IRS Releases Final Regulations Imposing PCORI Fee on Sponsors of Fully Insured and Self-Insured Health Plans

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The Internal Revenue Service (IRS) issued final regulations on December 5, 2012, requiring health insurance issuers and plan sponsors of self-insured health plans to finance the Patient-Centered Outcomes Research Institute (PCORI) Trust Fund through the payment of an annual fee (the PCORI fee). The Trust Fund, which was implemented as part of the Patient Protection and Affordable Care Act (Affordable Care Act), will fund the Institute’s research into the comparative effectiveness of medical treatments.

The PCORI fee is imposed on health insurance issuers and plan sponsors of self-insured health plans for plan or policy years ending on or after October 1, 2012 and before October 1, 2019. The fee imposed is based on the average number of covered lives. For plan or policy years ending on or after October 1, 2012 and before October 1, 2013, the fee is one dollar ($1) multiplied by the average number of covered lives for that plan year. The fee then increases to two dollars ($2) for plan years ending on or after October 1, 2013. For plan years ending on or after October 1, 2014, the fee increases are based on a formula that includes increases in the projected per capita amount of National Health Expenditures provided by the Department of Health and Human Services (HHS).

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

Fully Insured Health Plans and the PCORI Fee

Health insurance issuers are responsible for the PCORI fee for policy years ending on or after October 1, 2012, and before October 1, 2019. The PCORI fee applies to any accident or health policy (including a policy under a group health plan) issued with respect to individuals residing in the U.S., including any prepaid health care coverage arrangements such as health maintenance organizations (HMOs). The PCORI fee applies to any policy that provides accident and health coverage to active employees, former employees (including COBRA coverage and retirees), or qualifying beneficiaries. The PCORI fee does not apply to:

- Any insurance policy if substantially all of its coverage is of excepted benefits, such as stand-alone vision or dental plans;
- Any group policy issued to an employer where the facts and circumstances show that the group policy was designed and issued specifically to cover primarily employees who are working and residing outside of the U.S.;
- Any stop-loss or indemnity reinsurance policy; or
- Any insurance policy to the extent it provides an employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.
Calculating Covered Lives in a Fully Insured Plan

To determine the average number of lives covered under a health insurance policy during a policy year, an issuer must use one of the following methods:

- **Actual Count Method**—An issuer adds the total number of lives covered for each day of the policy year and divides that total by the number of days in the policy year.

- **Snapshot Count Method**—An issuer adds the total number of lives covered on any date during the same corresponding month in each of the first three quarters of the policy year and divides that total by the number of dates on which a count was made.

- **Member Months Method**—An issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months (an amount that equals the sum of the totals of lives covered on pre-specified days in each month of the reporting period) reported on the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit filed for that calendar year.

- **State Form Method**—An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that is filed with the issuer’s state and a method similar to the “member months” method.

An issuer must use the same method of calculating the average number of lives covered under a policy consistently for the duration of the year. In addition, for all policies for which a liability is reported on a Form 720, "Quarterly Federal Excise Tax Return," for a particular year, the issuer must use the same method of computing lives covered.

Self-Insured Health Plans and the PCORI Fee

The PCORI fee is imposed on the plan sponsor of an applicable self-insured health plan, which includes a plan established or maintained by a plan sponsor (generally, the employer) for the benefit of employees, former employees (including retirees), or other eligible individuals to provide accident or health coverage if any portion of the coverage is provided other than through an insurance policy. An applicable self-insured health plan includes a retiree-only plan and COBRA continuation coverage. Since the PCORI fee is imposed on the plan sponsor and not the plan, the Department of Labor (DOL) does not consider the fee to be a plan expense under Title I of ERISA.

Multiple self-insured arrangements established and maintained by the same plan sponsor with the same plan year may be treated as a single self-insured health plan for purposes of calculating the fee. As a result, the same life covered under each arrangement would count as only one covered life for purposes of calculating the fee. For example:

- A plan sponsor maintains one self-insured arrangement providing medical benefits and another providing prescription drug benefits with the same plan year. The two arrangements may be treated as one self-insured health plan for purposes of the fee.

