UBA PPACAAdvisor

Highlights of the Patient-Centered Outcomes (PCORI) / Comparative Effectiveness Fee

Updated June 2014

The Patient-Centered Outcomes Research Institute (PCORI) fee applies from 2012 to 2019. The fee is due based on plan/policy years *ending* on or after October 1, 2012, and before October 1, 2019. The fee is due by July 31 of the year following the calendar year in which the plan/policy year ended. This means that the first fee was due July 31, 2013, for those on November, December, and calendar year plan years. The first fee is not due until July 31, 2014, for those with plan years that start January 2 through October 1.

The fee will be calculated and paid by the insurer for fully insured plans (although the fee is usually being passed on to the plan). The plan sponsor of self-funded plans (which is usually the employer) must file and pay the fee for those plans. (If the plan uses a third party administrator, the TPA may assist with the calculation, but the plan sponsor must file the form.) Health reimbursement arrangements (HRAs) are considered self-funded plans, so employers will need to file for those plans, even if the insurer is filing for the related fully insured medical plan. If multiple employers participate in the plan, each must file separately unless the plan document designates one of them as the plan sponsor.

The fee is based on covered lives, so employees, retirees and COBRA participants and their covered dependent spouses and children are all counted. However, only the employee, retiree or COBRA participant needs to be counted for an HRA or a health flexible spending account (health FSA) – dependents covered by these accounts can be excluded.

The first year the fee is due, the fee is $1 per covered life during the plan or policy year. For the second year, the fee is $2 per covered life during the year. For the third through seventh years, the fee will be $2, adjusted for medical inflation, per covered life.

The fee applies to all types of employers, including private, government, not-for-profit and church employers. Grandfathered plans must pay the fee.

The fee is due on “group health coverage” which includes all medical plans. Retiree-only plans must pay this fee. “Group health coverage” does not include:

- Stand-alone dental and vision coverage (stand-alone means these benefits are elected separately from medical or are under separate policies)
- Life insurance
- Short- and long-term disability and accident insurance
- Long-term care
- Health FSAs to which only employee contributions, or minimal employer contributions are made, as long as the employee is eligible for medical coverage, too
- Health savings accounts
- Hospital indemnity or specified illness coverage
- Employee assistance and wellness programs that do not provide significant medical care or treatment
- Stop-loss coverage

Several options are available for calculating the fee:

- Actual count method – The plan counts its covered lives on each day of the plan year, and averages the result.
- Snapshot method – The plan determines the number of covered lives on the same day (plus or minus three days) of each quarter or month, and averages the result. (This method also allows the plan to count employees and retirees with self-only coverage separately from those with dependent coverage, and then multiply the count of employees and retirees who have dependent coverage by 2.35 to approximate the number of covered dependents, rather than actually counting them.)
- Form 5500 method – The plan determines the number of participants at the beginning and end of the plan year as reported on Form 5500. If dependents are covered, the plan adds the participant count for the start and the end of the plan year to get the total reportable lives. If dependents are not covered, the plan adds the participant count for the start and the end of the plan year and averages the result (this method cannot be used by insurers). Form 5500 must be filed by July 31 to use this option.

The same method must be used throughout a reporting year, but it may be changed from year to year.

If there are multiple self-funded plans (e.g., self-funded medical and HRA) with the same plan year, only one fee would apply to a covered life. However, if there are both fully insured and self-funded plans, a fee would apply to each plan unless the employee is only covered under one type of plan – the insurer would pay the fee on the insured coverage and the plan sponsor would pay the fee on the HRA. For example, with a fully insured medical plan and an integrated self-funded HRA, the insurer would pay a fee on the employees and dependents covered under the fully insured medical policy and the employer would pay a fee on the employees (but not the dependents) covered under the HRA.

The plan sponsor must report and pay the fee on IRS Form 720 each July 31. This will be an annual filing, even though Form 720 is generally filed quarterly. The plan sponsor may file electronically or with paper.

Note: PPACA created a private non-profit corporation called the Patient-Centered Outcomes Research Institute (PCORI). The Institute's job is to research the comparative effectiveness of different types of treatment for certain diseases, and to share its findings with the public and the medical community. The goal is to improve quality of treatment and reduce unnecessary spending. This fee is to support this research.

For additional information, please see:

- Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377): Questions and Answers
- An IRS chart that shows which types of benefits the fee applies to: Application of the Patient-Centered Outcomes Research Trust Fund Fee to Common Types of Health Coverage or Arrangements
- IRS Form 720
- IRS Form 720 instructions (see pages 8 to 9)

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