Application of the Patient-Centered Outcomes Research Trust Fund Fee to Common Types of Health Coverage or Arrangements

Type of insurance coverage or arrangement	Subject to the fee?	Person responsible for paying and reporting the fee
Accident and health coverage or major medical insurance coverage	Yes	• The issuer if insured • The plan sponsor if self-insured
Retiree-only health or major medical coverage	Yes	• The issuer if insured • The plan sponsor if self-insured
Health or major medical coverage under multiple policies or plans	Yes	• Each issuer or plan sponsor • See below for special rules for coverage under multiple applicable self-insured health plans
COBRA coverage	Yes	• The issuer if insured • The plan sponsor if self-insured
Health Reimbursement Arrangement (HRA), including a premium-only HRA	Yes, unless the arrangement satisfies the requirements for being treated as an excepted benefit	• The plan sponsor • See below for special rules for coverage under multiple applicable self-insured health plans and special counting rules for HRAs
Flexible Spending Arrangement (FSA)	Yes, unless the arrangement satisfies the requirements for being treated as an excepted benefit	• The plan sponsor • See below for special counting rules for FSAs
State & local government health or major medical plans for employees and/or retirees	Yes	• The issuer if insured • The plan sponsor if self-insured
Stand-alone dental or vision coverage	No	
Group insurance policy designed and issued specifically to cover primarily employees working and residing outside the United States	No	
Self-insured health plan designed specifically to cover primarily employees who are working and residing outside the United States	No	
Medicare (the insurance program established under title XVIII of the Social Security Act)	No	
Medicaid (the medical assistance program established by title XIX of the Social Security Act)	No	
Children's Health Insurance Program (CHIP) (the medical assistance program established under title XXI of the Social Security Act)	No	
Military health plans (programs established by Federal law for providing medical care (other than through insurance policies) to individuals (spouses or dependents) by reason of the individual being (or having been) a member of	No	

the Armed Forces of the United States)		
Certain Indian tribal government health plans (programs established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act))	No	
Health Savings Arrangements (HSAs)	No	
Archer Medical Savings Accounts (MSAs)	No	
Hospital indemnity or specified illness benefits	No	
Stop-loss or indemnity reinsurance	No	
Employee assistance programs, disease management programs, or wellness programs	No, provided the program does not provide significant benefits in the nature of medical care or treatment	
Accident-only coverage (including accidental death and dismemberment)	No	
Disability income coverage	No	
Automobile medical payment coverage	No	
Workers' compensation or similar coverage	No	
On-site medical clinic	No	

Special rule for coverage under multiple applicable self-insured health plans:

- Generally, separate fees apply for lives covered by each specified health insurance policy or applicable self-insured health plan.

- However, two or more applicable self-insured health plans may be combined and treated as a single applicable self-insured health plan for purposes of calculating the PCORI fee but only if the plans have:

    - The same plan sponsor; and
    - The same plan year.

For example, if amounts in an HRA may be used to pay deductibles and copays under a specified health insurance policy, the HRA (an applicable self-insured health plan) and the policy would be subject to separate PCORI fees. However, an HRA that may be used to pay deductibles and copays under the applicable self-insured health plan is not subject to a separate fee (and the fee will apply only to the applicable self-insured health plan) if both the HRA and the applicable self-insured health plan have the same plan sponsor and the same plan year.

- There is no similar rule for lives covered by more than one insurance policy subject to the PCORI fee.

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.

PCORI: Question & Answers

Affordable Care Act Provision 6301

Q1. What is the Patient-Centered Outcomes Research Trust Fund fee?

A1. The Patient-Centered Outcomes Research Trust Fund fee is a fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute will assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The institute will compile and distribute comparative clinical effectiveness research findings.

Q2. When does the PCORI fee go into effect?

A2. The PCORI fee applies to specified health insurance policies with policy years ending after Sept. 30, 2012, and before Oct.1, 2019, and applicable self-insured health plans with plan years ending after Sept. 30, 2012, and before Oct. 1, 2019.

Q3. How much is the PCORI fee?

A3. The amount of the PCORI fee is equal to the average number of lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year. For policy and plan years ending after Sept. 30, 2012, and before Oct. 1, 2013, the applicable dollar amount is $1. For policy and plan years ending after Sept. 30, 2013, and before Oct.1, 2014, the applicable dollar amount is $2. For policy and plan years beginning on or after Oct. 1, 2014, and before Oct. 1, 2019, the applicable dollar amount is further adjusted to reflect inflation in National Health Expenditures, as determined by the Secretary of Health and Human Services.

