EXPERT UPDATE

Health Reform's PCORI Fees

HENDERSON BROTHERS

The Affordable Care Act established the nonprofit Patient-Centered Outcomes Research Institute to promote the use of evidence-based medicine by disseminating comparative clinical effectiveness research findings. This new Institute, which is funded in part by fees collected from insurers and plan sponsors, will ideally help patients and clinicians to make better informed health care decisions. The fees, which are treated as an excise tax, are often referred to as the "PCORI fees", "PCOR fees" or "CER fees".

The Fees

Insurers are responsible for remitting the fees for "specified health insurance policies" while plan sponsors of "applicable self-insured health plans" are responsible for calculating and paying the PCORI fees. The chart below identifies who is responsible for reporting and remitting the fees:

Health Plan	Responsible Party
Group Health Insurance Policy	The Insurer
Comprehensive Self-Insured Health Plan	The Plan Sponsor
Health Reimbursement Arrangement (w/ Fully-insured plan)	The Plan Sponsor (remits for HRA only)
Medical Flexible Spending Account (when employer contributes)	The Plan Sponsor
Multiemployer Plan	Joint Board of Trustees
MEWA	The Committee
Employee Organization	The Employee Organization
VEBA	Trustee
Rural Cooperative	The Cooperative or Association

Annual Fee Schedule

Plan years ending October 1, 2012 – September 30, 2013:	$1 Per Member for Year
Plan years ending October 1, 2013 – September 30, 2014:	$2 Per Member for Year
Plan years ending October 1, 2014 up to September 30, 2019:	Not determined yet

*Policy years when health plan is fully insured

When to Remit the PCORI Fees

As communicated in a previous HBI compliance update, the Patient Centered Outcomes Research Institute fee is due by July 31, 2013 for plan years that ended on or after October 1, 2012 and before January 1, 2013. The annual fee due by July 31, 2013 is $1 per plan member. Plan years ending January 1, 2013 through September 30, 2013 will owe their first $1 per member fee by July 31, 2014. For all plans the second year fee increases to $2 per member, and then it is adjusted each year thereafter based on increases in the projected per capita amount of national health expenditures. The fee ends in 2019.

Preparing for First Payment

If you are a plan sponsor and one or more of the accident or health plans you provide is a self-insured arrangement with a plan year that ended sometime during fourth quarter 2012, now is the time to evaluate the different methods available for calculating the fees. The final regulations do not permit third-party reporting or payment of the fees, therefore, plan sponsors are required to remit fees directly to the IRS.

Reporting of the Fees on IRS Form 720

The fees are to be reported and paid once a year even though they are reported on an IRS Form 720 which is a Quarterly Federal Excise Tax Return form.

Plans and Benefits Subject to the Fees

A "specified health insurance policy" or "applicable self-insured health plan" is an accident or health program designed or issued to cover **individuals residing in the U.S**. The regulations indicate that an insurance policy or self-insured plan that **covers retirees and COBRA** participants is subject to the fees as well.

A Health Reimbursement Arrangement (HRA) that is designed to reimburse employees for certain out-of-pocket health plan expenses, like deductibles, coinsurance, co-pays, etc. consists of a promise by an employer to reimburse qualified medical expenses. As a result of this commitment to reimburse health expenses, this type of HRA is subject to the PCORI fees. A health Flexible Spending Account (health FSA) that receives contributions from the employer is also subject to the fees. Both the HRA and FSA described above are labeled as "non-excepted" account-based spending accounts and both are considered self-insured group health plans.

Plans that are not Subject to the Fees

The fees do not apply to an insurance policy or self-insured plan where the facts and circumstances show that the plan was designed or the policy was issued specifically to cover primarily employees who are working and residing outside the United States (i.e., Expatriate health plan).
Most EAPs, disease-management and wellness programs are also exempt unless they provide "significant" benefits in the nature of medical care or treatment. Further guidance would be welcome since "significant" has not been clearly defined with respect to medical care and treatment.

We have provided a chart below that summarizes the benefit plans NOT subject to the PCORI fee:

Benefits Not Subject
Coverage for only accident, disability income, or both
Supplement to liability insurance
Liability, general liability & auto liability
Workers compensation or similar insurance
Automobile medical payment insurance
Credit-only insurance
Coverage for on-site medical clinics
Stop Loss policies
Most EAP
Most Disease-management programs
Medical FSA (when contribution is from employee only)
Most Expatriate plans (facts & circumstances test applies)

Not Subject if Offered Separately
Limited scope dental
Limited scope vision
Benefits for long-term care, nursing home care, home health care, etc

Not Subject if Independent and Non-Coordinated
Coverage for specified disease or illness
Hospital Indemnity
Fixed indemnity insurance

Insured & Self-insured Health Plans Provided Together

The preamble states that where an individual is covered by both an **insured** specified health insurance policy and applicable **self-insured** health plan, that individual's life may be counted twice—the statute does not provide a way to allocate the fee between these separate arrangements.

