BURR ALERT

HEALTH CARE REFORM

PCORI FEE DEADLINE LOOMS FOR SELF-INSURED HEALTH PLANS

The Patient Centered Outcome Research Institute was created under the Affordable Care Act to "promote the use of evidence-based medicine by disseminating comparative clinical effectiveness research findings." The Institute is funded by a fee (the PCORI fee) assessed on the plan sponsor (generally the employer) of applicable self-insured health plans and by issuers of specified insurance policies. This alert addresses the PCORI fee owed by sponsors of self-insured plans. The fee is in effect for plan years ending on/after October 1, 2012 and before October 1, 2019.

Types of Plan Affected. The applicable self-insured health plans on which the PCORI fee is based are plans providing accident and health coverage where any part of the coverage is not provided by an insurance policy. Note that if a plan is partially self-insured and partially insured, the employer must treat the non-insured portion as a self-insured plan for purposes of the fee. Affected plans include: major medical plans, prescription drug plans, retiree plans and dental/vision/HRA/FSA plans that are not excepted from HIPAA. Plans excluded from the fee are: excepted benefits under HIPAA (such as stand alone dental and visions plans and certain HRA and FSA plans), HSAs, plans primarily covering ex-patriots, and wellness/EAPs if the plan does not provide significant benefits in the nature of medical care.

Calculation of Fee. For the initial year, the fee is one dollar per average covered life. Generally, a covered life includes every individual covered under the plan, including the employee/participant, covered spouse and dependents. An exception applies for HSA and FSA plans (if not excluded) where the employer sponsors another self-insured health plan (other than an HRA or FSA) with the same plan year. In that case, the employee/participant is the only covered life counted. Because many employers sponsor more than one health plan, covered plans having the same plan year may be aggregated. This means that the same individual who is covered by more than one plan will be counted only one time. Retirees, COBRA qualified beneficiaries, and statutory employees (such as life insurance agents) are also included in the count as covered lives.

Regulations provide three safe harbor methods for calculating the number of covered lives. However, for the initial year, plan sponsors may use "any reasonable method" for calculating the average number of covered lives for the plan year. The three safe harbor methods are: actual count, snapshot, and Form 5500. For plans that file a Form 5500, the Form 5500 method will probably be the easiest to calculate. It is based on the participant count reported on a timely filed 5500 for the plan year. For this purpose, "timely" means it is filed by the non-extended due date. The number of covered lives is the sum of the number of participants reported at the beginning of the plan year and at the end of the plan year. Under the actual count method, the actual lives covered on each day of the plan year are added for each day, then the total is divided by the number of days in the plan year resulting in the average number of covered lives. The snapshot method also involves counting the actual number of lives covered, but on select days during the

plan year. One date must be used during each quarter, and the date selected must be consistent across all four quarters. For example, if for the first quarter the date selected falls in the first month of the quarter, then the date selected for the remaining quarters must also fall within the first month of the subsequent quarters. In addition, the actual day of the month must be within three days of the date used for the first quarter. Instead of counting the actual number of lives covered on the selected date, under a variation of the snapshot method known as the factor method, the number of covered lives may be calculated as the sum of (i) the number of participants with employee only coverage plus (ii) the number of participants with any other type of coverage multiplied by 2.35.

Payment of fee. The PCORI fee is due to be paid no later than July 31 of the calendar year that follows the last day of the plan year. **For plan years that ended during October, November, or December of 2012, the initial fee is due by July 31, 2013.** For plan years that end during 2013, the fee is due July 31, 2014. The fee is paid annually using IRS Form 720. Click Form 720 for a link to the form and click here for a link to the instructions. Note that per the Department of Labor, the PCORI fee may not be paid out of ERISA plan assets unless the plan is a multiemployer plan. However, the IRS has issued guidance stating that the fee is deductible as an ordinary and necessary business expense.

For questions or assistance with the PCORI fee or any other health care reform issue, contact:

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