SecureOne Benefit Administrators, Inc

ACA News Alert!

Patient Centered Outcomes Research Institute Fee (PCORI) Update for 2016

June 2016

The Patient Centered Outcome Research Institute (PCORI) fees under the Patient Protection and Affordable Care Act (PPACA) are coming due July 31, 2016. This is not the same IRS filing as the Transitional Reinsurance Fee or the filing of the 1094-B/1095-B or 1094-C/1095-C.

RESPONSIBLE FOR PAYMENT OF THE FEE

Insurance carriers for individual or group insurance and Self-Insured Plan Sponsors (Employers) are responsible for paying the fee. Insurance Carriers and Plan Sponsors (Employers) must file a Form 720, the quarterly Federal Excise Tax Returns to report and pay the annual fees. Employers not filing a Form 720 today must file it annually to report the fees. Employers need to consult with their tax advisor with questions about filing of the excise tax returns. The fees are due on the 31st of July of the calendar year following the plan year they are assessed.

EFFECTIVE

Initially, for policy or plan years ending after September 30, 2012, issuers (Insurance Carriers) and Employers sponsoring certain group health plans (self-funded) were required to pay a fee of $1 per covered life per year. The fee has adjusted to $2.08 for policy or plan years ending BEFORE October 1, 2015 and $2.17 for plan years ending ON OR AFTER October 1, 2015 and before October 1, 2016

Exclusions

- Any Stop-Loss or indemnity reinsurance policy.
- Any group plans issued to an employer where the facts and circumstances support that the group policy was designed to cover employees working and residing outside the United States.
- Any prepaid health coverage arrangement, which means an arrangement under which the providers receive fixed payments or premiums as consideration for their agreement to provide health coverage.
- Any insurance policy or plan if substantially all of it's coverage is for "Excepted Benefits". Often Separate policies cover only dental and vision benefits this makes their "Excepted Benefits" under HIPAA. Benefits must meet two requirements for coverage to be "Excepted" if they are not covered by a separate contract.

    A. Employee must make a separate election for the coverages.
    B. Employees must make separate employee contributions for the coverage.

- FSA Plans
- Medicaid & Medicare
- SCHIP
- Federally Recognized Indian Health Services
- EAP; disease management programs and wellness programs are excluded if they do not provide significant medical care or treatment benefits.
- HRA—Health Reimbursement Arrangement—If the underlying plan is fully insured, the insurance carrier is responsible for the fees. The plan sponsor (employer) is responsible for the self-insured portion of the "HRA". If both the "HRA" and underlying plan are both self-insured, the arrangement can be treated as a single self-insured plan provided they both have the same plan year.

CALCULATION OF THE FEES

The plan year dates determine the fees!

Policy or plan year ending BEFORE October 1, 2015.	$2.08
Between October 1, 2015 and October 1, 2016	$2.17

Self Funded Calculation

We have three (3) methods:

1. Actual Count—This method requires the plan sponsor (employer) to count the actual number of individuals on each day of the plan year and divide the number by 365 or 366 as applicable.

2. Snapshot—Two method options:
    a. Plan sponsors (employer) can count the actual number of covered individuals on at least one day in each quarter. The covered lives in the snapshot days are then added together and divided by four (4).
    b. Plan sponsors (employer) can count the actual number of employees enrolled for single coverage on one day in each quarter. The plan must add to that day's single count, the number of employees enrolled for non-single coverage, multiply by 2.35. This sum of numbers for each quarter should be divided by four.

3. Form 5500 — This method uses the number reported by the plan sponsor (employer) annual form 5500. If a plan offers simple coverage, the plan sponsor can add the participants as of the first day of the plan year to the number of participants on the last day of the plan year. This sum should be divided by two (2) to determine the average covered lives. However, the 5500 form does not distinguish between single and multi-person enrollment categories. If the plan offers family coverage, then the 5500 calculation changes. The plan sponsor will need to add the number of participants at the beginning of the plan year to the number of participants at the end of the plan year. The sum of these two (2) numbers equals the average covered lives for fees purposes. Plan sponsors (employers) must be consistent in the calculation each year until the end.

SecureOne Calculations

SecureOne will be providing you with the PCORI count by utilizing the snapshot (version A). You will receive a notification from SecureOne as to the number of lives under your plan.

SecureOne; keeping our clients informed on the "ACA" front.

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