Taxes and fees — and how they may impact you

Affordable Care Act update for plan sponsors with insured and self-funded plans

The Affordable Care Act (ACA) includes a number of provisions that affect both insured and self-funded plans. Those provisions include three taxes and fees, which currently impact the cost of plans and one more tax scheduled to take effect in 2020. The responsibility for paying them falls on both health insurers and plan sponsors.

This flyer goes over these new taxes and fees based on current guidance. We want to help you stay up to date based on what we know at this time. We’ll provide updated information about how we expect these taxes and fees to impact your plan when more regulatory details are available.

New taxes and fees in place and coming soon

These four ACA-mandated taxes and fees are impacting health plan(s) today or will in coming years:

• Health Insurance Providers Fee
• Transitional Reinsurance Program Contribution
• Patient-Centered Outcomes Research Institute Fee (also known as the “Comparative Effectiveness Fee”)
• High-Value Plan Tax (also known as the “Cadillac Tax” effective in 2020)

Because the new federal taxes and fees are already impacting the cost of plans, with more to come, it’s important to understand each one. By doing so, you can better plan for the expected impacts.

The chart on the next page has a summary for each of the four taxes and fees.

Other ACA taxes are expected to impact health plans indirectly

The ACA also imposed new annual taxes on drug companies with more than $5 million in sales, beginning in 2011.

Beginning in 2013, the ACA also imposed an excise tax of 2.3 percent on the sale of any taxable medical device. The Omnibus Appropriation Bill, signed into law on December 18, 2015, includes a two-year moratorium on the medical device tax for 2016 and 2017.

The drug and medical device companies may build these costs into the prices of their products. If so, they will affect your premiums and/or claims costs.
### Health Insurance Providers Fee

**Description:** Health insurers have to pay an annual fee to offset at least a portion of premium subsidies and tax credits for qualifying individuals purchasing coverage on the public exchanges.

**Fee:** Industry fee of $8 billion in 2014, increasing to $14.3 billion in 2018. It goes up each year thereafter at the rate of premium growth.

**Time Period:** The Consolidated Appropriations Act of 2016, (the Omnibus Appropriations Bill) signed into law on December 18, 2015, includes a one-year suspension of the fee for calendar year 2017. The moratorium applies to the fee payment that would be due in the 2017 calendar year, and has no effect on the fee amount for the 2018 fee year. The fee is reinstated for calendar year 2018 and beyond.

**Impacted products:** All medical, dental and vision plans except expatriate health coverage; Medicare Supplement; coverage for specific diseases; hospital/fixed indemnity coverage; accident/disability-only coverage; long-term care and stop loss.

**Who pays:** Health insurers must pay the fee. The IRS determines the amount due by each health insurer and bills them annually. The total annual fee is allocated to each insurer based on its share of aggregated affected premiums.

**When the payment is due:** Insurers must pay the federal government annually, by no later than September 30 of each fee year.

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### Transitional Reinsurance Program Contribution

**Description:** Health insurers and self-funded plan sponsors are required to fund the transitional reinsurance program in effect from January 1, 2014 through December 31, 2016.

This program was created to stabilize premiums and to fund payments to individual market issuers covering high-cost individuals.

**Impacted products:** All medical plans except Medicare, Medicare Supplement, Medicaid, the State Children’s Health Insurance Program; expatriate health coverage; excepted benefits plans (including stand-alone vision and dental plans); stop loss; coverage that consists solely of benefits for prescription drugs; integrated health reimbursement arrangements (HRAs) and health savings accounts (HSAs); employee assistance plans; disease management and wellness programs to the extent they do not provide major medical coverage; and self-funded, self-administered plans where the self-funded plan sponsor is not using a third-party administrator to adjudicate claims or for the core administrative functions.

**Who pays:** Health insurance issuers pay for insured plans. Employers pay for self-funded plans. Both health insurers and self-funded plans are responsible for submitting the annual enrollment count and for scheduling reinsurance contributions payments to the federal government through [www.pay.gov](http://www.pay.gov).

