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Patient-Centered Outcomes Research Institute Fees (PCORI Fees)

The Affordable Care Act (ACA) created the Patient-Centered Outcomes Research Institute (Institute) to help patients, clinicians, payers and the public make informed health decisions by advancing comparative effectiveness research. The Institute's research is to be funded, in part, by fees paid by health insurance issuers and sponsors of self-insured health plans. These fees are widely known as Patient-Centered Outcomes Research Institute fees (**PCORI fees**), although they may also be called PCOR fees or comparative effectiveness research (CER) fees.

On Dec. 5, 2012, the Internal Revenue Service (IRS) issued **final regulations** on the PCORI fees. The final regulations address many important details regarding which health insurance issuers and plan sponsors are subject to the fees and how the fees are calculated and paid. For example, the regulations address how the PCORI fees apply to health reimbursement arrangements (HRAs) and health flexible spending accounts (FSAs).

The final regulations apply to **plan years ending on or after Oct. 1, 2012 and before Oct. 1, 2019**.

On May 28, 2013, the IRS released an **updated Form 720** that includes a section where issuers and plan sponsors will report and pay the PCORI fee. The IRS also released updated instructions along with the revised form.

WHEN ARE THE PCORI FEES EFFECTIVE?

The PCORI fees apply for **plan years ending on or after Oct. 1, 2012**. The PCORI fees do *not* apply for plan years ending on or after **Oct. 1, 2019**. For calendar year plans, the research fees will be effective for the 2012 through 2018 plan years.

HOW MUCH ARE THE PCORI FEES?

For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee is **$1** multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2013 and before Oct. 1, 2014, the fee is **$2** multiplied by the average number of lives covered under the plan.

For plan years ending on or after Oct. 1, 2014, the PCORI fee amount will grow based on increases in the projected per capita amount of National Health Expenditures.

WHAT POLICIES AND PLANS ARE SUBJECT TO PCORI FEES?

Health Insurance Policies and Health Plans

The PCORI fees apply to "specified health insurance policies" and "applicable self-insured health plans." ACA broadly defines these terms as follows:

- *Specified Health Insurance Policy* - An accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States, including prepaid health coverage arrangements.
- *Applicable Self-Insured Health Plan* - A plan providing accident or health coverage, any portion of which is provided other than through an insurance policy, which is established or maintained: (1) by one or more employers for the benefit of their employees or former employees; (2) by one or more employee organizations for the benefit of their members or former members; (3) jointly by one or more employers and

one or more employee organizations for the benefit of employees or former employees; (4) by a voluntary employees' beneficiary association (VEBA); or (5) by other specified organizations, including a multiple employer welfare arrangement (MEWA).

Governmental Entities

Governmental entities that are health insurance issuers or sponsors of self-insured health plans are subject to the PCORI fees, except the fees do not apply to "exempt governmental programs" – Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and any program established by federal law to provide medical care (other than through insurance policies) for members of the Armed Forces or veterans or for members of Indian tribes.

Excepted Benefits

The PCORI fees do *not* apply if substantially all of the coverage under a plan is for excepted benefits, as defined under HIPAA. Excepted benefits include, for example, stand-alone dental and vision plans, accident-only coverage, disability income coverage, liability insurance, workers' compensation coverage, credit-only insurance or coverage for on-site medical clinics.

A health FSA qualifies as an excepted benefit if: (1) other group health plan coverage, not limited to excepted benefits, is made available to the eligible class of participants; and (2) the maximum benefit payable under the FSA to any eligible participant does not exceed two times the participant's salary reduction election (or, if greater, $500 plus the amount of the salary reduction election).

Retiree Health Plans

Although stand-alone retiree health plans are generally exempt from many of ACA's requirements, sponsors and issuers of these plans are subject to the PCORI fees, unless the plan qualifies as an excepted benefit under HIPAA.

Continuation Coverage

The final regulations clarify that if continuation coverage under COBRA (or similar continuation coverage under federal or state law) provides accident and health coverage, the coverage is subject to ACA's PCORI fees.

Multiple Health Plans

There has been uncertainty regarding how the PCORI fees apply when an employer sponsors more than one health plan for its employees, for example, a full-insured major medical insurance policy and a self-insured prescription drug plan. The final regulations address this issue.

As a general rule, the final regulations do *not* allow an issuer or plan sponsor to disregard a covered life when calculating its PCORI fees merely because that individual is also covered under another specified health insurance policy or applicable self-insured plan.

