THE LATEST
FROM BCBSAZ FOR EMPLOYERS

Patient Centered Outcomes Research Trust Fund Fee

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Patient Centered Outcomes Research Trust Fund Fee

The Patient Protection and Affordable Care Act (PPACA) provides for the establishment of the Patient Centered Outcomes Research Institute (PCORI) intended to identify, prioritize and execute comparative clinical effectiveness research. The research is financed by the newly established Patient Centered Outcomes Research Trust Fund which will be funded in part by fees imposed on health insurers and plan sponsors of self-insured plans for policy years ending before Oct. 1, 2019. The Treasury Department and Internal Revenue Service have issued final regulations interpreting the PCORI fee provisions. We wanted to provide you with important information about these requirements.

Who must pay the fee?

The fee is imposed on insurers of “specified health insurance policies” which include accident and health insurance policies (including a policy under a group health plan) issued with respect to individuals living in the United States. Additionally, the fee applies to plan sponsors of self-insured employer group health plans that provide for accident and health coverage. The fee does apply to stand-alone HRAs, certain health FSAs (those which are not treated as HIPAA excepted benefits), COBRA coverage and retiree-only plans as well. Special rules apply for HRAs and those certain health FSAs when offered with another self-insured group health plan.

The fee does not apply to the following policy types:

- Excepted benefits coverage (this includes things like accident only policies, long term care benefits, specified diseases, fixed indemnity, certain limited scope dental and vision plans)
- Expatriate policies
- Stop loss or indemnity reinsurance policies
- Employee assistance plans
- Disease management or wellness programs if the program does not provide significant medical care or treatment benefits
- Medicare, Medicaid, CHIP and TRICARE
- Federally recognized Indian Health Services and programs under the Indian Health Care Improvement Act

When is the fee due and how is it paid?

Insurers and plan sponsors of self-insured plans must report and pay the fee once a year on IRS Form 720 which will be due July 31st.

How is the fee calculated?

The fee is calculated by multiplying the average number of lives covered under the policy by a set dollar amount.

- For each policy year ending on or after October 1, 2012 and before October 1, 2013, the set dollar amount is $1
- For each policy year ending on or after October 1, 2013 and before October 1, 2014, the set dollar amount is $2
- For policy years ending in any fiscal year beginning on or after October 1, 2014, the set dollar amount shall equal the sum of the dollar amount for the policy years ending in the previous fiscal year plus an amount equal to the product of the dollar amount for policy years ending in the preceding fiscal year multiplied by the percentage increase in the projected per capita amount of National Health Expenditures
- The fee does not apply to policy years ending after September 30, 2019

The regulations describe different methods insurers and plan sponsors of self-insured plans may use to determine the number of covered lives for purposes of calculating the fee.

Insured Groups

If you have insurance coverage with BCBSAZ, BCBSAZ will be selecting the method of counting lives from one of the counting methods permitted in the final regulation and will report and pay the fee related to this coverage. Please note that you may have obligations with respect to other coverage you may provide.

Self-Insured Groups

The final regulations described different methods sponsors of self-funded group health plans may use to determine the average number of covered lives during the plan year. These include the following:

> *Actual Count Method* – the plan sponsor may determine the average number of covered lives by adding the total of covered lives for each day of the plan year and divide by the total number of days in the plan year.
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> *Snapshot Method* – the plan sponsor may add the total number of covered lives on one date in each quarter of the policy year (or an equal number of dates each quarter) and divide by the total number of dates during which the count was made. To determine the number of lives covered on a date, the plan sponsor may use the actual number of lives covered on the designated date or the plan sponsor may add the number of participants with self only coverage on the designated date to the product of the number of participants with coverage other than self only on the date and 2.35.
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> *Form 5500 Method* – plan sponsors that only offer self-only coverage and that file an annual Form 5500 report may use the sum of the total participants covered at the beginning and end of the plan year as reported on the Form 5500, divided by 2. Plan sponsors that offer both self-only coverage and other than self-only coverage (e.g., family coverage) use the total participants covered at the beginning and at the end of the plan year (without dividing by 2) as the average number of covered lives during the plan year. To use this method, the Form 5500 must be filed no later than the due date for the fee for the applicable plan year.

The final regulation also includes some other specifications which plan sponsors should review to arrive at the correct count. For example, if the plan sponsor of a self-funded plan has more than one self-funded plan with the same plan year it may treat them as a single self-funded plan for purposes of this fee to avoid double counting of the members. Additionally, if a health FSA or HRA is sponsored by a plan sponsor that also has an applicable self-funded health plan (that is not a FSA or HRA), the two arrangements may be treated as one plan.

While the same counting method must be used consistently for the duration of a plan year, a different method

may be used from one plan year to the next.

What do I need to do?

Insured Groups

For BCBSAZ insured groups, BCBSAZ will be completing and submitting the Form 720 and paying this fee to the IRS. However, please be sure to consult your tax advisor if you have other plans to make sure you do not have other reporting or payment obligations.

Self-Insured Groups

Plan sponsors of self-funded plans must complete and submit the Form 720 and pay the required fee directly. BCBSAZ does provide some information where covered lives are reported which you may find useful in calculating this figure:

- BlueInsight available monthly
- ASC monthly claims invoice
- Annual Form 5500 disclosures
- Renewal package – monthly enrollment that ties to the experience periods used for the renewal calculation and typically last 24 months (provided annually with renewal)

This is intended to provide general information to our customers and is not legal advice. We encourage you to consult your legal or tax advisor.

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