Employers with Multiple Self-Insured Arrangements

When a plan sponsor maintains more than one self-insured accident or health coverage in addition to a self-insured major medical plan (i.e., an HRA or non-Excepted health FSA in addition to a major medical plan), the programs can be treated as a single self-insured health plan as long as the plans are all aligned on the same plan year. This also applies when a plan sponsor offers a self-insured medical plan with a separate self-insured prescription plan that operates on the same plan year. When self-insured plans are combined as stated above, the two arrangements can be treated as one, therefore the same life covered under the two self-insured plans will be counted as ONE life for the purpose of calculating the PCORI fee.

Calculating Fees for Sponsors of Self-Insured Plans

The regulations provide plan sponsors with self-insured plans an option to use any of three different counting methods. Although a plan sponsor may only apply one single method in determining the average number of lives covered under the plan for the entire plan year, it is not required to use the same method from one plan year to the next.

Actual Count Method

Plan sponsors may determine the average number of members (total lives) covered under the plan for the plan year by calculating the sum of the lives covered for each day of the plan year and dividing that sum by the number of days in the plan year. This method is called the "actual count method".

Snapshot Method

Plan sponsors may also determine the average number of lives covered under the plan for the plan year by adding the totals of lives covered on a date during the first, second, or third month in each quarter, or an equal number of dates for each quarter, then dividing that total by the number of dates on which a count was made.
This is 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 (i.e., dates used in each quarter should be within 3 days of the other dates used).

In addition, there are two methods *within* the snapshot method to count family members. One method, the "snapshot count method", requires the plan to count the actual number of lives covered on the designated date. For plan sponsors that have the capability to run a report that captures actual covered members, this appears to be the simplest approach. The other method, the "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.

Form 5500 Method

The third option, the "Form 5500 method", permits plan sponsors to determine the average number of 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 only may use this method if the Form 5500 is filed no later than the due date for the fee imposed for that plan year.** 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).
Important Note: While it makes sense for employers to use this method if they have more than 2 members covered per contract, it probably does not make sense to use this method if the employer wraps all ERISA plans into one single 5500 filing (i.e., "wrap Plan" or "mega-wrap Plan"). This is because generally the employer reports the life insurance participants in the wrap filing, not the health plan participants. In many cases there are more participants in a company paid life plan than there are in a contributory health plan.

Counting for Account-based Plans

Stand-alone plans -If a plan sponsor does not establish or maintain an applicable self-insured health plan other than a non-excepted health FSA or HRA, the plan sponsor may treat each participant's health FSA or HRA as covering a single life (spouses and dependents are not counted). This means that the plan sponsor is not required to include dependents as "lives" under these plans, but instead, only is required to count the employee – i.e., "one life per participant rule"

HRAs integrated with insured coverage - If a plan sponsor has other coverage, but that coverage is fully insured, the plan sponsor generally must remit the PCORI fees with respect to the average number of lives covered by the HRA in addition to the fees that will be paid for the insured plan by the insurer. The HRA's covered lives will be determined using the "one life per participant rule".

(Note, however, that the plan sponsor may disregard the lives covered solely under the fully insured option when counting the number of lives for HRA purposes.)

HRAs integrated with self-funded coverage. - If the same plan sponsor has another applicable self-insured health plan with the same plan year, then each person covered by both plans is only counted once. The individuals covered by both plans are counted using the counting method for the other applicable self-insured health plan (Form 5500 method, Actual Count, Snapshot). The one life per participant rule does not apply to this self-insured health plan package. Please note however, that if the HRA covers anyone who is not also covered under the other plan, the sponsor must pay the fee for those individuals using the one life per participant rule.

Special Transition Rules

The final regulations permit a plan sponsor of an applicable self-insured health plan to use any reasonable method to determine the average number of lives covered under an applicable self-insured health plan for a plan year that began before July 11, 2012 and ended on or after October 1, 2012.

Example: Plan year January 1, 2012 – December 31, 2012. Because this plan year began before July 11, 2012 and ended on or after October 1, 2012, the plan sponsor can use any reasonable method for determining the average number of covered lives on the plan for the first PCORI fee payment, due by July 31, 2013.

Example: Plan year August 1, 2012 – July 31, 2013. Because this plan did NOT begin before July 11, 2012, this self-insured plan sponsor must rely on one of the three counting methods summarized previously. This plan sponsor does not need to remit its first annual $1 per member fee until July 2014.

Source: http://www.hcaa.org/pdfs/Legislative/PPACA_ADMINISTRATORS_710.pdf

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