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Health Plans: PCORI Fee Is Due August 1, 2022

by Karen K. Hartford on June 23, 2022

What is the PCORI Fee?

The Affordable Care Act created a non-profit corporation, the Patient-Centered Outcomes Research Institute ("PCORI"), to conduct research to help individuals, providers, and policymakers make better healthcare choices by advancing comparative clinical effectiveness research. PCORI is financed by a fee imposed under Internal Revenue Code ("Code") Sections 4375 and 4376 on insurers of fully insured health plans and employers that sponsor self-insured health plans ("PCORI Fee").

The PCORI Fee was originally effective for plan years ending on or after October 1, 2012, and before October 1, 2019, but the Further Consolidated Appropriations Act of 2020 extended the PCORI fee through plan years ending on or before October 1, 2029. Final Regulations interpreting the law were published December 6, 2012.

This post addresses the PCORI fee obligations of plan sponsors with respect to self-insured health plans and does not address the PCORI fee obligations of insurers with respect to fully-insured health plans.

When is the PCORI Fee Due and How is it Reported?

The PCORI Fee is paid annually and is due by the July 31 immediately following the end of the calendar year in which the plan year ends unless that date falls on a weekend or federal holiday. ***For plan years ending in 2021, the fee is due by August 1 because July 31, 2022, is a Sunday.***

The PCORI fee is paid using Part II of IRS Form 720, Quarterly Federal Excise Tax Return. Electronic filing is available through the Electronic Federal Tax Payment System ("EFTPS") but is not required. Although Form 720 is a quarterly return, if it is used to pay PCORI Fees alone, it need only be filed once per year, for the second quarter.

What Self-Insured Plans are Subject to the Fee?

According to the preamble to the Final Regulations, the fee for self-insured plans applies to "any plan . . . providing accident or health coverage if any portion of the coverage is provided other than through an insurance policy" and the plan is established or maintained for employees or former employees by an employer, a union, or certain groups of employers (identified under the next question), *except* the following:

- government programs such as Medicare, Medicaid, the Children's Health Insurance Program, military health plans, and certain Indian tribal government health plans;
- HIPAA-excepted benefits under Code Section 9832(c), such as standalone dental or vision plans, accident-only plans, disability-only plans, hospital indemnity or specified illness benefit plans, onsite medical clinics, and healthcare Flexible Spending Accounts (FSAs) *unless* the FSA is a "non-excepted benefit" FSA, meaning that the employer contributes to the FSA: (i) more than $500 per plan year, or (ii) a dollar-for-dollar match of the employee's contribution;
- plans designed to cover primarily employees working and residing outside of the United States ("Expatriate Plans");
- Health Savings Accounts ("HSAs"); and
- Employee Assistance Plans ("EAPs"), Disease Management Plans, and Wellness Plans that do not provide "significant medical care or treatment." Note that there is currently no guidance defining "significant medical care or treatment."

To be clear, retiree-only plans and Health Reimbursement Arrangements (HRAs) are subject to the PCORI Fee.

Who Pays the PCORI Fee for Self-Funded Plans?

The PCORI Fee is imposed on the plan sponsor of self-insured health plans. The plan sponsor is:

- the employer, for a single employer plan;
- the employee organization, for a plan maintained by an employee organization;
- the joint board of trustees, for a multiemployer plan as defined in ERISA Section 3(37);
- the committee administering a multiple employer welfare arrangement as defined in ERISA Section 3(40) ("MEWA");
- the trustee of a voluntary employees' beneficiary association described in Code Section 501(c)(9); or
- the cooperative or association that establishes a rural electric cooperative as defined in ERISA Section 3(40)(B)(iv) or rural telephone cooperative association, as defined in ERISA Section 3(40)(B)(v).

How Is the Fee Calculated?

Generally, the amount of the PCORI Fee is the product of the average number of "covered lives" for the plan year multiplied by the "applicable dollar amount" for the plan year.

Covered Lives

"Covered lives" means participants, spouses, dependents, COBRA beneficiaries, and alternate payees.

