Patient-Centered Outcomes Research Institute Fees (PCORI)

The Affordable Care Act imposes a fee on employers that sponsor certain **self-insured health plans** to help fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI fees support research to evaluate and compare health outcomes and the clinical effectiveness of certain medical treatments, services, procedures, and drugs. The fee must be reported once a year on the second-quarter Form 720. It must be paid by July 31 of the calendar year immediately following the last day of the plan year to which the fee applies.

The fee was originally effective for plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. However, a 2019 continuing spending resolution reinstates PCORI fees for the 2020-2029 fiscal years. **As a result, specified health insurance policies and applicable self-insured health plans must continue to pay these fees through 2029**.

For plan years ending on or after Oct. 1, 2019, and before Oct. 1, 2020, the fee is **$2.54**, multiplied by the average number of lives covered under the plan. Because of the anticipated termination of the PCORI fee prior to its extension, plan sponsors may not have anticipated the need to identify the number of covered lives for plan years ending during this period. Thus, IRS Notice 2020-44 provides that plan sponsors may use **any reasonable method** for calculating the average number of covered lives for this period, in addition to existing methods, so long as it is **applied consistently for the duration of the plan year**.

Regulations explain how to calculate the average number of lives covered. Note that third-party reporting or payment of the PCORI fee is not allowed. The chart below illustrates how the fees may apply to specific types of health coverage or arrangements.

Application of PCORI Fees to Common Types of Health Coverage or Arrangements

Type of Insurance Coverage or Arrangement	Subject to the Fee?	Person Responsible for Paying and Reporting the Fee
Accident and health coverage or major medical insurance 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 and for HRAs
Flexible Spending Arrangement (FSA)	Yes, unless the arrangement satisfies the requirements for	• The plan sponsor • See below for special

	being treated as an excepted benefit (**Note:** A health FSA must qualify as excepted benefits in order to comply with certain ACA market reforms.)	rules for FSAs
Stand-alone dental or vision coverage	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	

Special rules apply for calculating covered lives under multiple applicable self-insured health plans, HRAs and FSAs.