The Patient-Centered Outcomes Research Institute ("PCORI") Fee

WHAT DO I NEED TO DO?

The Affordable Care Act created the Patient-Centered Outcomes Research Institute ("PCORI"), which is funded in part by fees that health insurance carriers and self-funded plan sponsors must make to the Patient-Centered Outcomes Research Trust Fund. The goal is to fund research that will find health care methods that are most effective and cost-efficient, ultimately reducing the cost of health care overall. The fee is sometimes referred to as the PCORI Fee and sometimes as the Comparative Effectiveness Fee.

HOW DO I COMPLY WITH THIS REQUIREMENT?

First, read the information set forth in this summary. It will explain who is subject to the payment requirement and how the payment is calculated and submitted to the federal government. Unfortunately, and by regulation, only the entity who owes the fee can remit the fee to the IRS. However, MedBen can provide you with data regarding the average number of covered lives on your plans using the Snapshot Method described in the regulations and as outlined in the summary below. Information regarding the fee for providing this information is available from your Group Service Representative.

IMPORTANT UPDATE!

The PCORI Fee payment requirement was supposed to sunset in 2020. However, the Further Consolidated Appropriations Act of 2020 (which passed Congress in December 2019) reinstated the fee requirement until 2029. That means that all health plans, regardless of your plan year start date, must make a PCORI filing in July 2020.

HOW DO I COUNT COVERED LIVES?

Only covered lives (both employees and dependents) residing in the United States are included. There are four methods that can be used to determine the average number of covered lives during the plan year for your affected plans. Once you have determined the method for counting covered lives, you multiply the resulting average number of covered lives by the fee for the applicable year.

Two counting methods apply to both fully insured policies and self-funded plans:

- **Actual Count Method** – This method takes the sum of covered lives on each day of the plan year and divides that number by the number of days in the plan year.
- **Snapshot Method** - This method takes the sum of covered lives on a selected day per time period in the previous plan year and divides that number by the number of time periods on which the count was taken.

The Snapshot Method is the method MedBen will use when counting and averaging your plan(s) covered lives. You will receive a report that shows the average number of lives per month and the average number of lives per quarter during the prior plan year. You can choose which to report on IRS Form 720 for each of your plans.

The following methods are for self-funded plans only:

- **Snapshot Factor Method** - This method takes the sum of single-only employee lives on a selected day per time period in the previous plan year and multiplies it by 2.35 (assumed dependent factor). The total is divided by the number of time periods on which the count was taken.

- **Form 5500 Method** - This method takes the number of "participants" reported on Form 5500 for the first day of the plan year and adds it to the number of "participants" reported on Form 5500 for the last day of the plan year. This method is not available if you filed for an extension for your plan's last 5500 tax return.

The same method must be applied consistently to a plan throughout the plan year. However, if you have more than one plan, you can use a different method for each plan. The method may also be changed from year to year. Please make sure to follow the PCORI counting rules when determining what your plan owes.

HOW MUCH DO I PAY?

The fee is paid per covered life (each employee, spouse, and dependent child) under the plan or policy, as described above. The fee is paid in July of each year based on the counts from the previous year. Here is how much you will have to remit in per covered life fees by plan year:

Plan Year Starts:	Plan Year Ends:	PCORI Fee is Due:	Using Covered Lives Data from **Plan Year**:	Amount to Remit per Covered Life:
February 1, 2018	January 31, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
March 1, 2018	February 28, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
April 1, 2018	March 31, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
May 1, 2018	April 30, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
June 1, 2018	May 31, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
July 1, 2018	June 30, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
August 1, 2018	July 31, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
September 1, 2018	August 31, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
October 1, 2018	September 30, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.45***
November 1, 2018	October 31, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.54***
December 1, 2018	November 31, 2019	***July 31, 2020***	2018 – 2019 Plan Year	***$2.54***
January 1, 2019	December 31, 2019	***July 31, 2020***	2019 Plan Year	***$2.54***

HOW DO I PAY THE PCORI FEE?

The fee must be submitted to the IRS using the second quarter Form 720 "Quarterly Federal Excise Tax Return" (generally, the April release date each year) but only once a year on the form's July 31st due date. To complete the form, fill in the average number of covered lives in column (a) and multiply by the amount already entered in column (b). Enter the total in the tax column on IRS Line No. 133.

WHO IS REQUIRED TO PAY?

If you provide group health benefits to your employees through an applicable self-funded health plan, then you – as the employer-sponsor of that plan - are required to pay the fee. If you provide group health benefits to your employees through an insurance policy, the health insurance carrier must pay the fee. If you offer multiple plan options, make sure you understand which benefits are provided through an insurance policy and which are self-funded. There are situations in which both the employer and the insurance carrier must pay the fee for the same covered lives. For instance, if you offer your employees health benefits through a fully-insured medical policy and you have established a self-funded HRA (health reimbursement arrangement) plan for the employees covered under the medical policy, both the insurance carrier and you, as the employer plan sponsor, must pay the fee. The insurance carrier will pay for the individuals covered under the medical policy and the employer must pay for the same individuals who have HRA accounts. Please note that disease management programs like WellLiving are exempt from this requirement.

The PCORI Fee must be paid on the following types of plans:

	Type of Coverage	Who Pays?
#1	Major medical or group health benefits coverage	Carrier – if fully-insured policy Employer – if self-funded plan
#2	COBRA coverage for major medical plan or policy (individuals on COBRA must be counted along with individuals in the underlying coverage)	Same as above
#3	Separate self-funded prescription coverage	If both plans are self-funded and are offered to the same group of employees, the employer can combine the count with the medical plan. If the medical plan is fully-insured, the employees in the self- funded drug plan will have to be counted and reported separately.
#4	Retiree medical plans and policies	Carrier – if fully-insured policy Employer – if self-funded plan
#5	Health Reimbursement Arrangement – Stand Alone	Employer
#6	Health Reimbursement Arrangement – Integrated	If both plans are self-funded and are offered to the same group of employees, the employer can combine the count with the medical plan. If the medical plan is fully-insured, the employees in the self-funded HRA will have to be counted and reported separately.
#7	Health Reimbursement Arrangement – Retiree Only	Employer

Some plans, policies and plan sponsors are exempt for reporting covered lives and paying the fee, as follows:

#1	Stand-alone dental and vision plans	Exempt as long as dental and/or vision benefits are not integrated with medical plan or policy.
#2	HIPAA-Excepted benefits	This includes disability, AD&D, long-term care, etc.
#3	Employee Assistance Programs	Exempt as long as the program doesn't provide significant benefits in the nature of medical care or treatment.
#4	Disease Management Programs (such as WellLiving)	Exempt as long as the program doesn't provide significant benefits in the nature of medical care or treatment.
#5	Wellness Programs	Exempt as long as the program doesn't provide significant benefits in the nature of medical care or treatment.
#6	Health Flexible Spending Accounts (FSAs)	Exempt as long as such program is a HIPAA-excepted benefit.
#7	Health Savings Accounts (HSAs)	Exempt as long as such program is a HIPAA-excepted benefit.
#8	Medicare and Medigap supplemental plans	Exempt
#9	Medicare Advantage and Medicare Part D plans	Exempt
#10	Stop-loss and limited indemnity plans and policies	Exempt

If you have any questions about the allowable counting methodologies, the reporting requirements, or the amount due this coming July 31st, please contact your Account Management Team who will be happy to get you more information.