PCOR Fee Requirement for Self-funded Plans, including Some HRAs and Health FSAs

Under the ACA, there is a new fee on health plans to fund a Patient-Centered Outcome Research ("PCOR") program which was established to fund research of the clinical effectiveness of medical treatments, procedures, and drugs. For insured plans, insurance carriers will pay a fee that equals $1 in the first year ($2 in the next year, then adjusted for inflation) multiplied by the average number of lives insured under a group health plan policy. For self-funded plans, the employer will pay a fee that equals $1 in the first year ($2 in the next year, then adjusted for inflation) multiplied by the average number of lives covered by the group health plan.

As the carrier is responsible for the fee with respect to insured plans,[1] the following provides detail with respect to self-funded plans, implicating employer obligations.

Q 1: What is the effective date?

A 1: Plan sponsors must comply with respect to **plan years beginning on or after November 1, 2011** (for calendar-year plans, that means the 2012 plan year).[2] No compliance is required with respect to plan years beginning on or after November 1, 2018 (for calendar-year plans, that means the fees would not apply beginning with the 2019 plan year).

Q 2: How do I pay the fee?

A 2: Plan sponsors will file Form 720 "Quarterly Federal Excise Tax Return." Despite the title, the form should be filed annually, using the 2nd quarter Form 720. The return is filed by **July 31** of the calendar year immediately following the last day of the plan year.

The upcoming schedule is as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2014 – January 31, 2015	$2.08/covered life/year	August 1, 2016*
March 1, 2014 – February 28, 2015	$2.08/covered life/year	August 1, 2016*
April 1, 2014 – March 31, 2015	$2.08/covered life/year	August 1, 2016*
May 1, 2014 – April 30, 2015	$2.08/covered life/year	August 1, 2016*
June 1, 2014 – May 31, 2015	$2.08/covered life/year	August 1, 2016*
July 1, 2014 – June 30, 2015	$2.08/covered life/year	August 1, 2016*

[1] UHC states that the fee will be rolled into the premium rates and will not be called out separately on the invoice.

[2] The technical effective date is for plan years ending after September 30, 2012, expiring for plan years ending after September 30, 2019. Another way to state this is that it applies to plan years ending on or after October 1, 2012 and before October 1, 2019.

August 1, 2014 – July 31, 2015	$2.08/covered life/year	August 1, 2016*
September 1, 2014 – August 31, 2015	$2.08/covered life/year	August 1, 2016*
October 1, 2014 – September 30, 2015	$2.08/covered life/year	August 1, 2016*
November 1, 2014 – October 31, 2015	**$2.17/covered life/year**[3]	August 1, 2016*
December 1, 2014 – November 30, 2015	**$2.17/covered life/year**	August 1, 2016*
January 1, 2015 – December 31, 2015	**$2.17/covered life/year**	August 1, 2016*

** July 31, 2016 is a Sunday.*

The form can be found at: http://www.irs.gov/uac/Form-720,-Quarterly-Federal-Excise-Tax-Return

An employer should complete Part II, IRS No. 133, rows (c) or (d), page 2.

Part II

IRS No.	Patient-Centered Outcomes Research Fee (see instructions)	(a) Avg. number of lives covered (see inst.)	(b) Rate for avg. covered life	(c) Fee (see instructions)	Tax	IRS No.
	Specified health insurance policies					
	(a) With a policy year ending before October 1, 2015		$ 2.08			
133	(b) With a policy year ending on or after October 1, 2015, and before October 1, 2016		$ 2.17			133
	Applicable self-insured health plans					
	(c) With a plan year ending before October 1, 2015		$ 2.08			
	(d) With a plan year ending on or after October 1, 2015, and before October 1, 2016		$ 2.17			

A plan sponsor should make corrections to a previously filed Form 720 by filing a Form 720X, Amended Quarterly Federal Excise Tax Return, including adjustments that result in an overpayment. https://www.irs.gov/pub/irs-pdf/f720x.pdf

Q 3: Who is a "plan sponsor" for purposes of paying the fee?

A 3: The "plan sponsor" is responsible for paying the fee. The term generally means the employer and is usually designated in the plan documents.

Where there is a controlled group of companies sharing a plan and no indication of the plan sponsor, the term generally means each separate employer.

Form 720 is a tax form (not an informational return form such as Form 5500). As such, an accountant or CPA would need to prepare with the employer's tax forms. TPAs and brokers cannot handle.

