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IRS issues final regulations on PCORI fees

The IRS recently issued final regulations that describe how fees for funding the Patient-Centered Outcomes Research Institute (PCORI) should be calculated and paid. The PCORI fee is imposed on insurers and plan sponsors of self-insured group health plans, and sponsors of calendar year plans will be required to pay the 2012 fee by July 31, 2013. Although the regulations address the similar requirements for both health insurers and employer-sponsored self-insured plans, this FYI focuses on the requirements for self-insured plans. Insurers will be required to pay the fees for insured plans, although it is likely that they will pass these fees on to sponsors of group health plans.

Background

The PCORI, created by the Patient Protection and Affordable Care Act (ACA), is charged with promoting research to evaluate and compare the health outcomes and clinical effectiveness, risks, and benefits of medical treatments, services, procedures, and drugs. PCORI is funded, in part, by fees assessed on health insurers and plan sponsors of self-insured group health plans.

The PCORI fee will first be assessed with respect to plan years ending after September 30, 2012 (i.e., that end on or after October 1, 2012, but before October 1, 2013). The initial fee is $1 times the average number of covered lives for that first plan year and $2 per covered life for the plan year ending after September 30, 2013. Fees for subsequent years are subject to indexing. The PCORI fee will not be assessed for plan years ending after September 30, 2019, which means that for a calendar year plan, the last year for assessment is the 2018 calendar year.

In the spring of 2011, the IRS issued Notice 2011-35 that requested comments on how the PCORI fee should be calculated and paid. On April 17, 2012, the IRS published proposed regulations concerning the application of these fees. (See our May 9, 2012 *For Your Information*.) The IRS issued final regulations on December 6, 2012.

Plans subject to the fee

The PCORI fee is assessed on plan sponsors of “applicable self-insured health plans.” For this purpose, an "applicable self-insured health plan” generally is any plan providing accident and health coverage, other than through insurance, that is established or maintained by employers or employee organizations on behalf of their employees or members. It also includes accident and health coverage provided by multiemployer plans, multiple employer welfare arrangements, voluntary employee beneficiary associations, certain non-profit associations, and rural electric cooperatives.

In the preamble to the final regulations, the IRS specifically states that retiree coverage and retiree-only plans are subject to the PCORI fee. The final regulations also clarify that accident and health coverage provided to individuals who have continuation coverage under COBRA or similar state continuation laws may be subject to the fee.

> Buck Comment. Thus, although retiree-only plans are exempt from many ACA requirements, they are subject to the PCORI fee.

The final regulations clarify that the following plans are not subject to the PCORI fee because they are not considered to be accident and health coverage:

- Plans that provide HIPAA excepted benefits, including limited-scope dental and vision plans, onsite medical clinics, accident-only or disability-only plans, and most flexible spending accounts (FSAs).
- Employee assistance, disease management, and wellness programs that do not provide significant benefits for medical care or treatment.
- Expatriate plans that are specifically designed to cover primarily employees working or residing outside of the US. (For this purpose, the US includes American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Virgin Islands, and any other US possessions.) The final regulations permit the plan sponsor to rely on the most recent address on file and to treat all family members as having the same place of abode in determining whether an individual is residing in the US.

Although self-insured governmental plans providing accident and health coverage to governmental employees and former employees are subject to the PCORI fee, Medicare, Medicaid, CHIP, and any federal program providing medical care (other than through insurance policies) to members of the armed forces, veterans or members of Indian tribes are exempt.

Special rules for multiple self-insured arrangements

The final regulations retain a provision in the proposed rule that permits multiple self-insured health plans to be treated as a single applicable self-insured health plan if they have the same plan sponsor and same plan year. Thus, plan sponsors that maintain one self-insured arrangement providing major medical benefits and a separate self-insured arrangement providing prescription drug benefits with the same plan years may treat the two as one applicable self-insured health plan. The same rule applies to plan sponsors that provide a self-insured major medical plan and a health reimbursement arrangement (HRA) with the same plan year—the two arrangements are treated as one self-insured health plan for purposes of assessing the PCORI fee.

> Buck Comment. If a plan sponsor provides major medical coverage under an insured plan in combination with a self-insured HRA, then the PCORI fee will be assessed on both plans. The insurer will pay the

PCORI fee on the insured medical plan, and the plan sponsor will pay the fee on the HRA. In this case plan sponsors can use the special rules discussed below to determine the required fees on the HRA.

Methods for determining the number of covered lives

The PCORI fee is assessed on the average number of lives covered by an applicable self-insured plan during the plan year. This includes not only the participant (i.e., the employee or member) but the participant's spouse and dependents covered by the plan. The final regulations make it clear that COBRA qualified beneficiaries and others with continuation coverage and individuals with retiree coverage must also be counted.

The proposed regulations required plan sponsors to use one of three alternative methods for determining the average number of lives covered by an applicable self-insured health plan during a plan year. They also permitted the plan sponsor to change methods each year. The final regulations generally retain these three methods but provide some important clarifications.

Actual count method

The actual count method remains unchanged from the proposed regulations. Under this method, a plan sponsor would add the total lives covered each day of the plan year and then divide that number by the total number of days in the plan year.