However, the regulations provide that multiple, self-insured arrangements established and maintained by the same plan sponsor with the same plan year are subject to a single fee. For example, if a plan sponsor establishes or maintains a self-insured arrangement providing major medical benefits, and a separate self-insured arrangement with the same plan year providing prescription drug benefits, the two arrangements may be treated as one applicable self-insured health plan so that the same life covered under each arrangement would count as only one covered life under the plan for purposes of calculating the fee.

HRAs and Health FSAs

Under the final regulations, HRAs and health FSAs are not completely excluded from the obligation to pay PCORI fees. However, under the special rule for multiple, self-insured arrangements, an HRA is not subject to a separate research fee if it is integrated with another self-insured plan providing major medical coverage, provided the HRA and the plan

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are established and maintained by the same plan sponsor and have the same plan year. This rule allows the sponsor to pay the PCORI fee only once with respect to each life covered under the HRA and other plan.

However, if an HRA is integrated with an insured group health plan, the plan sponsor of the HRA and the issuer of the insured plan will both be subject to the research fees, even though the HRA and insured group health plan are maintained by the same plan sponsor.

The same analysis applies to health FSAs that do not qualify as excepted benefits.

Employee Assistance, Disease Management and Wellness Programs

The final regulations clarify that employee assistance programs (EAPs), disease management programs and wellness programs that do not provide significant benefits in the nature of medical care or treatment are not subject to the PCORI fees. This exception also covers an insurance policy to the extent it provides for an EAP, disease management program or wellness program, if the program does not provide significant benefits in the nature of medical care or treatment.

WHO MUST PAY THE PCORI FEES?

The entity that is responsible for paying the PCORI fees depends on whether the plan is insured or self-insured.

- For insured health plans, the **issuer** of the health insurance policy is required to pay the research fees.
- For self-insured health plans, the research fees are to be paid by the **plan sponsor**.

Although sponsors of fully-insured plans are not responsible for paying research fees, issuers may shift the fee cost to sponsors through a modest premium increase.

The Department of Labor (DOL) has advised that, because the PCORI fees are imposed on the plan sponsor under ACA, it is not permissible to pay the fees from plan assets under ERISA, although special circumstances may exist in limited situations. On Jan. 24, 2013, the DOL issued a set of answers to frequently asked questions (FAQs) regarding ACA implementation. These FAQs include a limited exception that allows multiemployer plans to use plan assets to pay PCORI fees, unless the plan document specifies another source of payment for the fees.

The final regulations provide that when two or more related employers provide health coverage under a single self-insured plan, the employer responsible for the PCORI fees is the one designated in the plan documents as the plan sponsor or as the plan sponsor for purposes of reporting the research fees. This designation must be made by the due date for reporting the research fees, which is July 31 of each year for plan years ending in the preceding calendar year. If this designation is not made in a timely fashion, then each employer is required to report and pay research fees with respect to its own employees.

HOW ARE THE PCORI FEES CALCULATED?

The PCORI fees are based on the **average number of lives covered** under the plan or policy. This generally includes employees and their enrolled spouses and dependents. The final regulations clarify that individuals who are receiving **continuation coverage** (such as COBRA coverage) must be included in the number of covered lives under the plan in calculating the PCORI fee.

The final regulations outline a number of alternatives for issuers and plan sponsors to determine the average number of covered lives. As a general rule, plan sponsors and issuers may only use one method for determining the average number of covered lives for each plan year.

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Insured Health Plans

Health insurance issuers have the following options under the final regulations for determining the average number of covered lives:

- *Actual Count Method* – This method involves calculating the sum of lives covered for each day of the plan year and dividing that sum by the number of days in the plan year.
- *Snapshot Method* – This method involves adding the total number of lives covered on a date in each quarter of the plan 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.
- *Form Method* – As an alternative to determining the average number of lives covered under each individual policy for its respective plan year, this method involves determining the average number of lives covered under all policies in effect for a calendar year based on the data included in the National Association of Insurance Commissioners Supplemental Health Care Exhibit (Exhibit) that some issuers are required to file. For issuers that are not required to file an Exhibit, there is a similar available method that uses data from equivalent state insurance filings.

Self-insured Health Plans

Sponsors of self-insured plans may determine the average number of covered lives by using the *actual count method* or *snapshot method*. Alternatively, plan sponsors may use the *Form 5500 method*, which involves a formula using the number of participants reported on the Form 5500 for the plan year.

For HRAs and health FSAs that are required to be reported separately (for example, because they are integrated with an insured group health plan and do not qualify as excepted benefits), the regulations simplify the determination of average number of covered lives by allowing plan sponsors to assume one covered life for each employee with an HRA or health FSA.

