Kapnick Compliance

June 2022

# PCORI FEES

## LEGISLATIVE BRIEF


## SUMMARY

The Affordable Care Act (ACA) requires health insurance issuers and employers that sponsor self-funded group health plans to pay Patient-Centered Outcomes Research Institute (PCORI) fees. Employers that sponsor fully insured health plans are not required to pay the fee directly, but employers sponsoring self-funded plans must pay the fee annually on IRS Form 720.

The fees are due by July 31 of the calendar year following the policy or plan year to which the fee applies. For calendar year plans, the fee due July 31, 2022 is $2.79 per covered life.


### OVERVIEW OF PCORI FEES

The ACA requires health insurance issuers and employers that sponsor self-insured health plans to pay PCORI fees, regardless of the plan's grandfathered status. (Please refer to page 4 for a list of arrangements subject to the PCORI fee and the responsible party for paying the fee.) This article focuses on employers that sponsor self-insured health plans.

### DUE DATE FOR REPORTING PCORI FEES ON FORM 720

Initially, PCORI fees applied for plan year ending on or after October 1, 2012, but did not apply to plan years ending on or after October 1, 2019. However, the PCORI fee was extended to plan years ending on or before September 30, 2029 as part of the Further Consolidated Appropriations Act of 2020. As a result, for calendar year plans, the fee will remain effective through the 2028 plan year.

Employers that sponsor self-funded health plans are required to pay PCORI fees annually on IRS Form 720 (Quarterly Federal Excise Tax Return) by July 31 of the calendar year following the policy or plan year to which the fee applies.

The IRS instructions for filing Form 720 include information on reporting and paying the PCORI fees. See the chart on page 6 for the due date and fee applicable for your policy or plan year.

### APPLICABLE RATE AND COUNTING COVERED LIVES

**General Rule:** A separate PCORI fee applies for each applicable self-insured plan, and is based on the average number of lives covered under that plan. Covered lives include not only covered active employees, but also covered spouses, dependents, retirees, former employees on disability who are still covered, and COBRA beneficiaries. Later in this section we will address the methods that may be utilized to calculate the average number of covered lives.

Using Part II, Number 133 of Form 720, sponsors of self-funded plans are required to report the average number of lives covered under the plan separately for applicable self-insured health plans. That number is then multiplied by the applicable rate for that tax year, as follows:

- **$1** for plan years ending before Oct. 1, 2013 (2012 for calendar year plans).
- **$2** for plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014.
- **$2.08** for plan years ending on or after Oct. 1, 2014 and before Oct. 1, 2015 (see Notice 2014-56).
- **$2.17** for plan years ending on or after Oct. 1, 2015 and before Oct. 1, 2016 (see Notice 2015-60).
- **$2.26** for plan years ending on or after Oct. 1, 2016 and before Oct. 1, 2017 (see Notice 2016-64).
- **$2.39** for plan years ending on or after Oct. 1, 2017 and before Oct. 1, 2018 (see Notice 2017-61).
- **$2.45** for plan years ending on or after Oct. 1, 2018 and before Oct. 1, 2019 (see Notice 2018-85).
- **$2.54** for plan years ending on or after Oct. 1, 2019 and before Oct. 1, 2020 (see Notice 2020-44).
- **$2.66** for plan years ending on or after Oct. 1, 2020 and before Oct. 1, 2021 (see Notice 2020-84).
- **$2.79** for plan years ending on or after Oct. 1, 2021 and before Oct. 1, 2022 (see Notice 2022-4).

The fees for applicable self-insured health plans are then combined to equal the total tax owed.

**Exceptions to the General Rule:**

- ***Multiple Self-Insured Arrangements***

  If a single employer/plan sponsor maintains two or more self-insured arrangements (e.g., plan sponsor maintains a self-insured HRA or health FSA in addition to self-insured group health plan providing major medical coverage), the arrangements may be combined and treated as a single self-insured health plan for purposes of calculating the fee if the plans have the same plan year.

  - Multiple insured arrangements: There is no similar rule for lives covered by multiple insured arrangements. A PCORI fee is required for each covered life under each insured arrangement (i.e., there may be more than one PCORI fee payment required for the same covered life even though the arrangements are maintained by a single plan sponsor).
  - Self-funded HRA and Fully Insured Group Health Plan: If a plan sponsor provides major medical coverage under an insured group health plan and a self-insured HRA, a PCORI fee must be paid on both the HRA (by the plan sponsor) and the insured group health plan (by the insurer), because only multiple self-funded arrangements may be treated as a single plan. This means there may be two PCORI fee payments for the same covered lives even though the HRA and the insured group health plan are maintained by the same plan sponsor. However, the plan sponsor may use the special counting rule below to determine the required fees on the HRA.

