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PCORI Fee Due July 31, 2013 For Plans Years Ending October 1, 2012 - December 31, 2012

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By July 31, 2013, most issuers of health insurance policies and plan sponsors of self-insured health plans must pay a fee of $1 per covered life as a result of new provisions in the Patient Protection and Affordable Care Act. The fee will partially fund the Patient-Centered Outcome Research Institute ("PCORI"), which is a private, nonprofit corporation that is designed to support comparative clinical effectiveness research findings.

The PCORI fee must be paid by issuers and plan sponsors. This means that the party responsible for paying the fee will typically be the insurance issuer or the employer or employee organization funding a self-insured plan. (An HRA is considered a self-funded plan.)

The fee is a temporary fee that affected parties will be required to pay for plan or policy years ending on or after October 1, 2012 and before October 1, 2019. The fee will increase to $2 for policy years ending after October 1, 2013, and may also be increased for plan years ending on or after October 1, 2014, depending on increases in the projected per capita amount of National Health Expenditures.

The PCORI fee must be reported and paid on Form 720, which is the Quarterly Federal Excise Tax Return Form. Form 720 was recently revised in order account for the PCORI fee.

In Part II of Form 720, the filer must insert the average number of covered lives in column (a), and multiply it by the rate for the average covered lives in column (b). Form 720 may be filed electronically and is available at www.irs.gov/efile. Although Form 720 is a quarterly form, the filer need only file once a year for the PCORI fee.

The IRS has provided several methods for calculating the average number of covered lives. Notably, COBRA beneficiaries and individuals covered by retiree-only plans are not excluded from consideration in calculation of the fee.

Some of the more common calculation methods include:

- **ACTUAL COUNT METHOD:** Add the total number of lives covered for each day of the plan or policy year and divide the total by the number of days in the plan or policy year.
- **SNAPSHOT METHOD**: This method varies depending on the whether the calculation is being done by an issuer or a plan sponsor. Essentially, the formula requires adding the total lives covered on a date during the first, second, or third month of each quarter, and dividing the total by the number of dates on which a count is made. Each date used for the subsequent quarters must correspond with the date used for the first quarter, and all the dates must be within the same policy year. A variation of the snapshot method - using a factor (2.35) to determine the total lives - is also available for self-insured plans.
- **FORM 5500 METHOD:** Plan sponsors may use this method to calculate the number of covered lives based on the number of reportable participants on the Form 5500. The actual calculation differs depending on what type of coverage is offered (employee-only, family, etc.). Note that this method can only be used if the Form 5500 is filed on or before July 31 of the applicable year.
- **NAIC MEMBER MONTHS METHOD:** Insurance issuers may use the member months reported on the National Association of Insurance Commissioners Supplemental Health Care Exhibit and divide by 12 to determine the covered lives.
- **STATE FORM METHOD:** If an insurance issuer is not required to file NAIC forms, the issuer may use the comparable form filed with the issuer's domicile state and apply the same technique as applied in the NAIC Member Months Method.

While a single method must be used for an entire plan year, the calculation method may vary from year to year. The IRS has also provided several formulas in addition to the calculation methods mentioned above, including calculation methods that may be used in the first and last year the PCORI fee is effective.

While there is no provision allowing for correction of minor calculation errors without penalty, the final IRS guidance states that penalties may be waived or abated if the issuer or plan sponsor has reasonable cause for the mistake, and the failure to properly file was not due to willful neglect.

Jackson Lewis LLP