plans offering hospital or other fixed indemnity coverage.

Significantly, two or more arrangements established or maintained by the same plan sponsor that provide for accident and health coverage and have the same plan year, are treated as a single plan. For example, a plan sponsor with separate major medical and prescription drug plans, or who sponsors an HRA, sponsors only one plan as long as all have the same plan year. This avoids paying multiple fees for essentially the same coverages.

Adding Up The Numbers

There are three ways to determine the average number of lives under a plan. These are the "actual count method," the "snapshot method," and the "Form 5500 method." Sponsors are required to use the same method for all plans each year, but may switch methods from year to year:

Actual Count Method

Under this method, the sponsor adds up the daily tally of covered lives during the plan year and divides by the total number of days in the plan year.

Snapshot Method

Under this method, the sponsor adds total lives on one or more days during each of the quarters of the plan year, and divides by the total number of dates on which a count was made. Each date used in quarters 2, 3 and 4 must be within 3 days of the date in the first quarter that corresponds with that date. For example, if the sponsor counted lives on the 15th of each month in the first quarter, it must use a date within 3 days of the 15th in the following months.

If this method is used, lives on a particular date can be determined using either a "snapshot factor" or a "snapshot count." The "snapshot factor" method counts the number of individuals with self-only coverage on a day and multiplies that by 2.35. The "snapshot count" method uses the actual number of lives on the designated date.

Form 5500 Method

This method can be used as long as the 5500 is filed on or before July 31 of the year following the year in question. If the plan is restricted to self-only coverage, the sponsor adds the total participant counts reported on the 5500 at the beginning and at the end of the plan year, and divides by two to determine covered lives. If there are coverages in addition to self-only coverage, total lives equals the sum of the reported beginning and year-end participant counts.

There are special rules for health FSAs and HRAs. In the case of an FSA or HRA, the sponsor does not need to count spouses, dependents or other beneficiaries. And, as noted above, if the HRA

not need to count spouses, dependents or other beneficiaries. And, as noted above, if the HRA and/or FSA has the same plan year as the sponsor's health plan, it will not be double counted for purposes of paying the fee. Similarly, if a sponsor has both self-insured and insured options under its plan, the sponsor is not required to pay a fee for insured lives.

Conclusion

This is obviously new territory for plan sponsors, and it's important to get started correctly under the new law. If you have any questions about any of these requirements or methods of calculating liability, contact any member of the Fisher Phillips Employee Benefit Practice Group.

This Legal Alert provides information about a specific federal regulation. It is not intended to be, and should not be construed as, legal advice for any particular fact situation.