BUTZEL LONG

Client Alert:
Employee Benefits

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IRS Fee Payable for Many Employer-Sponsored Health Plans by July 31, 2013

Background

July 31, 2013 is the deadline for many employers which sponsor certain health plans to pay a new fee to the Internal Revenue Service ("IRS").

The Patient-Center Outcomes Research Institute Fee ("PCORI Fee") (sometimes referred to as Clinical Effectiveness Fee ("CER")) is a fee imposed on (1) insurers of insured plans, and (2) self-insured plan sponsors, to fund the Patient Centered Outcomes Research Institute ("Institute"). Through research, the Institute will assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings. The fee applies for each plan year ending on or after October 1, 2012, but before October 1, 2019 (i.e., for seven full plan years).

Who Pays the Fee and When is it Due?

For fully-insured plans, the insurer pays the fee.

For self-insured plans, the plan sponsor (e.g., employer) pays the fee.

Since the fee is imposed on the insurer/plan sponsor and not the plan, the fee cannot be paid with plan assets. Fees are considered excise taxes.

The fee is reported on IRS Form 720, and is due July 31 of the year following the last day of the plan year. So, for example, the first fees are to be reported and paid on July 31, 2013 for a calendar year plan. Payment of the fee and filing the IRS Form 720 cannot be delegated to a third party (such as a third party administrator).

What Plans are Subject to the Fee?

As noted above, insured and self-insured health plans are subject to the fee. Stop-loss and indemnity reinsurance policies are not subject to the fee. Excepted benefits (e.g., stand-alone vision and dental plans) are not subject to the fee, and most health flexible spending arrangements ("FSAs") are not subject to the fee.[1] Retiree-only plans are subject to the fee.

Employee assistance programs ("EAPs"), disease management programs and wellness programs are not subject to the fee if they do not provide significant benefits in the nature of medical care or treatment.

[1] A health FSA that is treated as an "excepted benefit" is not subject to the fee. Benefits under a health FSA are excepted benefits if: (1) the employee has other coverage available under a group health plan of the employer for the year; (2) the other coverage is not limited to benefits that are excepted benefits; and (3) the maximum benefit payable for the employee under the health FSA for the year does not exceed two times the employee's salary reduction election under the health FSA for the year (or, if greater, the amount of the employee's salary reduction election under the health FSA for the year, plus $500).

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How Much is the Fee?

During the first plan year the fee applies (i.e., for plan years ending on or after October 1, 2012, but before October 1, 2013), the fee is $1 times the average number of lives covered under plan. The fee increases to $2 for the next plan year and then is subject to increases based on increases in national health care expenditures. All individuals covered under the plan during the plan year (i.e., employee, spouse, and dependents covered during the plan year) must be counted in computing the average number of lives. COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) beneficiaries are included when calculating the fee.

Multiple self-insured plans for the same employer (e.g., an arrangement providing major medical benefits and a separate arrangement providing prescription drug benefits) are subject to only one fee if the plans have the same plan year. If the employer has insured and self-insured plans, the employer and the insurer are subject to the fee. If the plan sponsor provides both self-insured and fully-insured options under one applicable self-insured health plan, the plan sponsor can disregard the lives covered solely under the fully-insured options of the plan.

How Do You Calculate the Fee?

Only individuals who reside in the United States are taken into account in calculating the fee.

For health FSAs which are subject to the fee, and for health reimbursement arrangements (“HRAs”), the IRS provides special rules for determining the fee. By means of only one example:

- If the employer does offer a self-funded health insurance plan other than a health FSA, or HRA, the employer can treat each participant’s health FSA or HRA as covering a single life. In other words, the employer does not have to count spouses or other dependents of the individual participant in the health FSA or HRA.

For self-insured plans, a plan sponsor uses one of the following methods to calculate the fee[2]:

1. Actual Count - Add the total covered lives each day of the plan year and divide that total by the number of days in the plan year.
2. Snapshot - Add the total covered lives on a date during the first, second or third month of each quarter of the plan year and then divide that total by the number of dates on which a count was made. There are two different methods to determine the number of lives covered on a designated date.
3. IRS Form 5500 - [This method cannot be used if the employer uses an extension to file IRS Form 5500]:

   - For a plan with self-only coverage: use the sum of total participants on IRS Form 5500 on first and last day of the plan year divided by 2.

   - For a plan with other than self-only coverage: use the sum of total participants on IRS Form 5500 on first and last day of the plan year.
4. For the First Year the Fee Applies - For a plan year beginning before July 11, 2012, and ending on or after October 1, 2012, a plan sponsor may determine the average number of lives covered under the plan for the plan year using any reasonable method

[2] Alternative methods apply for fully-insured plans.

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ATTORNEYS AND COUNSELORS

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