Overview

Insurers and health plans will be required to pay new fees and taxes that are intended to help fund the implementation of the Patient Protection and Affordable Care Act (PPACA).

Comparative effectiveness research fee (CERF)

PPACA established the Patient-Centered Outcomes Research Institute (PCORI) to fund and conduct research that determines the effectiveness of various forms of medical services that treat, manage, diagnose or prevent illness or injury. The work of PCORI is partially funded by a fee on health insurers and self-funded group health plans.

Health insurance industry fee

This fee on health insurers (including HMOs) starts at $8 billion in 2014 and increases year over year before reaching $14.3 billion in 2018. After 2018, it will continue to increase with premium growth. The fee, which applies only to insured business, will be based on each insurer’s share of the taxable health insurance premium base (among all health insurers of U.S. health risks). In December 2015, this fee was suspended for 2017.

Reinsurance fee

This fee on health plans totals $25 billion, which will be collected over the three-year period from 2014 through 2016. The majority of the money will be used to fund a reinsurance program, which is intended to lessen the impact of adverse selection in the individual market. The fee applies to both insured and self-funded commercial major medical plans. For an insured plan, the fee is the responsibility of the health insurer. For a self-funded plan, the fee is the employer’s responsibility.

Excise “Cadillac” tax

This 40% tax on high-cost employer medical plans has been delayed from 2018 to 2020. Proposed regulations are still pending and there are many open issues. For more information, visit http://www.cigna.com/health-care-reform/cadillac-tax.
The following chart provides an overview of these three fees.

<table>
<thead>
<tr>
<th>What it is/fee duration</th>
<th>COMPARATIVE EFFECTIVENESS RESEARCH FEE</th>
<th>HEALTH INSURANCE INDUSTRY FEE</th>
<th>REINSURANCE FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What it is/fee duration</strong></td>
<td>Annual fee on insured and self-funded health plans until 2019</td>
<td>Permanent, annual fee on health insurers beginning in 2014 (suspended for 2017 as of December 2015)</td>
<td>Annual fee on insured and self-funded health plans from 2014-2016</td>
</tr>
<tr>
<td>Purpose</td>
<td>Fund comparative effectiveness research</td>
<td>Help fund federal and state Marketplaces/Exchanges</td>
<td>Fund reinsurance program to help lessen impact of adverse selection in the individual market</td>
</tr>
</tbody>
</table>
| Amount | • Applies for plan years beginning on or after 10/2/2011  
• First payments were due 7/31/2013  
• Fee continues through 9/30/2020  
• Initial annual fee begins at $1 per participant, including dependents  
• Increases to $2 for plan years beginning on or after 10/2/2012  
• Amount for future years is indexed to national health expenditures | • $8 billion in 2014  
• Increases each year to $14.3 billion in 2018  
• Increases with premium growth after 2018  
• Allocated to insurers based on prior year's share of total earned premium | • $12 billion in 2014  
• $8 billion in 2015  
• $5 billion in 2016 |
| Who pays | • Insured: Insurers  
• Self-funded: Employers; insurers are not allowed to pay or calculate | • Insured: Insurers | • Insured: Insurers  
• Self-funded: Employers |
| Tax implications | Tax deductible | Tax deductible for employers as part of premium | Tax deductible |
| Estimated cost impact | • $1 per member per year (PMPY) in first year  
• Increases in future years | • Estimated to be 2%-2.5% of premium in 2014  
• Increasing to 3%-4% of premium in future years | • $63 PMPY in 2014  
  - Paid in two installments of $52.50 and $10.50  
• $44 PMPY in 2015  
  - Paid in two installments of $33.00 and $11.00  
• $27 PMPY in 2016  
  - Paid in two installments of $21.60 and $5.40 |
### COMPARATIVE EFFECTIVENESS RESEARCH FEE
- Insured individual and group medical plans
- Self-funded group medical plans
- Stand-alone, insured, behavioral health plans
- Limited medical plans (also known as voluntary plans)
- Individuals on a temporary U.S. Visa who live in the U.S.
- Medicare Surrounder and Medicare Expand policies
- Retiree only plans for post-65 retirees where Medicare is the primary payer
- Health Reimbursement Accounts (HRAs)
- Flexible Spending Accounts (FSAs) if the employer contribution is > $500 and that is more than the employee contribution

### HEALTH INSURANCE INDUSTRY FEE
- Insured individual and group medical plans
- Stand-alone, insured dental and vision plans
- Behavioral health and pharmacy plans
- Medicare Advantage plans
- Retiree-only plans
- Part D prescription benefit plans
- Medicaid (and CHIP) programs
- Taft–Hartley Plans to the extent the plans meet the other criteria for inclusion

### REINSURANCE FEE
- Insured individual and group medical plans
- Self-funded group medical plans
- Taft–Hartley Plans to the extent the plans meet the other criteria for inclusion
- Group retiree medical plans covering individuals not eligible for Medicare or for whom Medicare is the secondary payer
  - Active Employees age 65+
  - Pre-65 Retirees
- Medical plans that are integrated with a Health Reimbursement Account (HRA)
- Short-Term Abroad (STA) expatriate plans
- Self-funded expatriate plans (in 2014 only)

### Excludes:
- Self-funded employer sponsored group health plans
- Nonprofit corporations that receive more than 80% of their revenue from government sponsored poverty programs (Medicaid, CHIP) and that comply with certain restrictions on political activity
- VEBAs established by a union or collective bargaining agreement
- Medicare supplemental coverage that meets the requirements of section 1882(g)(1)
- Coverage for specific diseases or hospital indemnity coverage
- Accident only coverage
- ASO/Stop-loss
- Employee Assistance Plan (EAP), disease management programs and wellness programs that do not provide significant health insurance benefits
- U.S.-issued expatriate plans after 2015