Legislative Brief

Health Care Reform - PCORI Fees

June 26, 2014

PCORI Fees Due July 31, 2014

OVERVIEW OF PCORI FEES

The Affordable Care Act (ACA) created the Patient-Centered Outcomes Research Institute, a non-profit entity, to help patients, clinicians, payers and the public make informed health decisions by advancing comparative effectiveness research. The Institute's research is funded, in part, through fees paid by health insurance issuers and self-insured health plan sponsors. These fees are widely known as PCORI fees (but also known as PCOR fees). See page 3 for a list of arrangements subject to the PCORI fee and the person responsible for paying and reporting the fee. The requirement to pay PCORI fees applies regardless of grandfathered plan status. **Note: PCORI fees are not payable from plan assets.**

Employers who sponsor fully insured health plans will not be required to pay the fee directly. The fee will be paid by the health insurance company issuing the insurance policy. However, it can reasonably be assumed that carriers will include the fee when setting the employer's rates.

DUE DATE FOR REPORTING PCORI FEES ON FORM 720

Health insurance companies and plan sponsors will file IRS Form 720 (Quarterly Federal Excise Tax Return) annually to report and pay the PCORI fee, no later than July 31 of the calendar year following the policy or plan year to which the fee applies (e.g., PCORI fees are due by July 31, 2014, for plan years ending in 2013).

The IRS provided instructions for filing form 720, which include information on reporting and paying the PCORI fees. See the chart on pages 4 for the due date and fee applicable for your policy or plan year.

FEE AMOUNT

General Rule:

A separate PCORI fee applies for each specified health insurance policy or applicable self insured plan, and is based on the average number of lives covered under that plan or policy. This includes not just active employees, but also means covered spouses, dependents, retirees, former employees on disability who are still covered and COBRA beneficiaries are counted (counting number of lives is sometimes referred to as "counting belly-buttons"). See below for details regarding the methods that may be utilized to calculate average number of lives.

Using Part II, Number 133 of Form 720, issuers and plan sponsors are required to report the average number of lives covered under the plan separately for specified health insurance policies and applicable self-insured health plans. That number is then multiplied by the applicable rate for that tax year, as follows:

- **$1** for plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans).
- **$2** for plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014.
- For plan years ending on or after Oct. 1, 2014, the rate will increase for inflation.

The fees for specified health insurance policies and applicable self-insured health plans are then combined to equal the total tax owed.

Exceptions to the General Rule:

- ***Multiple Self-Insured Arrangements***:

  If one plan sponsor maintains two or more self-insured arrangements (e.g., plan sponsor maintains a self-insured HRA or health FSA in addition to self-insured group health plan providing major medical coverage), the arrangements may be combined and treated as single self-insured health plan for purposes of calculating the fee if the plans have the same plan year.

  - Multiple insured arrangements:

    There is no similar rule for lives covered by multiple insured arrangements. A PCORI fee is required for each covered life under each insured arrangement (i.e., there may be more than one PCORI fee payment required for the same covered life even though the arrangements are maintained by a single plan sponsor).

  - Self-funded HRA and Insured Group Health Plan

    If a plan sponsor provides major medical coverage under an insured group health plan and a self-insured HRA, a PCORI fee must be paid on both the HRA (by the plan sponsor) and the insured group health plan (by the insurer), because only multiple self-funded arrangements may be treated as a single plan. This means there may be two PCORI fee payments for the same covered lives even though the HRA and the insured group health plan are maintained by the same plan sponsor. However, the plan sponsor may use the special counting rule below to determine the required fees on the HRA.

- ***Special Exemption for Health FSA Treated as an Excepted Benefit:***

  No PCORI fee will apply to a health FSA that satisfies the requirement of an excepted benefit under IRC Sec. 9832(c) and the special rules under Treas. Reg. Sec. (54.9831-1(c)(3)(v). This means that a health FSA is not subject to the PCORI fee if the health FSA satisfies two conditions:

  (1) Maximum benefit requirement: The maximum benefit payable under the health FSA to any participant in the class for a year cannot 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 for the health FSA for the year, plus $500.

  (2) Availability requirement: Some other non-excepted group health plan coverage (e.g., major medical such as a PPO, HDHP or HMO) must be made available for the year to the class of FSA participant s by reason of their employment. The coverage may be either self-insured by the employer or a fully insured plan sponsored by the employer. In our experience, most employers that offer health FSAs also offer group health coverage and satisfy this requirement.

  For example, a health FSA funded exclusively by employee salary reduction contributions (with annual coverage capped by the amount of the annual salary reduction election) will by, definition, satisfy the maximum benefit requirement.