Example 1. Employer XYZ is a holding company with no employees that owns all the issued and outstanding shares of Employer X, Employer Y, and Employer Z.

Employer X, Employer Y, and Employer Z have established the XYZ Group Health Plan to provide accident and health coverage, provided other than through an insurance policy, for the benefit of their employees. The XYZ Group Health Plan has a calendar year plan year. In addition, there is no plan sponsor identified or designated in the plan document. As a self-insured health plan for employees of two or more employers, the XYZ Group Health Plan is an applicable self-insured health plan. However, a plan sponsor is not identified or designated in the governing

[3] $2.17 applies to for plan years ending on or after October 1, 2015 and before October 1, 2016.

plan document. Accordingly, the plan sponsor is identified as Employer X, Employer Y, and Employer Z, each with respect to its own employees covered under the plan.

Accordingly, Employer X, Employer Y, and Employer Z each must file a Form 720 reflecting their separate liabilities, calculated based upon lives covered that are employees of that employer, or spouses, dependents, or other beneficiaries of employees of that employer and the applicable dollar amount in effect for the plan year.

Example 2. The same facts as Example 1, except that the governing plan document designates Employer X as the plan sponsor of the XYZ Group Health Plan for purposes of the fee. Accordingly, the plan sponsor is Employer X. Employer X must file a Form 720, calculated based upon lives covered that are employees of Employer X, Employer Y, or Employer Z, or spouses, dependents, or other beneficiaries of employees of those employers and the applicable dollar amount in effect for the plan year.

Q 4: What does this apply to?

A 4: The fee and reporting requirement applies to an "applicable self-insured health plan" which is an employer plan that provides for health coverage other than through an insurance policy. This includes a self-insured medical plan, a health reimbursement arrangement ("HRA") and, in some cases, a health flexible spending account (unless it qualifies for the exception below).

However, it does not include any of the following:

- Most dental and vision plans.[4]
- A health FSA that satisfies two conditions:
  - the maximum benefit payable to any participant in the class for a year cannot exceed 2 times the employee's salary reduction election under the health FSA for the year (or, if greater, the amount of the employee's salary reduction election for the health FSA for the year, plus $500); and
  - other nonexcepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their employment.
- A health savings account ("HSA").
- An employee assistance program ("EAP"), disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.
- Any stop loss policy.
- Coverage for on-site medical clinics.
- A plan not covering individuals residing in the United States.
- Coverage only for accident (including accidental death and dismemberment).
- Disability income coverage.
- Workers' compensation or similar coverage.
- Supplemental benefits provided under a separate policy, certificate, or contract of insurance.
- Benefits for long-term care.
- Medicare supplemental health insurance or similar supplemental coverage provided under a group health plan.[5]

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[4]

- the benefits are provided under a separate policy, certificate, or contract of insurance (applicable to insured benefits only); or
- a participant may decline the coverage (meaning the participant may opt-out of the coverage upon request) (insured or self-insured); or
- claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan (insured or self-insured).

- Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance[6] if:
  - the benefits are provided under a separate policy, certificate, or contract of insurance;
  - there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and
  - the benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

It does include:

- retiree-only plans; and
- continuation coverage (COBRA or similar continuation coverage under other federal law or under state law).

Q 5: What if we have more than one applicable self-insured arrangement?

A 5: Two or more self-funded arrangements established or maintained by the same plan sponsor that provides for health coverage that have the same plan year may be treated as a single applicable self-insured health plan for purposes of calculating the fee.

For example, if a plan sponsor establishes or maintains a self-insured arrangement providing major medical benefits and a separate self-insured arrangement with the same plan year providing prescription drug benefits, the two arrangements may be treated as one applicable self-insured health plan so that the same life covered under each arrangement would count as only one covered life under the plan.

Similarly, if a plan sponsor provides a health reimbursement arrangement ("HRA") that 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 applicable self-insured health plan.

Fully insured and self-insured arrangements with a common plan sponsor cannot be treated as one plan. However, an applicable self-insured health plan that provides accident and health coverage through fully-insured options and self-insured options may determine the PCOR fee by disregarding the lives that are covered solely under the fully-insured options.

Q 6: What about HRAs and non-exempted health FSAs where there is no other self-funded plan?

A 6: If a plan sponsor does not maintain an applicable self-insured health plan other than an HRA or non-exempted health FSA (see Q&A 3), the plan sponsor may treat each participant's health FSA or HRA as covering a single covered life (and therefore the plan sponsor is not required to include as covered lives any spouse, dependent, or other beneficiary of the individual participant in the health FSA or HRA, as applicable). This may apply in cases where the employer offers an insured health plan and an HRA.