- ***Special Exemption for Health FSA Treated as an Excepted Benefit***

  No PCORI fee applies to a health FSA that satisfies the requirement of an excepted benefit under IRC Sec. 9832(c) and the special rules under Treas. Reg. Sec. 54.9831-1(c)(3)(v). This means that a health FSA is not subject to the PCORI fee if the health FSA satisfies two conditions:

(1) Maximum benefit requirement: The maximum benefit payable under the health FSA to any participant in the class for a year cannot exceed two times the employee's salary reduction under the health FSA for the year or, if greater, the amount of the employee's salary reduction for the health FSA for the year, plus $500.

(2) Availability requirement: Some other non-excepted group health plan coverage (e.g., major medical such as a PPO, HDHP, or HMO) must be made available for the year to the class of FSA participants by reason of their employment. The coverage may be either self-insured or fully insured. In our experience, most employers that offer health FSAs also offer group health coverage and satisfy this requirement.

For example, a health FSA funded exclusively by employee salary reduction contributions (with annual coverage capped by the amount of the annual salary reduction election) will, by definition, satisfy the maximum benefit requirement.

However, some health FSAs provide for employer matching funds on elected salary reduction contributions. A health FSA with direct employer contributions will generally satisfy the maximum benefit condition, provided the employer matching contribution does not exceed the greater of the participant's salary reduction election or $500. A design that offers direct employer FSA contributions in excess of this level would cause the FSA to be subject to the PCORI fee. **Typically, most health FSAs will not be subject to the PCORI fee because they satisfy the requirements to be an excepted benefit.**

If the PCORI fee applies to a health FSA, the plan sponsor may use the special counting rule below to determine the required fees on the health FSA.

- ***Special Counting Rule for HRAs and FSAs***
  - Plan sponsors are permitted to assume one covered life for each employee with an HRA.
  - Plan sponsors are permitted to assume one covered life for each employee with an FSA.

**METHODS AVAILABLE TO CALCULATE THE ANNUAL FEE**

Plan sponsors with self-insured plans may use one of the below methods to calculate the annual fee. Plan sponsors may only apply a single method in determining the average number of lives covered under the plan for the entire plan year. However, a plan sponsor is not required to use the same method from one plan year to the next.

1. ***Actual Count Method.*** Average number of lives covered for the plan or policy year is determined by calculating the sum of the lives covered for each day of the plan or policy year and dividing that sum by the number of days in the plan or policy year.

2. ***Snapshot Method.*** Average number of lives covered under a policy or plan year is determined by adding the total number of dates for each quarter and dividing the total by the number of dates on which a count was made. Specific dates do not need to be used for each month or quarter; however, similar dates should be used for each month (e.g., each date used for the second, third and fourth quarters must be within 3 days of the date that would correspond with the first quarter).

   In addition, there are two methods within the snapshot to count family members: (1) "snapshot count method" requires the plan to count the actual number of lives covered on the designated date; or (2) "snapshot factor method" allows the plan to count the actual number of participants with self-only coverage on the designated date, plus the number of participants with coverage other than self-only coverage on the designated date multiplied by 2.35.

3. ***Form 5500 Method.*** Plan sponsors may determine the average number of lives covered under the plan for the plan year based on a formula that includes the number of participants actually reported on the Form 5500 for the plan year. A plan sponsor may only use this method if the Form 5500 is filed no later than the due date for the PCORI fee imposed for that plan year (if the plan files for an extension it may not be able to use this method). Under this method, the total number of lives is determined by simply adding the total participant counts at the beginning and end of the year and dividing by 2 for a plan that only offers single coverage. If a plan offers single coverage along with other coverage (e.g., family coverage), the total number or lives is determined by adding total participant counts at the beginning and end of the year (without dividing by 2).

**PCORI FEE SHOULD BE FILED SEPARATELY FROM OTHER EXCISE TAX LIABILITY**

- Plan sponsors that file Form 720 only to report the PCORI fee will not need to file Form 720 for the first, third, or fourth quarter of the year.
- Plan sponsors that file Form 720 to report quarterly excise tax liability for each quarter of the year (e.g., to report the foreign insurance tax ) should not make an entry on the line for the PCORI tax on those filings.

**CORRECTIONS AND AMENDMENTS**

Plan sponsors may use Form 720X, "Amended Quarterly Federal Excise Tax Return" to adjust any errors made or liabilities reported on a previously filed Form 720, including adjustments that result in an overpayment. Form 720X and the accompanying instructions do not specifically identify or refer to the PCORI fees,. However, there is space to include an explanation of adjustments, which plan sponsors can use to identify the PCORI fee.

Penalties related to late filing of Form 720 or late payment of the fee may be waived or abated if the issuer or plan sponsor has reasonable cause and the failure was not due to willful neglect.

