THE GROUP BENEFIT NEWS BULLETIN

REMINDER

PCORI Fee and Filing Due by End of July

Just a friendly reminder that the Patient-Centered Outcomes Research Institute (PCORI) fee and filing is due by July 31st, 2016. Employers can find the form at the following address: https://www.irs.gov/pub/irs-pdf/f720.pdf. IRS No. 133 is located on the second page, under Part II. Employers will list the "average number of covered lives" per the results of the chosen counting method. For plan years ending on or after October 1, 2015 and before October 1, 2016, the fee is **$2.17** per covered life. For plan years that ended prior to October 1, 2015, the fee due this July is **$2.08** per covered life.

Please see below for further information on counting methods. Filing instructions for the form can be found here: https://www.irs.gov/pub/irs-pdf/i720.pdf. On Page 9, Part II, the details for counting and plan qualifications are outlined.

Background:

PPACA created a new Patient-Centered Outcomes Research Institute to research and compare health outcomes and the effectiveness, benefits, and risks of various medical treatments/procedures. Fees are to be collected from both the fully-insured and self-funded markets. For fully-insured employers, the carriers hold responsibility for payment of the fee. For self-funded employers, the plan sponsor is responsible for the fee. For those on a calendar plan year the fee will be collected for years 2012-2018. For non-calendar plan years, the fee will be collected on plan years ending after September 30th, 2012 through September 30th, 2019. A Form 720 must be completed annually illustrating the fee amount due to the IRS.

PCORI fees are due by July 31st of the calendar year immediately following the last day of the plan year. For 2013 (the first year), the fee is $1 per average covered life under the plan. The second year fee is set at $2 per covered life. For subsequent years, the fee is indexed based on the prior year's fee plus an adjustment for medical inflation. Fully-insured HRAs are to be counted individually while self-funded are only counted once. Retirees and those enrolled via COBRA or state benefits continuation programs are counted as well. Multiple methods exist on how to determine "average covered life" based on Fully-Insured or Self-Funded Status.

Fully Insured Plans

For fully-insured employers, the carriers are responsible for calculating the average number of covered lives, submitting the form 720 and paying the fee on behalf of the employer. Full-Insured employers should expect this fee to be rolled into their premiums.

Self-funded Plans

Self-funded plans may determine the average number of covered lives by using any of the following methods. Like fully insured plans, plan sponsors must use the same method consistently for the duration of any year and the same method for all policies subject to the fee.

- **Actual Count*** ** – Count the total covered lives for each day of the plan year and divide by the number of days in the plan year.
- **Snapshot Method-"Count Method"*** ** – Count the total number of covered lives on a single day in a quarter (or more than one day) and divide the total by the number of dates on which a count was made. (The date or dates must be consistent for each quarter.)
    - **Snapshot Method-"Factor Method"** – In the case of self-only coverage, determine the sum of: (1) the number of participants with self-only coverage, and (2) the number of participants with other than self-only coverage multiplied by 2.35.
- **Form 5500 Method** – For self-only coverage, determine the average number of participants by combining the total number of participants at the beginning of the plan year with the total number of participants at the end of the plan year as reported on the Form 5500 and divide by 2. In the case of plans with self-only and other coverage, the average number of total lives is the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500.

As of December 5th 2012, the IRS updated the first year requirement that the beginning date to be May 14th rather than actual beginning date of plan year for anyone whose plan year began before May 14th and will end after September 30th 2012. In addition with respect to the snapshot method, Each date used for the second, third, and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy year or plan year.

Fees do not apply to excepted benefits, such as stand-alone dental and vision plans, FSA, Expatriate, Stop Loss, Indemnity Reinsurance Policies, Medicare, Medicaid, SCHIP, Non-Insurance health programs for members of the Armed Forces or veterans, or federally recognized Indian Health Services.

As always, TBPG will continue to monitor all updates and keep you informed of any pertinent information. If you have any questions, please contact your TBPG representative.