Q 7: How do I calculate the fee?

A 7: The amount of the fee for a plan year is equal to the "average number of lives covered under the plan" (see Q&A 8) for the plan year multiplied by the "applicable dollar amount" (see Q&A 9).

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[5] To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

[6] To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

A plan sponsor must use the same method of calculating the average number of lives covered under the plan consistently for the duration of the plan year. However, a plan sponsor may use a different method from one plan year to the next.

Q 8: How do I determine the "average number of lives covered under the plan"?

A 8: For plan years 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 for the plan year using any reasonable method.

For later years, "average number of lives covered under an applicable self-insured health plan" is determined under one of the following 3 methods:

1. The Actual Count Method

Under this method, the employer adds the totals of lives covered for each day of the plan year and divides by the number of days in the plan year.

Example. Employer A is the plan sponsor of the Employer A Self-Insured Health Plan, which has a calendar year plan year. Employer A calculates the sum of covered lives under the plan for each day of the plan year ending December 31, 2013 as 3,285,000.

The average number of covered lives under the plan for the plan year ending December 31, 2013 is 9,000 (3,285,000 divided by 365).

2. The Snapshot Dates Method

A plan sponsor may add 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 divide that total by the number of dates on which a count was made. For this purpose, the date or dates for each quarter must be the same (for example, the first day of the quarter, the last day of the quarter, the first day of each month, etc.).

The number of lives covered on a designated date may be determined using 1 of 2 ways:

A. Snapshot factor method

Under the snapshot factor method, the number of lives covered on a date is:

the number of participants with self-only coverage on that date

+

the number of participants with coverage other than self-only coverage on the date * 2.35.

B. Snapshot count method

Under the snapshot count method, the number of lives covered on a date equals the actual number of lives covered on the designated date.

Example 1. Employer B is the plan sponsor of the Employer B Self-Insured Health Plan, which has a calendar year plan year. Employer B has designated the first day of each quarter of the plan year as the date that Employer B counts the covered lives under the Employer B Self-Insured Health Plan. On January 1, 2013, Employer B Self-Insured Health Plan covers 2,000

covered lives, on April 1, 2013, 2,100 covered lives, on July 1, 2013, 2,050 covered lives, and on October 1, 2013, 2,050 covered lives.

Under the snapshot count method, Employer B must determine the average number of covered lives under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013 as 2,050 -- 8,200 (2,000 + 2,100 + 2,050 + 2,050) divided by 4. To calculate the fee for the plan year ending December 31, 2013, Employer B must determine the applicable dollar amount and multiply that amount by the average number of lives covered under the plan.

Example 2. Same facts as Example 1, except Employer B determines the number of covered lives not covered by self-only coverage based on the number of participants with coverage other than self-only multiplied by 2.35. On January 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 600 employees and other than self-only coverage to 800 employees. On April 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 608 employees and other than self-only coverage to 800 employees. On July 1, 2013 and October 1, 2013, Employer B Self-Insured Health Plan provides self-only coverage to 610 employees and other than self-only coverage to 809 employees. Under the snapshot factor method, Employer B must determine the average number of covered lives under the Employer B Self-Insured Health Plan for the plan year ending December 31, 2013 as 9,988 [(600+(800 x 2.35)) + (608 + (800 x 2.35)) + (610 + (809 x 2.35)) + (610 + (809 x 2.35))] divided by 4, or 2,497.

The final regulations require a plan sponsor that uses the snapshot method to determine the counts used based on a date during the first, second, or third month of each quarter (or more dates in each quarter if an equal number of dates is used for each quarter). Each date used for the second, third, and fourth quarters must be within 3 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. If a plan sponsor uses multiple dates for the first quarter, the plan sponsor must use dates in the second, third, and fourth quarters that correspond to each of the dates used for the first quarter or are within 3 days of such corresponding dates, and all dates used must fall within the same policy year or plan year. The 30th and 31st day of a month are treated as the last day of the month for purposes of determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or 31 are used as snapshot dates for a calendar year plan, June 30 is the corresponding date for the second quarter). Thus, for example, if a plan sponsor uses the snapshot method to determine the average number of lives covered under an applicable self-insured health plan with a calendar year plan year and uses Monday, January 7, 2013, as the counting date for the first quarter, the plan sponsor may use any date beginning with Thursday, April 4, 2013, and ending with Wednesday, April 10, 2013, as the counting date for the second quarter (because all of those days are within three days of April 7, 2013, the date that corresponds to the January 7, 2013 counting date for the first quarter).