  However, some health FSAs provide for employer matching funds on elected salary reduction contributions. A health FSA benefit funded directly by an employer in this way, through some form of match, may or may not satisfy the maximum benefit requirement, depending on the level of employer funding. A health FSA with direct employer contributions will generally satisfy the maximum benefit condition, provided the employer matching contribution does not exceed the greater of the participant's salary reduction election or $500. A design that offers direct employer FSA contributions in excess of this level would cause the FSA to be subject to the PCORI fee. Typically, most health FSAs will not be subject to the PCORI fee because they satisfy the requirements to be an excepted benefit.

  If the PCORI fee will apply to a health FSA, the plan sponsor may use the special counting rule below to determine the required fees on the health FSA.

- ***Special Counting Rule for HRAs and FSAs:***

  - Plan sponsors are permitted to assume one covered life for each employee with an HRA.
  - Plan sponsors are permitted to assume one covered life for each employee with an FSA.

CALCULATING THE ANNUAL FEE

Methods for Determining Fees by Health Insurance Companies

1Health insurance companies have the choice of using any of four alternative methods to determine the average number of lives covered under policies that it issues. Insurers may only apply a single method in determining the average number of lives covered under the policy for the year. In addition, insurers must use the same method of counting lives for all policies reported on a single Form 720. (Note: Insurers using the actual count or snapshot method may change to the snapshot or actual count method from one policy year to the next.)

1. ***Actual Count Method***. An insurer may determine the average number of lives covered for the plan or policy year by calculating the sum of the lives covered for each day of the plan or policy year and dividing that sum by the number of days in the plan or policy year.

2. ***Snapshot Method***. An insurer may determine the average number of lives covered under a policy for a policy year by adding the total number of lives covered on a date during the first, second, or third month in each quarter of the policy year, or an equal number of dates for each quarter, and dividing the total by the number of dates on which a count was made (called the "snapshot method"). The regulations do not require that a specific date be used for each month or quarter, but do provide specific rules to ensure that similar dates are used each month (for example, each date used for the second, third, or fourth quarters must be within 3 days of the date that would correspond with the first quarter).

3. ***Members Month Method***. As an alternative to determining the average number of lives covered under each individual policy for its respective policy year, an insurer may determine the average number of lives covered under all policies in effect for a calendar year based on the "member months" reported on the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit divided by 12. The applicable dollar amount with respect to an issuer's policies for the calendar year is the applicable dollar amount for policy years ending on December 31 of such calendar year except that the applicable dollar amount for calendar year 2019 is the applicable dollar amount for policy years ending on September 30, 2019.

4. ***State Form Method***. An insurer that is not required to file the NAIC Exhibit (mentioned above) may determine the average number of lives covered under all of its policies in effect for a calendar year using data in any form that is equivalent to the Exhibit that is filed with the state of domicile if the state form reports lives covered in the same manner as member months is reported on the Exhibit. The applicable dollar amount with respect to an insurer's policies for the calendar year is the applicable dollar amount for policy years ending on December 31 of such calendar year except that the applicable dollar amount for calendar year 2019 is the applicable dollar amount for policy years ending on September 30, 2019.

Methods for Determining Fees by Plan Sponsors of Self-Insured Plans

Plan sponsors with self-insured plans a choice to use any of three alternative methods. Plan sponsors may only apply a single method in determining the average number of lives covered under the plan for the entire plan year. However, a sponsor is not required to use the same method from one plan year to the next.

1. ***Actual Count Method*** (see above)
2. ***Snapshot Method*** (see above). In addition there are 2 methods within the snapshot method to count family members:
   (1) "snapshot count method" requires the plan to count the actual number of lives covered on the designated date; or
   (2) "snapshot factor method" allows the plan to count the number of participants with self-only coverage on the designated date, plus the number of participates with coverage other than self-only coverage on the designated date multiplied by 2.35.
3. ***Form 5500 Method***. Plan sponsors may determine the average number of covered lives covered under the plan for the plan year based on a formula that includes the number of participants actually reported on the Form 5500 for the plan year. A plan sponsor may only use this method if the Form 5500 is filed no later than the due date for the PCORI fee imposed for that plan year (if the plan files for an extension it may not be able to use this method). Under this method, the total number of lives is determined by simply adding the total participant counts at the beginning and end of the year and dividing by 2 for a plan that only offers single coverage. If a plan offers single coverage along with other coverage (e.g., family coverage), the total number of lives is determined by adding the total participant counts at the beginning and end of the year (without dividing by 2).

FILE PCORI FEE SEPARATE FROM OTHER EXCISE TAX LIABILITY

Issuers or plan sponsors that file Form 720 only to report the PCORI fee will not need to file Form 720 for the first, third or fourth quarter of the year.

Issuers or plan sponsors that file Form 720 to report quarterly excise tax liability for the first, third or fourth quarter of the year (for example, to report the foreign insurance tax) should not make an entry on the line for the PCORI tax on those filings.

