ALAMO INSURANCE GROUP INC
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BENEFITS BUZZ

January 2025

PCORI Fee Amount Adjusted for 2025

The IRS recently issued Notice 2024-83 to increase the Patient-Centered Outcomes Research Institute (PCORI) fee amount for plan years ending on or after Oct. 1, 2024, and before Oct. 1, 2025. The updated PCORI fee amount is **$3.47** multiplied by the average number of lives covered under the plan.

For plan years that ended on or after Oct. 1, 2023, and before Oct. 1, 2024, the PCORI fee amount is **$3.22** multiplied by the average number of lives covered under the plan.

The PCORI fee is imposed on health insurance issuers and self-insured plan sponsors to fund comparative effectiveness research. It applies through the plan or policy year ending before Oct. 1, 2029.

PCORI fees are reported and paid annually on IRS Form 720 (Quarterly Federal Excise Tax Return). These fees are due each year by July 31 of the year following the last day of the plan year. For plan years ending in 2024, the PCORI fee is due by July 31, 2025. Employers with self-insured health plans should have reported and paid PCORI fees for 2023 by July 31, 2024.

The PCORI fees are calculated based on the average number of covered lives under the plan or policy. This generally includes employees and their enrolled spouses and dependents unless the plan is a health reimbursement arrangement (HRA) or health flexible spending account (FSA). Final rules outline a number of alternatives for issuers and plan sponsors to determine the average number of covered lives.

New Mental Health Parity Requirements Take Effect in 2025

In September 2024, federal agencies released a final rule to strengthen the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). The final rule is designed to help ensure individuals do not face greater restrictions to obtaining mental health and substance use disorder (MH/SUD) benefits than they would face for medical/surgical (M/S) benefits.

Significantly, the final rule adds protections against more restrictive nonquantitative treatment limitations (NQTLs), such as network composition, out-of-network reimbursement rates and prior authorization requirements. For example, the final rule requires group health plans and health insurance issuers to collect and evaluate data related to the NQTLs they place on MH/SUD care and make changes if the data shows they are providing insufficient access.

The final rule generally applies for plan years beginning on or after Jan. 1, 2025; however, certain key requirements, such as the NQTL data evaluation requirements, apply for plan years beginning on or after Jan. 1, 2026.

The final rule also establishes minimum standards for developing comparative analyses to assess whether an NQTL, as written and in operation, complies with MHPAEA's requirements. Plans and issuers that cover both M/S benefits and MH/SUD benefits and impose NQTLs on MH/SUD benefits must perform and document a comparative analysis of the design and application of each applicable NQTL.

In many cases, issuers and third-party administrators will help prepare comparative analyses for employer-sponsored health plans. However, the final rule requires the comparative analyses for ERISA-covered plans to also include a **plan fiduciary's certification** that they have engaged in a prudent process and monitored their service providers.