the Taben Group
Flex Administration in cooperation with Surency life and health

FAQ's: Patient Centered Outcome Research Institute (PCORI) Fee

Background

The Affordable Care Act (ACA) included a requirement that health plan sponsors and issuers of individual and group health insurance policies pay a new fee to help fund the Patient-Centered Outcomes Research Institute (PCORI). It is the intent of the Act that the PCORI will improve health care delivery and outcomes by giving patients a better understanding of the prevention, treatment, and care options available, as well as the science that supports those options.

The IRS recently issued regulations that describe how fees for funding the PCORI should be calculated and paid. Final Regulations were issued on December 2, 2012, following Notice 2011-35, issued in 2011 requesting comments on how the fee should be calculated and paid.

Please note: This notice provides general guidance only and focuses on self-insured requirements particularly as they pertain to Flexible Spending Accounts and Health Reimbursement Arrangements.

How much is the fee?

During its first year (plan years ending on or after October 1, 2012, but before October 1, 2013), the fee will amount to $1 per covered life, per year. During its second year (plan year ending on or after October 1, 2013), the fee will be $2 per covered life. Fees in subsequent plans years are subject to indexing with the fee expiring in 2019.

How are the fees calculated?

Fee amounts are based on the average number of lives covered by certain accident and illness insurance and self-insured health plans during the year. For self-insured plans, the fee is based upon the average number of lives covered by a self-insured plan during the plan year. This includes not only the participant (i.e., the employee or member) but the participant's spouse and dependents covered by the plan. The final regulations make it clear that COBRA qualified beneficiaries and others with continuation coverage and individuals with retiree coverage must also be counted. One limitation is that the fees apply only to U.S. residents.

The Regulations allow plan sponsors to use one of three methods for determining the average number of lives covered by an applicable self-insured health plan during a plan year. They also permit the plan sponsor to change methods each year.

Actual count method

Under this method a plan sponsor would add the total lives covered each day of the plan year and then divide that number by the total number of days in the plan year.

Snapshot methods

There are two "snapshot methods" that may be utilized by the plan sponsor. Under either method, a plan sponsor would add the number of total lives covered by the plan on a date during each quarter and then divide that total by four. A plan sponsor could elect to base the determination on more than one date in each quarter, provided an equal number of dates are used for each quarter (if more than on date is used per quarter, then the total number of lives covered is divided by the total number of dates). The final regulations provide that each date used during the second, third, and fourth quarter must be within three days of the date in that quarter that corresponds to the date used for the first quarter. For this purpose, the 30th and 31st days of a month are treated as the last day of the month for purposes of determining a corresponding date for any month that has fewer than 31 days. All dates must be within the same plan year.

- Factor method. Under this method, the number of lives covered on a date is equal to the sum of the number of participants with self-only coverage on the date plus the number of participants with coverage other than self-only coverage on that date multiplied by 2.35.

- Count method. Under this method, the number of lives equals the actual number of lives covered on the designated date.

Form 5500 method

A plan sponsor may determine the average number of lives covered by a plan for a year based on the number of participants reported on the Form 5500 filed for that plan year. For this method the plan sponsor will add the total number of members at the beginning of the plan year with the total number at the end of the plan year as reported on Form 5500. Then divide the sum by two.

Special rule for first year of PCORI fee

The final regulations provide that 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 year using any reasonable method.

Special rules for Heath Flexible Spending Accounts (FSAs) and HRAs:

The Final Regulations contain special rules for health FSAs that are not HIPAA-excepted benefits and HRAs. The IRS has determined that HRAs and FSAs are self-funded group health plans. Below are special rules that apply to non-excepted FSAs and HRAs:

- If you do not offer a self-funded health insurance plan other that an FSA or HRA, you can treat each employee's FSA or HRA as a covering a single life. You do not have to count spouses or other dependents.
- If your group has fully insured health coverage, the employer will need to pay the fee for HRA or FSA participants.

- If you offer and HRA and/or FSA along with a self-funded health plan and both share the same plan year calendar, then each person covered by both plans would be counted only once, not twice for the health plan and HRA or FSA. If the HRA or FSA covers anyone who is not also covered by the self-funded health plan, you must pay the fee for those individuals using the one life per participant rule.
- If a plan sponsor provides major medical coverage under an insured plan in combination with a self-insured HRA, then the PCORI fee will be assessed on both plans. The insurer will pay the PCORI fee on the insured medical plan, and the plan sponsor will pay the fee on the HRA. In this case plan sponsors can use the special rules discussed below to determine the required fees on the HRA.

Which Health FSAs are HIPPAA-excepted benefits?

Many federal group health plan mandates do not apply to health FSAs that provide only "excepted benefits". These include an exception from the PCORI Fee and certain other health care reform mandates (see below), as well as the HIPAA portability requirements. Further, if your health FSA is an excepted benefit may be able to take advantage of the special limited COBRA obligation.

Benefits provided under a health FSA are excepted for a "class of participants" if the health FSA is a health flexible spending arrangement as defined in Code *106(c) (2) and meets two conditions:

- *Maximum Benefit Condition*. The maximum benefit available through the health FSA to each participant for a plan year cannot exceed two times the participant's salary reduction election under the health FSA for the year (or, if greater, the amount of the participant's salary reduction election for the health FSA for the year, plus $500). In short, a health FSA will meet this condition if the employer either:
    - Does not contribute to the health FSA
    - Contributes a one-for-one employer match (employer $600, employee $600).
    - An employer contribution of $500 or less (employer $500, employee $200).
- *Availability Condition*. Other non-excepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their employment.

What plans are NOT subject to the fee?

The final regulations clarify that the following plans are not subject to the PCORI fee because they are not considered to be accident and health coverage:

- Plans that provide HIPAA accepted benefits, including limited-scope dental and vision plans, onsite medical clinics, accident-only or disability-only plans, and most FSAs, i.e. accepted benefits FSAs discussed above.
- Employee assistance, disease management, and wellness programs that do not provide significant benefits for medical care or treatment.
- Expatriate plans that are specifically designed to cover primarily employees working or residing outside of the US. (For this purpose, the US includes American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Virgin Islands, and any other US possessions.) The final

regulations permit the plan sponsor to rely on the most recent address on file and to treat all family members as having the same place of abode in determining whether an individual is residing in the US.

Who is responsible to pay the fee?

The PCORI organization is supported by a trust fund financed in part by fees from health plan issuers (for fully insured plans) and plan sponsors (for self-funded plans). The organization responsible for paying the fee is determined by whether the plan in question if fully insured or self-funded. For self-funded plans the employer (i.e. plan sponsor) pays the fees. The Internal Revenue Service (IRS) does not intend to develop a process to allow third parties to file and pay this fee on behalf of self-funded employer groups. This is because plan administrators may not be aware of other plans to which the fee applies as well of the fact that the fee reporting is to be included in the applicable employer's Quarterly Federal Excise Tax Return Form.

How is the tax paid?

The IRS will treat this fee as an excise tax. Therefore, it will be included with the Quarterly Federal Excise Tax Return Form 720.

When is the due date for filing the excise tax?

The IRS Form 720 must be filed by July 31 of the year after your self-funded plan year ends. For example, if the last day of your group's plan year is October 30, 2012, you will have to file form 720 by July 31, 2013.

Additional Questions?

Contact Jackie Bone, Manger of Flex Services, at 800-675-7341 ext. 102 or jbond@taben.com