Healthcare Reform

Patient-Centered Outcomes Research Institute Fee

The Affordable Care Act assesses an annual Patient-Centered Outcomes Research Institute (PCORI) fee to sponsors of self-funded health plans and fully insured individual and group health plans. The PCORI fee is effective through September 2029.

What is the Purpose of the Fee?

The nonprofit organization, the Patient-Centered Outcomes Research Institute, will use these fees to fund research to compare different medical treatments and interventions to determine what treatments are most effective with the help of clinicians, purchasers, policymakers and patients. The mission is to help doctors and patients make evidence-based, well-founded healthcare decisions.

How Much is the Fee?

Fee:	Plan years ending between:	Filing Date:
$3.00 per average number of covered lives	Oct. 1, 2022 and Dec. 31, 2022	July 31, 2023
$3.00 per average number of covered lives	Jan. 1, 2023 and Sept. 30, 2023	July 31, 2024
$2.79 per average number of covered lives	Oct. 1, 2021 and Dec. 31, 2021	July 31, 2022
$2.79 per average number of covered lives	Jan. 1, 2022 and Sept. 30, 2022	July 31, 2023
$2.66 per average number of covered lives	Oct. 1, 2020, and Dec. 31, 2020	July 31, 2021
$2.66 per average number of covered lives	Jan. 1, 2021 and Sept. 30, 2021	July 31, 2022
$2.54 per average number of covered lives	Oct. 1, 2019, and Dec. 31, 2019	July 31, 2020
$2.54 per average number of covered lives	Jan. 1, 2020 and Sept. 30, 2020	July 31, 2021

The fee is tax deductible.

How Do You Determine the Fee?

Self-funded plans have three ways to determine the average number of covered lives.

1) **Actual Count Method –** Add the actual total lives covered for each day of the plan year and divide that total by the number of days in the plan year.
2) **Snapshot Method –** Employers using this method should refer to the regulations for a full description, but, in general, add the number of covered lives (as determined under either the "Snapshot Count Method" or the "Snapshot Factor Method" (described below) on a date during the first, second or third month of each quarter of the plan year (or more dates in each quarter if an equal number of dates is used in each quarter), and divide that total by the number of dates on which a count was made. Each date used for the second, third and fourth quarter must be within three days of the date in that quarter that corresponds to the date(s) used for the first quarter, and all dates used must fall within the same plan year.

The regulations give employers two choices for determining the average number of covered lives on the designated dates as follows:

a) The "Snapshot Count Method" which looks at the actual number of lives covered on the designated date, or

b) The "Snapshot Factor Method" which takes the sum of the number of participants with self-only coverage on the designated date plus the number of participants with family coverage on the designated date multiplied by 2.35.

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3) **Form 5500 Method –** The employer can use this method if they file Form 5500 or Form 5500-SF for the applicable plan year no later than the July 31, due date for Form 720. If the employer provides self-only coverage, then add the total participants covered at the beginning and the end of the plan year, as reported on the 5500, and divide by 2.

   If the employer provides self-only and family coverage, add the total participants covered at the beginning and end of the plan year as reported on the 5500.

The plan sponsor must use the same method for the duration of the plan year, but may use a different method in a subsequent plan year.

What Types of Coverage Are Exempt from the Fee?

The fee does not apply to lives covered by HIPAA-excepted benefits, (including flexible spending accounts (FSAs) as long as they meet the criteria for excepted benefits), health savings accounts, employee assistance programs, disease management programs or wellness programs if the program doesn't provide significant medical care or treatment benefits; or government programs such as Medicare, Medicaid, state children's health insurance programs and other federal programs covering members of the armed forces and Indian tribes.

What do Employers Need to Know?

Sponsors of self-funded plans are required to file federal excise tax form (Form 720) to report their liability of this fee by July 31 of the calendar year immediately following the last day of the plan year and pay the fee directly to the IRS.

Does the PCORI Fee Apply to an Applicable Self-Funded Health Plan that has a Short Plan Year?

Yes. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

What is the PCORI Fee Due Date for a Short Plan Year?

The due date for the PCORI fee is July 31 of the year following the last day of the plan year (including a short plan year).

Can a Plan Sponsor that Overpaid the PCORI Fee Reduce the PCORI Fee Due the Following Year for the Amount of the Overpayment?

No. Plan sponsors cannot reduce the PCORI fee due July 31 for any overpayment from a prior year. A plan sponsor should make corrections to a previously filed Form 720, including adjustments that resulted in an overpayment, by filing a Form 720X, Amended Quarterly Federal Excise Tax Return. Form 720X may be filed anytime within the applicable limitation period. Form 720X is available on IRS.gov.

PLEASE NOTE: This material represents a high-level summary of ACA provisions and may not be construed as tax, legal or compliance advice. Please consult your professional benefits adviser or legal counsel regarding how these provisions may impact your specific benefit plan.

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