Q4. How does an issuer of a specified health insurance policy or plan sponsor of an applicable self-insured health plan determine the average number of lives covered under the policy or plan in order to calculate the PCORI fee for the year?

A4. The PCORI fee is imposed on an issuer of a specified health insurance policy and a plan sponsor of an applicable self-insured health plan based on the average number of lives covered under the policy for the policy year or the plan for the plan year.

The PCORI fee final regulations were published on Dec. 6, 2012. The final regulations require issuers of specified health insurance policies to use one of four alternative methods — the actual count method, the snapshot method, the member months method or the state form method — to determine the average number of lives covered under a specified health insurance policy for a policy year. The final regulations require plan sponsors of applicable health plans to use one of three alternative methods — the actual count method, the snapshot method or the Form 5500 method — to determine the average number of lives covered under the applicable self-insured health plan for a plan year.

The final regulations explain the available methods in detail.

Q5. Which individuals are taken into account for determining the lives covered under a specified health insurance policy or applicable self-insured health plan?

A5. Generally, all individuals who are covered during the policy year or plan year must be counted in computing the average number of lives covered for that year. Thus, for example, an applicable self-insured health plan must count an employee and his dependent child as two separate covered lives unless the plan is a health reimbursement arrangement (HRA) or flexible spending arrangement (FSA).

Q6. If an employer provides COBRA coverage or otherwise provides coverage to its retirees or other former employees, do covered individuals (and their beneficiaries) count as 'lives covered' for purpose of calculating the PCORI fee?

A6. Yes. These covered individuals and their beneficiaries must be taken into account in calculating the average number of lives covered.

Q7. Who is responsible for reporting and paying the PCORI fee?

A7. Issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans are responsible for reporting and paying the PCORI fee.

Q8. What form will be used to report and pay the PCORI fee?

A8. Issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans will file annually Form 720, Quarterly Federal Excise Tax Return, to report and pay the PCORI fee. The Form 720 will be due on July 31 of the year following the last day of the policy year or plan year. Electronic filing is available but not required. Payment will be due at the time the Form 720 is due. Deposits are not required for the PCORI fee.

Issuers and plan sponsors who are required to pay the PCORI fee but are not required to report any other liabilities on a Form 720 will be required to file a Form 720 only once a year. They will not be required to file a Form 720 for the other quarters of the year.

Issuers and plan sponsors who are required to pay the PCORI fee as well as other liabilities on a Form 720 will use their Form 720 for the 2nd quarter to report and pay the PCORI fee that is due July 31. Only one Form 720 should be filed for each quarter.

The IRS is revising the Form 720 and the instructions to Form 720. The revised form will provide for the reporting and payment of the PCORI fee.

Q9. What exceptions to the PCORI fee apply?

A9. The PCORI fee does not apply to exempt governmental programs, including Medicare, Medicaid, Children's Health Insurance Program (CHIP) and any program established by federal law for providing medical care (other than through insurance policies) to members of the Armed Forces, veterans and members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

Also, health insurance policies and self-insured plans that provide only excepted benefits, such as plans that offer benefits limited to vision or dental benefits and most flexible spending arrangements (FSAs), are not subject to the PCORI fee. Further, health insurance policies or self-insured plans that are limited to employee

assistance programs, disease management programs or wellness programs are not subject to the PCORI fee if these programs do not provide significant benefits in the nature of medical care or treatment.

The PCORI fee applies only to policies and plans that cover individuals residing in the United States. Thus, the PCORI fee does not apply to policies and plans that are designed specifically to cover employees who are working and residing outside the United States.

Q10. Are health insurance policies or self-insured health plans for tax-exempt organizations or governmental entities subject to the PCORI fee?

A10. Yes. Unless the health insurance policy or self-insured health plan is an exempt governmental program described above, the policy or plan is a specified health insurance policy or applicable self-insured health plan subject to the PCORI fee and, accordingly, the health insurance issuer or plan sponsor is responsible for the PCORI fee.

Q11. When does the PCORI fee expire?

A11. The PCORI fee is effective for policy and plan years ending after Sept. 30, 2012, and before Oct. 1, 2019.