The reinsurance contributions fee must be paid each year from 2014 to 2016.

**The U.S. Department of Health & Human Services (HHS) allows the following counting methods for self-funded plans:** Actual Count, Snapshot Count, Snapshot Factor and Form 5500. Enrollment can be calculated using either a daily, monthly or quarterly average of the first nine months of the year. The fourth quarter of each year is not factored into the enrollment calculation, if using one of the first three methods. Form 5500 calculation method is based on average number of covered lives filed with the U.S. Department of Labor for the last applicable plan year.

The calculation of covered lives will directly impact the amount of reinsurance contributions the issuer or plan sponsor will have to pay. It is essential the plan sponsor understands the financial impact of the various options for calculating the applicable covered lives.

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| **Transitional Reinsurance Program Contribution** | **Insured and self-funded plans**  
When the payment is due: The annual enrollment count is due by November 15 of each year to the HHS and has to be submitted through [www.pay.gov](http://www.pay.gov).  
Fee: HHS set the 2016 annual per capital contribution rate at $27. Payment of the fee has to be scheduled during the submission process, in either one installment, due by January 15 following the benefits year, or in two installments:  
• The first installment is due by January 15 following the benefits year.  
• The second installment is due by November 15 following the benefits year.  
For detailed information regarding reinsurance contributions submission, please visit [www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html). | Temporary  
2014 to 2016 |
| **Patient-Centered Outcomes Research Institute Fee** | **Insured and self-funded plans**  
Description: Health insurers and self-funded plan sponsors have to pay an annual fee to fund clinical outcomes effectiveness research.  
Fee: The fee is equal to the average number of lives covered during the policy or plan year multiplied by the applicable dollar amount for the year.  
For policy and plan years ending after September 30, 2012, and before October 1, 2013, the applicable dollar amount was $1.  
For policy and plan years ending after September 30, 2013 and before October 1, 2014, it was $2.  
For policy and plan years ending after September 30, 2014, and before October 1, 2015, it was $2.08.  
For policy and plan years ending after September 30, 2015 and before October 1, 2016, it is $2.17. After that, it is subject to the adjustment for the increase in national health expenditures. The fee is set to end in 2019.  
Who pays: For insured plans, the health insurance issuers are responsible.  
For self-funded plans, the plan sponsors are responsible. Separate fees apply for lives covered by each specified health insurance policy or applicable self-insured health plan, e.g. HRA or FSA under a separate policy is subject to a separate PCORI fee.  
When the payment is due: The IRS treats this fee as an excise tax. A federal excise tax return (Form 720) must be filed by July 31 of the year after the policy or plan year ends.  
2012 to 2019 |
| **High-Value Plan Tax (also known as the “Cadillac tax”)** | **Insured and self-funded plans**  
Description: Tax on high-value health plans, measured by premium (insured) or COBRA-equivalent rates (self-funded) cost.  
Fee: Plans with premiums of more than $10,200 (single) or $27,500 (family), are subject to a 40 percent excise tax on the amount above those costs. The amounts are adjusted for cost of living, age and gender. In 2019, it was subject to an increase by Consumer Price Index plus 1 percent and in 2020 and beyond, by Consumer Price Index.  
Time period: The Consolidated Appropriations Act for 2016, (the Omnibus Appropriations Bill), signed into law in December 2015, includes a two-year delay of the “Cadillac Tax.” This excise tax was scheduled to be implemented in 2018. Barring further action by Congress and the President, the tax is now scheduled to begin impacting health coverage in 2020.  
Who pays: The health insurer pays the excise tax for insured plans. The plan sponsor pays for self-funded plans.  
When the payment is due: The IRS hasn’t issued guidance for administering this excise tax, including the method and timing for payment. We’ll give you updated information once the regulatory guidance is available. | Ongoing — delayed to 2020 and beyond |
Learn more about the ACA
Visit our website for more about the ACA, its many requirements and how we’re preparing for the changes ahead.
Go to www.healthreformconnection.com.