In addition, the final regulations permit a self-insured health plan that provides accident and health coverage through fully-insured options and self-insured options to determine the plan's PCORI fees by disregarding the lives that are covered solely under the fully-insured options.

Under a special transition rule, for plan years that end on or after Oct. 1, 2012 and began before July 11, 2012, plan sponsors of self-insured plans may use any reasonable method for determining the average number of covered lives under the plan.

HOW ARE THE PCORI FEES REPORTED AND PAID?

In general, the PCORI fees are assessed, collected and enforced like taxes under the Internal Revenue Code. The final regulations direct issuers and plan sponsors to report and pay the research fees once a year on **IRS Form 720** (Quarterly Federal Excise Tax Return).

Form 720 and full payment of the research fees will be due by **July 31** of each year. It will generally cover plan years that end during the preceding calendar year. Thus, the first possible deadline for filing Form 720 is **July 31, 2013**.

On May 28, 2013, the IRS released an **updated Form 720** that includes a section where issuers and plan sponsors will report and pay the PCORI fee. The IRS also released updated instructions along with the revised form.

On Jan. 24, 2013, the Departments of Labor, Health and Human Services (HHS) and the Treasury (Departments) issued **ACA Implementation FAQs** that address payment of PCORI fees from plan assets. In general, because the fee is imposed on the plan sponsor and not on the plan itself, the plan sponsor must pay the fee outside the plan, meaning that **plan assets cannot be used to pay the fee**. However, there are certain circumstances in which PCORI fees may be paid from plan assets.

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Multiemployer Plans

In the case of a multiemployer plan, the plan sponsor liable for the PCORI fee would generally be the independent joint board of trustees appointed and directed to establish the employee benefit plan. According to the Departments, a multiemployer plan's joint board of trustees would be **permitted to pay PCORI fees from assets of the plan**, unless the plan document specifies a source other than plan assets for payment of the fee.

The Employee Retirement Income Security Act (ERISA) imposes certain responsibilities on fiduciaries that are designed to avoid misuse and mismanagement of plan assets. Generally, plan assets must be used for the exclusive benefit of plan participants and beneficiaries.

The Departments understand that a multiemployer plan's joint board of trustees normally has no function other than to sponsor and administer the multiemployer plan and has no source of funding independent of plan assets to pay PCORI fees. The fee is not an excise tax or penalty imposed on the trustees in connection with a violation of federal law or a breach of their fiduciary obligations in connection with the plan.

In addition, the Departments stated that the joint board would not be acting in a capacity other than as a fiduciary of the plan in paying a PCORI fee. As a result, the Departments believe that it would be unreasonable to construe ERISA's fiduciary provisions as prohibiting the use of plan assets to pay a PCORI fee to the Federal government.

Non-Multiemployer Plans

According to the Departments, there may be rare circumstances where sponsors of employee benefit plans that are not multiemployer plans would also be able to use plan assets to pay the PCORI fee. For example, a VEBA that provides retiree-only health benefits may be able to use plan assets to pay a PCORI fee if the sponsor is a trustee or board of trustees that:

- Exists solely for the purpose of sponsoring and administering the plan; and
- Has no source of funding independent of plan assets.

However, this exception would not necessarily apply to other plan sponsors required to pay the PCORI fee. For example, a group or association of employers that act as a plan sponsor, but that also exist for reasons other than solely to sponsor and administer a plan, may not use plan assets to pay the fee even if the plan uses a VEBA trust to pay benefits under the plan. These entities or associations, such as employers that sponsor single employer plans, would have to identify and use some other source of funding to pay the PCORI fee.

ARE THE PCORI FEES DEDUCTIBLE?

On May 31, 2013, the IRS issued a Chief Counsel Memorandum addressing the deductibility of the PCORI Fees. According to the IRS, the required PCORI fee will be an ordinary and necessary business expense paid or incurred in carrying on a trade or business and, therefore, will be deductible under Section 162 of the Internal Revenue Code.

WHAT SHOULD EMPLOYERS DO NOW?

Because the first possible deadline for reporting and paying the PCORI fees is July 31, 2013, employers have some time before they must start paying these research fees. However, employers should take the following steps to assess their compliance obligations:

- Determine which employee benefit plans will be subject to the research fees;
- Assess plan funding status (insured vs. self-insured) to determine whether the employer or a health policy issuer will be responsible for the fees; and
- For any self-insured plans, select an approach for calculating average covered lives.

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