## SUBSEQUENT CHARTS AND SCHEDULES

Below is a list of arrangements subject to the PCORI fee (and the party responsible for payment thereof), as well as a list of arrangements that are not subject to PCORI fees. A PCORI fee period and payment schedule is provided on page 6. You may use this schedule to look up your plan year to determine the applicable annual fee per covered life and when the fee must be paid.

If you have questions about PCORI fees, please contact your Kapnick service team.

| COVERAGE OR ARRANGEMENTS SUBJECT TO PCORI FEE | PARTY RESPONSIBLE FOR PAYING AND REPORTING THE FEE |
|---|---|
| Accident and health coverage or major medical insurance coverage | The issuer if insured; the plan sponsor if self-insured |
| Retiree-only health or major medical coverage | The issuer if insured; the plan sponsor if self-insured |
| Health or major medical coverage under multiple policies or plans | Each issuer or plan sponsor (unless special rule for coverage under multiple self-insured plans is applicable) |
| COBRA coverage | The issuer if insured; the plan sponsor if self-insured |
| Health Reimbursement Arrangement (HRA) (including premium-only HRA), unless satisfies requirement for being treated as an excepted benefit | The plan sponsor; see special rules for coverage under multiple self-insured health plans and special counting rules for HRAs |
| Flexible Spending Arrangement (FSA), unless satisfies requirement for being treated as an excepted benefit | The plan sponsor; see special counting rules for FSAs |
| State and local government health or major medical plans for employees and/or retirees | The issuer if insured; the plan sponsor if self-insured |

## TYPES OF COVERAGE OR ARRANGEMENTS NOT SUBJECT TO PCORI FEE

- Stand-alone dental or vision coverage
- Group insurance policy designed and issued specifically to cover primarily employees working and residing outside the U.S.
- Medicare
- Medicaid
- Children's Health Insurance Program
- Military health plans
- Certain Indian tribe governmental health plans (other than through insurance policies) to members of Indian tribes
- Health Savings Arrangements (HSAs)
- Archer Medical Savings Accounts (MSAs)
- Hospital indemnity or special illness benefits
- Stop-loss or indemnity reinsurance
- Employee assistance programs, disease management programs, or wellness programs (provided the program does not provide significant benefits in the nature of medical care or treatment)
- Accident-only coverage (including accidental death and dismemberment)
- Disability income coverage
- Automobile medical payment coverage
- Workers' compensation or similar coverage
- Onsite medical clinic

## PCORI FEE PERIODS AND PAYMENT SCHEDULE

| Plan Year* | Annual Fee per covered life | When fee must be paid |
|---|---|---|
| *Ending before Oct. 1, 2013* | *$1* | *July 31 following plan year end* |
| *Ending on or after Oct. 1, 2013 and before Oct. 1, 2014* | *$2* | *July 31 following plan year end* |
| *Ending on or after Oct. 1, 2014 and before Oct, 1, 2015* | *$2.08* | *July 31 following plan year end* |
| *Ending on or after Oct. 1, 2015 and before Oct. 1, 2016* | *$2.17* | *July 31 following plan year end* |
| *Ending on or after Oct. 1, 2016 and before Oct. 1, 2017* | *$2.26* | *July 31 following plan year end* |
| *Ending on or after Oct. 1, 2017 and before Oct. 1, 2018* | *$2.39* | *July 31 following plan year end* |
| *Ending on or after Oct. 1, 2018 and before Oct. 1, 2019* | *$2.45* | *July 31 following plan year end* |
| *Ending on or after Oct. 1, 2019 and before Oct. 1, 2020* | *$2.54* | *July 31 following plan year end* |
| February 1, 2020 through January 31, 2021 | $2.66 | **July 31, 2022** |
| March 1, 2020 through February 28, 2021 | $2.66 | **July 31, 2022** |
| April 1, 2020 through March 31, 2021 | $2.66 | **July 31, 2022** |
| May 1, 2020 through April 30, 2021 | $2.66 | **July 31, 2022** |
| June 1, 2020 through May 31, 2021 | $2.66 | **July 31, 2022** |
| July 1, 2020 through June 30, 2021 | $2.66 | **July 31, 2022** |
| August 1, 2020 through July 31, 2021 | $2.66 | **July 31, 2022** |
| September 1, 2020 through August 31, 2021 | $2.66 | **July 31, 2022** |
| October 1, 2020 through September 30, 2021 | $2.66 | **July 31, 2022** |
| November 1, 2020 through October 31, 2021 | $2.79 | **July 31, 2022** |
| December 1, 2020 through November 30, 2021 | $2.79 | **July 31, 2022** |
| January 1, 2021 through December 31, 2021 | $2.79 | **July 31, 2022** |

*Fee continues each year, and expires for plans ending on or after 10/1/2029