3. The Form 5500 Method

A plan sponsor with a Form 5500 reporting requirement may determine the average number of lives covered under a plan for a plan year based on the number of reportable participants for the Form 5500 that is filed for the applicable self-insured health plan for that plan year.

For a self-insured plan that offers self-only coverage and coverage for dependents (coverage other than self-only coverage), the average number of covered lives under the plan for the plan year equals the sum of the total participants covered at the beginning and end of the plan year, as reported on the Form 5500 for the applicable self-insured plan.[7]

[7] If the plan only provides for self-only coverage, the average number of lives covered under the plan for the plan year is the number of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 filed for the applicable self-insured health plan, divided by 2.

Example. Employer C is the plan sponsor of the Employer C Self-Insured Health Plan, which has a fiscal year plan year ending on July 31, 2013. The Employer C Self-Insured Health Plan offers self-only coverage and family coverage. Employer C files a Form 5500 for the Employer C Self-Insured Health Plan for the plan year ending July 31, 2013 reflecting 4,000 plan participants on the first day of the plan year and 4,200 plan participants on the last day of the plan year.

For purposes of calculating the fee using the Form 5500 method, Employer C must treat the number of covered lives for the plan year ending July 31, 2013 as equal to the sum of 4,000 and 4,200, or 8,200. To calculate the fee for the plan year ending July 31, 2013, Employer C must determine the applicable dollar amount and multiply that amount by the average number of lives covered under the plan.

In order to use the Form 5500 method, the plan sponsor must have filed the Form 5500 by the due date for the PCOR fee for that year. If the plan sponsor files an extension (as is common for Form 5500 filings), it may not be able to use this method.

Q 9: What is the "applicable dollar amount"?

A 9: For the first year, the applicable dollar amount is $1.

For the second year, the applicable dollar amount is $2.

For the third year, the applicable dollar amount is $2.08.

For the fourth year, the applicable dollar amount is $2.17.

Q 10: What about short plan years?

A 10: There is no relief.

The PCOR fee for a short plan year is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year. Thus, for example, the PCOR fee for an applicable self-insured health plan that has a short plan year that starts on April 1, 2013, and ends on Dec. 31, 2013, is equal to the average number of lives covered for April through Dec. 31, 2013, multiplied by $2 (the applicable dollar amount for plan years ending on or after Oct. 1, 2013, but before Oct. 1, 2014).[8]

Q 11: Will USI handle the filing?

A 11: No. Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare.

Parties other than the plan sponsor such as third party administrators and USI *cannot* report or pay the fee.

Q 12: What about International plans?

A 12: The term "specified health insurance policy" includes only an accident and health insurance policy that is issued with respect to an individual residing in the United States. The fee applies to individuals on a temporary U.S. Visa who live in the U.S. The fee does not apply to a self-funded

[8] See FAQ 12 & 13, http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

health plan if the facts and circumstances show that it was designed specifically to cover primarily employees who are working and residing outside of the United States.

Q 13: What if I don't comply?

A 13: Penalties may apply for filing a return late; depositing taxes late; paying taxes late; willfully failing to collect and pay tax or file a return; negligence; and fraud. These penalties are in addition to the interest charged on late payments.[9]

Q 14: Is it deductible?

A 14: Yes.

The PCOR Fee is deductible as an ordinary and necessary expense. See: http://www.irs.gov/pub/irs-utl/AM2013-002.pdf

The DOL states that because the fee is a tax assessed against the plan sponsor, the fee may not be paid with plan assets (which include salary reduction contributions and COBRA premiums paid by qualified beneficiaries).

Q 15: Where can I find additional information?

A 15: Visit: http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

For the regulations, visit: http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

[9]

- For failure to file, there shall be added to the amount required to be shown as tax on such return 5% of the amount of such tax if the failure is for not more than 1 month, with an additional 5% for each additional month or fraction thereof during which such failure continues, not exceeding 25% in the aggregate.
- For failure to pay, there shall be added to the amount shown as tax on such return 0.5% of the amount of such tax if the failure is for not more than 1 month, with an additional 0.5% for each additional month or fraction thereof during which such failure continues, not exceeding 25% in the aggregate.