Applicable Dollar Amount

The "applicable dollar amount" is adjusted and published annually by the IRS to reflect inflation in National Health Expenditures, as determined by the Secretary of Health and Human Services. For plan years ending after September 30, 2020, and before October 1, 2021, the applicable dollar amount is $2.66. For plan years ending after September 20, 2021, and before October 1, 2022, the applicable dollar amount is $2.79.

Counting Covered Lives

For self-insured plans, there are three options for counting covered lives: (i) the actual count method; (ii) the Form 5500 method; and (iii) the snapshot method, which itself includes two alternatives. The three methods are summarized below, but more details may be found in Section 46.4376-1 of the Final Regulations.

- ***Actual Count Method***: This method requires calculating the sum of the actual number of covered lives for each day of the plan year and dividing that sum by the number of days in the plan year.
- ***Form 5500 Method***: This method uses the participant counts reported on Form 5500 to calculate the average number of covered lives. The wrinkle with this method is that the plan sponsor must file Form 5500 by the due date for the PCORI Fee (generally, July 31); therefore, if a calendar-year plan sponsor files Form 5500 on extension, as many do, it cannot use this method. To determine a plan's average covered lives using the Form 5500 method, a plan that offers only single coverage will add the participant count reported at the start of the year to the participant count reported at the end of the year and divide that sum by 2. Plans that offer other coverage levels (*e.g.,* employee + 1, family coverage) simply add the participant counts at the start and end of the year, without dividing by 2.
- ***Snapshot Method***: This method includes two alternatives.
    - The "snapshot count" method calculates covered lives by adding the total lives covered on a date or dates during the first, second, or third month of each quarter of the plan year, and then dividing the sum by the number of dates on which the count was made. The dates selected from each quarter do not have to

be the same, but the dates from the second, third, and fourth quarter must be within 3 days of the date that corresponds to the date from the first quarter.

- The "snapshot factor" method works the same as the snapshot count method except instead of counting all covered lives on the snapshot date, it requires counting the number of participants with self-only coverage on the snapshot date and the number of participants with other coverage levels on the snapshot date. The calculation of average covered lives on the snapshot date is equal to the sum of: (a) the number of participants with self-only coverage on the snapshot date, plus (b) the number of participants with other coverage levels on the snapshot date multiplied by 2.35; all divided by the total number of dates on which the count was made.

Special Rules for Counting Lives in Non-Excepted Benefit FSAs, HRAs and For Multiple Self-Funded Plans

Plan sponsors that maintain only a non-excepted benefit FSA or an HRA need only count one covered life for each participant in the FSA or HRA. In other words, even though funds from an FSA or HRA may be used to provide benefits to spouses or dependent children, in this limited circumstance, the plan sponsor may disregard other beneficiaries in the count of covered lives and simply count individual participants.

In addition, plan sponsors that maintain multiple self-insured plans with the same plan year need not count a life participating in multiple self-insured plans more than once. Stated another way, a plan sponsor may aggregate multiple self-insured plans with the same plan year and treat them as a single plan for purposes of calculating the PCORI Fee. It is important to note, however, that the plans must all be self-insured to qualify for aggregation. For example, if a plan sponsor maintains an HRA that is integrated with a fully insured major medical plan, the plan sponsor will incur a PCORI Fee for its HRA participants, and the insurer will pay a second PCORI Fee for the same participants who participate in the insured medical plan.

What Else Should an Employer Sponsoring a Self-Insured Health Plan Know?

- Because the PCORI Fee is imposed on the plan sponsor and not the plan, the Department of Labor has indicated that the fee may not be paid from plan assets (*i.e.*, assets held in a trust or employee contributions for the benefits).
- The PCORI Fee is deductible by the plan sponsor as an ordinary and necessary business expense under Code Section 162(a).
- If the plan sponsor discovers a mistake in the Form 720 filing after it is submitted, including an overpayment, it can file an amended return using Form 720-X.

- The Instructions to Form 720 provide that plan sponsors should keep records of the Form 720 filing for at least four years. Be sure to retain records to substantiate the calculation of the PCORI Fee.

August 1 is fast approaching. If you need assistance identifying the plans subject to the fee or calculating your plans' liability, or if you have general questions regarding the PCORI Fee, please contact a member of our Employee Benefits & Executive Compensation Group.

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