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Plans Must Pay Per-Participant Fee on July 31, 2013

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Companies that sponsor self-funded medical plans (and insurers) will have to pay a fee starting as early as July 31, 2013 as part of federal health care reform. Final regulations issued recently provide more details as to how this fee is calculated and paid.

One of the new requirements of the Patient Protection and Affordable Health Care Act ("PPACA") is the establishment of a new private, nonprofit corporation called the Patient-Centered Outcomes Research Institute. The role of the Institute is to "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." PPACA provides that the Institute will be funded through a new Patient-Centered Outcomes Research Trust Fund, which is to be financed in part by fees paid by insurance companies and also by sponsors of self-insured health plans.

Specifically, the fee is due for each plan year ending on or after October 1, 2012. The amount of the fee for the first year (plan years ending before October 1, 2013) is one dollar for each of the "average number of lives" covered under the plan for the year. The regulations provide multiple permissible methods for calculating the average number of lives, one of which is to use the number of participants reported on the Form 5500 for that year.

Other features of the new fee clarified by the regulations include:

- The fee will increase to two dollars for plan years ending on or after October 1, 2013 and before October 1, 2014, and will be indexed for the remaining years that the fee will be imposed (the fee applies only to plan years ending before October 1, 2019).
- The fee is reported once annually and paid using Form 720, "Quarterly Federal Excise Tax Return," which is due by July 31st of the calendar year following the last day of the plan year. This means that for any plan years ending between October 1, 2012 and December 31, 2012, the first report will be due July 31, 2013. For any plan years ending in 2013, the report will be due July 31, 2014.
- The fee applies to retiree-only plans and to COBRA participants, but is not required for plans that provide only "excepted benefits" or for EAPs. There are also rules designed to limit double-counting where participants are covered under multiple plans.
- The fee also applies to insured plans but is payable by "issuers" of

"specified health insurance policies." Employers with insured group medical plans might expect that this fee will be passed through from their insurers, but the insurers are directly responsible for reporting and paying the fee.

If you have any questions about your obligation to file and pay this new fee, or any other aspect of health care reform, contact a member of the Benefits Law Group.

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