MAY 2019

Compliance Alert!

Exude, Inc. is providing you with the following update based on the most recent information available.

Patient-Centered Outcomes Research Institute Fee (PCORI)

DUE JULY 31, 2019

~This fee applies to self/level funded medical plans, HRAs and some FSAs.~

What is the PCORI fee?

The Patient-Centered Outcomes Research Institute Fee, also known as PCORI, was created as a result of the Affordable Care Act (ACA) in order to fund research to evaluate the effectiveness of medical treatments, procedures and strategies that treat, manage, diagnose or prevent illness or injury.

When does the PCORI fee expire?

The PCORI fee is effective for plan years ending on or after October 1, 2012 and before October 1, 2019.

What plans does this apply to and who is responsible for paying it?

Health insurance issuers of fully insured medical coverage pay this fee directly and it is built into premium rates.

Employers that sponsor self-insured health plans are responsible for fees under PCORI. This includes level funded health plans, Health Reimbursement Arrangements (HRAs), and some Flexible Spending Accounts (FSAs).

The below chart shows more detail on applicable plans.

Type of Insurance Coverage/Arrangement	Subject to the fee?	Responsible for paying & reporting the fee
Accident and health coverage or major medical 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 & 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 & issued specifically to cover primarily employees working & residing outside the United States	No	
Self-insured health plan designed specifically to cover primarily employees who are working & residing outside the United States	No	

Type of Insurance Coverage/Arrangement	Subject to the fee?	Responsible for paying & reporting the fee
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 the Armed Forces of the United States)	No	
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	

How do I know if my FSA is an excepted benefit?

To be an excepted benefit and avoid the PCORI fee, a health FSA must satisfy 2 conditions:

1. Maximum Benefit Condition (includes employee & employer contributions): The maximum benefit payable to any employee under the health FSA for the year does not exceed 2 times the employee's salary reduction election for health FSA benefits or, if greater, the employee's salary reduction election plus $500.
    - Thus, the health FSA is an excepted benefit if:
        - The employer does not make any contributions to the FSA,
        - The employer makes a dollar-for-dollar match to the FSA, or
        - The employer contributions are no more than $500 to the FSA.

-AND-

2. Availability Condition: The employer also offers other non-excepted health coverage (e.g. major medical coverage) to the employees who are eligible for the health FSA. (The employee is not required to actually enroll in the major medical coverage.)

Note: According to agency guidance, a health FSA that does not qualify as an excepted benefit is not integrated with a group health plan, and thus, it will fail to satisfy certain ACA market reforms.

How much is the fee and when is it due?

Plan sponsors of applicable self-insured health plans are required to report and pay the fee for a plan year no later than July 31st of the calendar year immediately following the last day of the plan year to which a fee applies.

The fee varies by plan year and is multiplied by the average number of covered lives on the plan. A listing of the fee by plan year can be found on the IRS website. The below fee by plan year start date assumes a 12 month plan year.

Fee Due July 31, 2019	
Plan Year Start Date	Fee Per Average Covered Life
February 1, 2017 - October 1, 2017	$2.39
November 1, 2017 - January 1, 2018	$2.45

How do I calculate what my organization owes?

Plan sponsors may choose from 3 methods when determining the average number of lives covered by their plans (including covered spouses/dependents), indicated below.

- ***Actual Count Method*:** Plan sponsors may calculate the sum of the lives covered for each day in the plan year and then divide that sum by the number of days in the year.
- ***Snapshot Method*:** Plan sponsors may choose from two methods to calculate the number of lives covered on a designated date.
    - Snapshot Count Method: Calculate the sum of lives covered on one date in each quarter of the year (or an equal number of dates in each quarter) and then divide that number by the number of days on which a count was made.
    - Snapshot Factor Method: The number of lives covered on a date is equal to the sum of:
        - The number of participants with self-only coverage on that date PLUS
        - The number of participants with coverage other than self-only on that date multiplied by 2.35.
- ***Form 5500 Method*:** Plan sponsors subject to Form 5500 filing, may use this method, which is based on the number of participants reported on the 5500. This method can only be used if the 5500 is filed no later than the PCORI due date on July 31st.
    - If the plan offers self-only coverage, add the number of participants covered at the beginning of the plan year to the number of employees covered at the end of the plan year, as reported on Form 5500, and divide by 2.
    - For plans that offer more than self-only coverage, add the number of participants covered at the beginning and end of the plan year, as reported on Form 5500, but do not divide by 2.

Special counting rule for HRAs and FSAs

- For HRAs and FSAs, it is permissible to assume one covered life for each covered employee, not counting covered spouses and dependents.

What if I have an HRA and a self/level funded medical plan?

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

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

For example, for an employer with an HRA integrated with a self-insured health plan with the same plan year, the fee need only be paid with respect to the self-insured health plan.

Where do I pay the PCORI fee?

The fee is paid via IRS Tax Form 720.

For an IRS Q & A on PCORI, please click here.

If you have any questions, please contact your Exude representative.

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