On April 17, 2012, the Internal Revenue Service (IRS) published proposed regulations implementing and providing guidance on the fees imposed by the Patient Protection and Affordable Care Act (the Affordable Care Act) on the issuers of specified health insurance policies and the plan sponsors of applicable self-insured health plans to fund the Patient-Centered Outcomes Research Trust Fund (the “Trust Fund”) (hereinafter, the “fee” or “fees”). The Affordable Care Act established the Patient-Centered Outcomes Research Institute, and the Trust Fund is a funding source for this Institute. While the fees are imposed on employers sponsoring self-insured health plans and the issuers of the policies for fully-insured health plans, this bulletin focuses on the application of the proposed regulations to employers sponsoring self-insured health plans.

The fee for funding the Trust Fund is imposed on a plan sponsor of an applicable self-insured health plan for plan years ending on or after October 1, 2012 and before October 1, 2019. The fee imposed is based on the average number of lives covered under the plan. For plan years ending on or after October 1, 2012 and before October 1, 2013, the fee is one dollar ($1) multiplied by the average number of lives covered under the plan for that plan year. The fee then increases to two dollars ($2) for plan years ending on or after October 1, 2013. For plan years ending on or after October 1, 2014, the fee increases based on a formula that includes increases in the projected per capita amount of National Health Expenditures provided by HHS.

The proposed regulations apply to plan years ending on and after October 1, 2012 and before October 1, 2019. Issuers and plan sponsors may rely on these proposed regulations pending the issuance of final regulations.

Applicable Self-Insured Health Plans for Purposes of the Fee

An applicable self-insured health plan includes a plan established or maintained by a plan sponsor (generally, the employer) for the benefit of employees, former employees (retirees), or other eligible individuals to provide accident or health coverage if any portion of the coverage is provided other than through an insurance policy. An applicable self-insured health plan includes a retiree-only plan.

Multiple self-insured arrangements established and maintained by the same plan sponsor with the same plan year may be treated as a single applicable self-insured health plan for purposes of calculating the fee, so that the same life covered under each arrangement would count as only one covered life under the plan. For example:

- A plan sponsor maintains one self-insured arrangement providing medical benefits and another providing prescription drug benefits with the same plan year. The two arrangements may be treated as one self-insured health plan for purposes of the fee.
- A health reimbursement arrangement (HRA) is integrated with another applicable self-insured health plan that provides major medical coverage. The HRA and the major medical plan may be treated as
one self-insured health plan. Note, however, that an HRA integrated with an insured group health plan is subject to the fee as an applicable self-insured health plan. In that case, the issuer of the insured group health plan would also be subject to the fee.

Arrangements Not Subject to the Fee

According to the proposed regulations, the fee does not apply to limited-scope dental and vision benefits or health flexible spending arrangements (health FSAs) that are excepted benefits. The fee also does not apply to employee assistance programs (EAPs), wellness programs, and disease management programs that do not provide significant benefits in the nature of medical care or treatment.

Calculating the Average Number of Covered Lives

As provided earlier in this bulletin, the fee equals the product of the average number of lives covered under the plan for a plan year and the applicable dollar amount. The average number of lives covered under an applicable self-insured health plan for a plan year can be calculated by any one of three different methods:

- The actual count method;
- The snapshot method (using the snapshot factor or snapshot count); and
- The Form 5500 method.

A plan sponsor must use a single method for calculating the average number of covered lives for an entire plan year, but a different method may be used from one plan year to the next. Examples of each calculation method are included in the regulations.

In the “actual count” method, a plan sponsor adds the totals of lives covered by the plan for each day of the plan year and divides the total by the number of days in the plan year.

The “snapshot” calculation method involves 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. The date or dates used for each quarter must be the same (e.g., first day of the quarter, last day of the quarter, first day of the month). When using the snapshot method, the number of lives covered on a date is equal to either: 1) the actual number of lives covered on the designated date (“snapshot count” method); or 2) the sum of the number of participants with self-only coverage on that date, plus the product of the number of participants with coverage other than self-only coverage on the designated date and 2.35 (“snapshot factor” method).

A plan sponsor may also use the Form 5500 method to calculate the average number of lives for a plan year based on the number of reportable participants for the Form 5500, “Annual Return/Report of Employee Benefit Plan,” filed for the applicable self-insured health plan. For an applicable self-insured health plan offering self-only and other coverage (e.g., employee plus spouse, employee plus children, family), the average number of lives equals the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 filed for the plan. For an applicable self-insured health plan offering only self-only coverage, the average number of lives covered equals the sum of the total participants covered at the beginning and the end of the plan year, reported on the Form 5500, divided by two.
If a plan sponsor only maintains a health FSA (that is not an excepted benefit) or HRA, the plan sponsor may treat each participant’s health FSA or HRA as covering a single covered life (and not include any spouse, dependent, or other beneficiary of the participant). If a plan sponsor maintains a health FSA or HRA and another applicable self-insured health plan (other than a health FSA or HRA), the plan sponsor may treat the two arrangements as a single plan. In this case, the special counting rule (i.e., treating each participant’s health FSA or HRA as covering a single covered life) applies only to participants in the health FSA or HRA that do not participate in the other applicable self-insured health plan. If such individuals also participate in the other applicable self-insured health plan, they will be counted under one of the methods, described above, used by the plan sponsor.

Special Rule for Calculating Covered Lives During First Year of Fee

For plan years beginning before July 11, 2012 and ending on or after October 1, 2012, a plan sponsor may use any reasonable method for determining the average number of lives covered under the plan for the plan year.

Reporting and Payment of Fees on IRS Form 720

Plan sponsors will report and pay the fees only once per year on IRS Form 720, “Quarterly Federal Excise Tax Return,” by July 31 of the calendar year immediately following the last day of the plan year. A Form 720 return generally covers plan years that end during the preceding calendar year. Full payment of the fee is due annually by the July 31 due date. The first potential due date for reporting and filing the fee on Form 720 is July 31, 2013.


IRS Request for Comments

Comments on the proposed regulations are due by July 16, 2012.

Resources

The full text of the proposed regulations is available at:
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