TYPES OF INSURANCE COVERAGE OR ARRANGEMENTS SUBJECT TO PCORI FEE	PARTY RESPONSIBLE FOR PAYING AND REPORTING THE FEE
Accident and health coverage or major medical insurance coverage	The issuer if insured; the plan sponsor if self-insured
Retiree-only health or major medical coverage	The issuer if insured; the plan sponsor if self-insured
Health or major medical coverage under multiple policies or plans	Each issuer or plan sponsor (unless special rule for coverage under multiple self-insured plans is applicable)
COBRA coverage	The issuer if insured; the plan sponsor if self-insured
Health Reimbursement Arrangement (HRA) (including premium-only HRA), unless satisfies requirement for being treated as an excepted benefit	The plan sponsor; see special rules for coverage under multiple self-insured health plans and special counting rules for HRAs
Flexible Spending Arrangement (FSA), unless satisfies requirement for being treated as an excepted benefit	The plan sponsor; see special counting rules for FSAs
State and local government health or major medical plans for employees and/or retirees	The issuer if insured; the plan sponsor if self-insured

TYPES OF INSURANCE COVERAGE OR ARRANGEMENTS NOT SUBJECT TO PCORI FEE

- Stand-alone dental or vision coverage
- Group insurance policy designed and issued specifically to cover primarily employees working and residing outside the United States
- Self-insured health plan designed specifically to cover primarily employees working and residing outside the United States
- Medicare (the insurance program established under Title XVIII of Social Security Act (SSA))
- Medicaid (the medical assistance program established by Title XIX of the SSA)
- Children's Health Insurance Program (CHIP) the medical assistance program established under Title XXI of the SSA
- Military health plans (program established by Federal law for providing medical care (other than through insurance policies) to individuals (spouses or dependents) by reason of the individual being (or having been) a member of the Armed Forces of the United States)
- Certain Indiana tribe governmental health plans (other than through insurance policies) to members of Indian tribes (as defined in Section 4 (d) Indian Health Care Improvement Act))
- Health Savings Arrangements (HSAs)
- Archer Medical Savings Accounts (MSAs)
- Hospital indemnity or special illness benefits
- Stop-loss or indemnity reinsurance
- Employee assistance programs, disease management programs, or wellness programs (provided the program does not provide significant benefits in the nature of medical care or treatment)
- Accident-only coverage (including accidental death and dismemberment)
- Disability income coverage
- Automobile medical payment coverage
- Workers' compensation or similar coverage
- On-site medical clinic

PCORI FEE PERIODS AND PAYMENT SCHEDULE

Plan Year*	Annual Fee per covered life	When fee must be paid
November 1, 2011 through October 31, 2012	$1	July 31, 2013
December 1, 2011 through November 30, 2012	$1	July 31, 2013
January 1, 2012 through December 31, 2012	$1	July 31, 2013
February 1, 2012 through January 31, 2013	$1	July 31, 2014
March 1, 2012 through February 28, 2013	$1	July 31, 2014
April 1, 2012 through March 31, 2013	$1	July 31, 2014
May 1, 2012 through April 30, 2013	$1	July 31, 2014
June 1, 2012 through May 31, 2013	$1	July 31, 2014
July 1, 2012 through June 30, 2013	$1	July 31, 2014
August 1, 2012 through July 31, 2013	$1	July 31, 2014
September 1, 2012 through August 31, 2013	$1	July 31, 2014
October 1, 2012 through September 30, 2013	$1	July 31, 2014
November 1, 2012 through October 31, 2013	$2	July 31, 2014
December 1, 2012 through November 30, 2013	$2	July 31, 2014
January 1, 2013 through December 31, 2013	$2	July 31, 2014
February 1, 2013 through January 31, 2014	$2	July 31, 2015
March 1, 2013, through February 28, 2014	$2	July 31, 2015
April 1, 2013 through March 31, 2014	$2	July 31, 2015
May 1, 2013 through April 30, 2014	$2	July 31, 2015
June 1, 2013 through May 31, 2014	$2	July 31, 2015
July 1, 2013 through June 30, 2014	$2	July 31, 2015
August 1, 2013 through July 31, 2014	$2	July 31, 2015
September 1, 2013 through August 31, 2014	$2	July 31, 2015
October 1, 2013 through September 30, 2014	$2	July 31, 2015
November 1, 2013 through October 31, 2014	TBD	July 31, 2015
December 1, 2013 through November 30, 2014	TBD	July 31, 2015
January 1, 2014 through December 31, 2014	TBD	July 31, 2015

Fee continues each year, and expires for plans ending before 10/1/2019

The health care reform law—the Affordable Care Act (ACA)—has many complex requirements for employers and health plans. Please contact Kapnick Insurance Group with any questions about how you can prepare for any of the health care reform requirements. This Kapnick Insurance Group Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal or tax advice. The information contained in this communication is intended to provide general information regarding health care reform and related topics, and is based on general information available at the time it was prepared. Readers should contact their tax and/or legal counsel for advice that is appropriate to their specific circumstances. This information cannot be used by any taxpayer to avoid tax penalties.

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