As a reminder, Patient-Centered Outcomes Research Institute (PCORI) Fees are due no later than July 31, 2015. This applies to many insurers and self-funded plans with a calendar year plan or reporting years beginning on or after January 1, 2014 and ending December 31, 2014. This also applies to certain tax-exempt entities. The following is a reminder regarding the reason for the fee, the amount of the fee and how to report and pay the fee.

The PCORI fee supports clinical effectiveness research which is intended to assess the clinical effectiveness, risk and benefits of available medical treatments. The PCORI Fee is part of the Affordable Care Act (ACA) and is imposed on health insurers and plan sponsors of self-insured health plans. Fees are reported on Internal Revenue Service (IRS) Form 720. For policy and plan years ending after September 30, 2014, and before October 1, 2015, the applicable dollar amount is $2.08. Fees apply to policy or plan years ending on or after October 1, 2012, and before October 1, 2019.

1) **Payment Process and Timing**
   a) PCORI fees are to be reported and paid once a year, even though they are reported on IRS Form 720 (Quarterly Federal Excise Tax Return).
   b) Reports and payments for policy and plan years that end on the calendar year are due by July 31 of the following year (plans ending on December 31, 2014, must pay fees by July 31, 2015).
   c) Employers who do not file any other federal excise taxes using Form 720 need only to file by July 31, the close of the second quarter. Employers required to file other quarterly federal excise taxes are required to file for PCORI fees at the close of the second quarter. Lines requiring PCORI fee information may be left blank for first, third and fourth quarter filings.

Form 720 and instructions may be found at www.irs.gov. The portion of Form 720 applicable to PCORI fees can be found on page 2, Part II, Line 133. Please review the applicable instructions to assist in your filing.

As a reminder, the fee is applied and determined based on the following:

2) **Affected Policies or Plans**
   a) The fees paid by insurers generally apply to any accident or health insurance policy issued with respect to U.S. residents.
   b) The fees paid by self-insured plan sponsors generally apply to plans established or maintained by an employer or employee organization (or by certain other entities, including VEBAs) that provide health or accident coverage, so long as any portion of that coverage is not provided through an insurance policy. Policies and plans are not subject to the fees if they cover only excepted benefits.
   c) Also exempt are EAPs, disease-management programs and wellness programs if they do not provide significant benefits in the nature of medical care or treatment.
   d) No exclusion is provided for retiree-only plans.

e) Under the proposed regulations, **plan sponsors of fully-insured health plans are not responsible for the fees; only plan insurance carriers.**

3) **Definition of Self-Insured Plan Sponsor**

a) Controlled group rules do not apply to PCORI fees. Consequently, if a plan is maintained by more than one employer, each employer that maintains the plan will generally be responsible for filing and paying its portion of the fees.

4) **Multiple Self-Insured Arrangements**

a) If the same plan sponsor maintains more than one arrangement that provides self-insured accident or health coverage [e.g., if the sponsor maintains a health reimbursement arrangement (HRA) or health flexible spending account (FSA) in addition to major medical coverage] the arrangements can be treated as a single self-insured health plan if the arrangements have the same plan year.

b) If the same plan sponsor maintains a separate fully-insured plan in addition to an HRA or FSA, the insurer is responsible for payment of the fee for the fully-insured health plan. The plan sponsor is responsible for counting the covered lives and payment of the fee for the HRA or FSA.

c) Health FSAs are generally excepted benefits, meaning that few FSAs will incur a fee. The fee applies when a health FSA is offered without other conventional group health plan coverage. The PCORI fee also applies when the employer contribution to the FSA exceeds two times any participant's salary reduction election or the amount could exceed the participant's salary reduction election plus $500. Few FSAs will incur a fee.

5) Average Number of Lives Covered

a) For self-insured plans, any one of the following three methods may be used to determine the average number of lives covered:

i. "Actual count method" calculated based on the average lives for the plan year by adding the covered lives (participants plus dependents) for each day of the plan year and dividing by the number of days in the plan year.

ii. "Snapshot count" calculated by adding the total lives for one day in each quarter (or an equal number of days for each quarter), and divide by the number of days used (minimum of four). With this method, the plan sponsor may look to actual lives covered (employees, spouses and dependents), or it can add the number of individuals with self-only coverage, to the product of the number of participants with coverage other than self-only multiplied by 2.35. [(self-only) + (other than self-only x 2.35)] The IRS determined that the average non-self-only election covers 2.35 participants.

iii. "Form 5500 method" based on the number of participants as of the beginning and end of the plan year as reported on Form 5500. The Form 5500 does not report dependents though - only employees. So, for plans with dependent coverage, the plan sponsor must add together the number of reported participants on the first and last day of the plan year (while this seems like over-counting, the regulations clarify that this inflated count is intended to reflect those dependents not reported on the Form). For plans without dependent coverage, the plan sponsor can simply add the two numbers, then divide by

two (under the Form 5500 method, the total number of lives is determined by simply adding the participant counts at the beginning and end of the year).

b) Insurers cannot use the Form 5500 method, but they can use the actual count and snapshot methods as well as two other methods based on information reported to the NAIC or state regulators.

c) For health FSA and HRA coverage that is not disregarded under the rule for multiple self-insured arrangements (or because it offers only excepted benefits), each participant can be treated as a single life, regardless of how many other individuals (e.g., spouse, dependents and other beneficiaries) are actually covered.