- A health reimbursement arrangement (HRA) is integrated with another applicable self-insured health plan that provides major medical coverage. The HRA and the major medical plan may be treated as one self-insured health plan. Note, however, that an HRA integrated with an insured group health plan is subject to the fee as an applicable self-insured health plan. In that case, the issuer of the insured group health plan would also be subject to the fee.
If a group health plan offers both fully insured and self-insured options, a plan sponsor may disregard the lives that are covered solely under the fully insured options for purposes of calculating the fee on its self-insured options.

Under the final regulations, the PCORI fee does not apply to:

- HIPAA-excepted benefits, such as stand-alone dental and vision plans and on-site medical clinics;
- Health savings accounts (HSAs);
- HRAs that are integrated with a self-insured group health plan;
- Health flexible spending arrangements (FSAs);
- Employee assistance plans, disease management programs, and wellness programs, to the extent they do not provide significant medical benefits;
- A plan that, as demonstrated by the facts and circumstances surrounding the adoption and operation of the plan, was designed specifically to cover primarily employees who are working and residing outside the U.S.;
- Stop-loss and indemnity reinsurance policies; and
- Plans or coverage provided by an Indian tribe to tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the tribe).

Calculating Covered Lives in a Self-Insured Plan

The average number of lives covered under an applicable self-insured health plan for a plan year can be calculated by any one of three different methods:

- **Actual Count Method**—A plan sponsor adds the total number of lives covered by the plan for each day of the plan year and divides the total by the number of days in the plan year.

- **Snapshot Method (using the snapshot count or snapshot factor)**—The “snapshot” calculation method involves adding the totals of lives covered on one date in each quarter, or more dates if an equal number of dates are used for each quarter, and dividing that total by the number of dates on which a count was made. The date or dates used for each quarter must be the same (e.g., first day of the quarter, last day of the quarter, first day of the month). When using the snapshot method, the number of lives covered on a date is equal to either: 1) the actual number of lives covered on the designated date (“snapshot count” method); or 2) the sum of the number of participants with self-only coverage on that date, plus the product of the number of participants with coverage other than self-only coverage on the designated date and 2.35 (“snapshot factor” method).

- **Form 5500 Method**—A plan sponsor may also use the Form 5500 method to calculate the average number of lives for a plan year based on the number of reportable participants for the Form 5500, “Annual Return/Report of Employee Benefit Plan,” filed for the applicable self-insured health plan. For an applicable self-insured health plan offering self-only and other coverage (e.g., employee plus spouse, employee plus children, family), the average number of lives equals the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 filed for the plan. For an applicable self-insured health plan offering only self-only coverage, the average number of lives covered equals the sum of the total participants covered at the beginning and the end of the plan year, reported on the Form 5500, divided by two.
A plan sponsor must use a single method for calculating the average number of covered lives for an entire plan year, but a different method may be used from one plan year to the next. Examples of each calculation method are included in the final regulations.

If a plan sponsor only maintains a health FSA (that is not an excepted benefit) or HRA, the plan sponsor may treat each participant’s health FSA or HRA as covering a single covered life (and not include any spouse, dependent, or other beneficiary of the participant). If a plan sponsor maintains a health FSA or HRA and another applicable self-insured health plan (other than a health FSA or HRA), the plan sponsor may treat the two arrangements as a single plan. In this case, the special counting rule (i.e., treating each participant’s health FSA or HRA as covering a single covered life) applies only to participants in the health FSA or HRA that do not participate in the other applicable self-insured health plan. If such individuals also participate in the other applicable self-insured health plan, they will be counted under one of the methods, described above, used by the plan sponsor.

For plan years beginning before July 11, 2012, and ending on or after October 1, 2012, a plan sponsor may use any reasonable method for determining the average number of lives covered under the plan for the plan year.

**Reporting and Payment of Fees on IRS Form 720**

Health insurance issuers and plan sponsors will report and pay the fees only once per year on IRS Form 720, “Quarterly Federal Excise Tax Return,” by July 31 of the calendar year immediately following the last day of the plan year. A Form 720 return generally covers plan years that end during the preceding calendar year. Full payment of the fee is due annually by the July 31 due date. The first potential due date for reporting and filing the fee on Form 720 is July 31, 2013.

Form 720 may be filed electronically and is available at: [www.irs.gov/efile](http://www.irs.gov/efile). Any claim for a refund of the fees must be filed on Form 8849, “Claim for Refund of Excise Taxes,” or Form 720X, “Amended Quarterly Federal Excise Tax Return.”

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