Snapshot methods

There are two different "snapshot methods." Under either method, a plan sponsor would add the number of total lives covered by the plan on a date during each quarter and then divide that total by four. A plan sponsor could elect to base the determination on more than one date in each quarter, provided an equal number of dates are used. The final regulations provide that each date used during the second, third, and fourth quarter must be within three days of the date in that quarter that corresponds to the date used for the first quarter. For this purpose, the 30th and 31st days of a month are treated as the last day of the month for purposes of determining a corresponding date for any month that has fewer than 31 days. All dates must be within the same plan year.

- Snapshot factor method. Under this method, the number of lives covered on a date is equal to the sum of the number of participants with self-only coverage on the date plus the number of participants with coverage other than self-only coverage on that date multiplied by 2.35.
- Snapshot count method. Under this method, the number of lives equals the actual number of lives covered on the designated date.

Form 5500 method

A plan sponsor may determine the average number of lives covered by a plan for a plan year based on the number of participants reported on the Form 5500 filed for that plan year. The final regulations provide that this method can only be used if the Form 5500 is filed no later than the due date for paying the PCORI fee. For plans that offer only self-coverage, the number of lives equals the sum of the participants covered at the beginning and end of the plan year divided by two. For plans that also cover spouses or dependents, the number of lives equals the sum of the total participants covered at the beginning and end of the plan year.

Buck Comment. Sponsors of calendar plans must pay the PCORI fee by July 31st following the close of the plan year, the same date by which the plan must file its Form 5500 for that plan year if no extension is taken. This might limit the utility of the Form 5500 Method for those sponsors.

Special rules for health FSAs and HRAs

The final regulations contain special rules for health FSAs that are not HIPAA-excepted benefits and HRAs:

- If the health FSA or an HRA is the only applicable self-insured coverage provided by the plan sponsor (i.e., the plan sponsor does not offer any other self-insured health coverage subject to the PCORI fee), the plan sponsor may treat each participant's health FSA or HRA as covering a single life; the participant's spouse or dependents are not counted as covered lives.
- If a plan sponsor offers a non-account self-insured plan, in addition to the health FSA or HRA, and both arrangements have the same plan year, it may treat the two arrangements as a single plan as described above. However, the special counting rule for health FSAs or HRAs will only apply to those participants who do not participate in the non-account plan.

Special rule when a health plan offers both fully insured and self-insured options

If a health plan provides accident and health coverage through both self-insured and fully-insured options, the plan sponsor may disregard lives that are only covered under the insured options.

Special rule for first year of PCORI fee

The final regulations provide that for a plan year beginning before July 11, 2012, and ending on or after October 1, 2012, a plan sponsor may determine the average number of lives covered under the plan year using any reasonable method.

Who is the plan sponsor?

The final regulations retain the provisions in the proposed regulations regarding the definition of plan sponsor with minimal changes. Thus, a plan sponsor of an applicable self-insured health plan for purposes of reporting and paying the PCORI fee will be:

- The employer, in the case of a single-employer plan
- The employee organization, in the case of a plan established or maintained by that organization
- In the case of a multiemployer plan, MEWA, or VEBA, the association, committee, joint board of trustees, or similar group that represents the parties that established or maintain the plan
- The cooperative or association that established or maintains a plan by a rural electric cooperative

The final regulations retain the rule that when a single plan is established or maintained by more than one employer (even related employers) or by more than one employee organization, the entity identified as the plan sponsor – or designated as the plan sponsor for PCORI fee purposes – in the plan documents under which the plan is operated will be responsible for reporting and paying the PCORI fee. If the plan sponsor is not identified or designated in the plan document, each entity maintaining the plan must report and pay the PCORI fee with respect to its own employees or members.

Buck Comment. Related employers that provide coverage to their employees through a single plan may want to designate a plan sponsor in order to consolidate the filing and payment of the PCORI fee.

Due date for reporting and paying the fee

The final regulations confirm that plan sponsors will be required to report and pay the PCORI fee for a plan year no later than July 31 of the calendar year immediately following the last day of such plan year. This means that sponsors of calendar year plans or plans with plan years that began between October 2, 2011 and December 31, 2011 must make their initial payment of the PCORI fees by July 31, 2013. Plans with plan years beginning after January 1, 2012 but prior to October 2, 2012 will not have to report and pay the PCORI fee until July 31, 2014. As discussed in the proposed regulations, Form 720 (Quarterly Federal Excise Tax Return Form) will be used for this purpose. The final regulations also confirm that third parties cannot report or remit the fees on behalf of plan sponsors.

.According to the preamble to the final regulations, the Department of Labor has taken the position that because the PCORI fee is assessed on the plan sponsor, and not the plan, use of plan assets to pay the fee will generally not be permitted by ERISA. The DOL will provide more guidance about PCORI fee payments on its website. Also, although the final regulations do not address the deductibility of PCORI fees for federal tax purposes, it appears that plan sponsors may be able to deduct the fees as ordinary and necessary business expenses.

In closing

Sponsors of calendar year plans should begin determining the number of self-insured plans that will be subject to the PCORI fee as well as the number of lives covered by these programs during 2012. Sponsors that want to use the 5500 method for calculating covered lives need to ensure that the Form 5500 for those plans will be filed by July 31, 2013, and that no extensions will be necessary.

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