informed on reform

Fees and Taxes FACT SHEET

This Fact Sheet reflects Final Regulations published by the Internal Revenue Service (IRS) on December 5, 2012 for the Comparative Effectiveness Research Fee (CERF). It reflects Final Regulations published by the Department of Health and Human Services (HHS) in May 2012 and additional guidance included in Proposed Rules issued on November 30, 2012 for the Reinsurance Assessment. It reflects the Health Insurance Industry Fee proposed regulations issued by the Treasury Department and the Internal Revenue Service (IRS) in March 2013.

Insurers and health plans will be required to pay three new fees as a result of provisions contained in the Patient Protection and Affordable Care Act (PPACA).

1. Comparative Effectiveness Research Fee

PPACA established the Patient-Centered Outcomes Research Institute* (the Institute) to conduct research to determine which of two or more treatments works best when applied to actual patients in the "real world." The work of the Institute is partially funded by a fee on health insurers and self-insured group health plans.

2. 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).

3. Reinsurance Assessment

This assessment 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 high-risk individuals entering the individual market. The assessment applies to both insured and self-insured commercial medical plans. For an insured plan, the assessment is the responsibility of the health insurer. For a self-insured plan, the assessment is the employer's responsibility, but an employer may choose to have its third party administrator make the payment on behalf of the plan.

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THE FOLLOWING CHART PROVIDES AN OVERVIEW OF THESE THREE FEES.

	COMPARATIVE EFFECTIVENESS RESEARCH FEE	HEALTH INSURANCE INDUSTRY FEE	REINSURANCE ASSESSMENT
What it is/ fee duration	Annual fee on insured and self-insured health plans until 2019	Permanent, annual fee on health insurers beginning in 2014	Annual fee on insured and self-insured health plans from 2014–2016
Purpose	Fund comparative effectiveness research	Help fund federal and state Exchanges	Fund reinsurance program to help lessen impact of high-risk individuals entering individual market
Amount	• Begins at $1 per participant, including dependents, for plan years beginning 11/1/2011 through 10/1/2012 (first payments are due 7/31/2013) • Increases to $2 for the following year • Future amounts will be 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-insured**: Employers; insurers are not allowed to pay or calculate	**Insured**: Insurers	• **Insured**: Insurers • **Self-insured**: Employers are responsible, but they may choose to have their administrator make the payment on the plan's behalf
Tax implications	Tax deductible	Not tax deductible	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 • Estimated $40–$45 PMPY in 2015 • Estimated $25–$30 PMPY in 2016

	COMPARATIVE EFFECTIVENESS RESEARCH FEE	HEALTH INSURANCE INDUSTRY FEE	REINSURANCE ASSESSMENT
Business affected	• **Insured individual and group medical plans** (i.e., Guaranteed Cost or Shared Returns including Minimum Premium) • **Self-insured group medical plans** • Standalone 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 Surround and Medicare Expand policies • Retiree-only plans • Health Reimbursement Accounts (HRAs) • Flexible Spending Accounts (FSAs) if the employer contribution is > $500 and it is more than the employee contribution **Excludes:** • Expatriate coverage provided primarily for employees who work and reside outside the U.S. • U.S.-based "trailing dependents" of expatriate employees who live overseas • Exempt FSA plans • Medicare Parts A-D coverage • Medicaid coverage • Health Savings Accounts (HSAs) • Standalone dental and vision plans • Employee Assistance Plans (EAPs)	• **Insured individual and group medical plans** (i.e., Guaranteed Cost or Shared Returns including Minimum Premium) • **Standalone dental and vision plans** • Behavioral health and pharmacy plans • Medicare Advantage plans • Part D prescription benefit plans • Medicaid (and CHIP) programs • Taft-Hartley Plans to the extent the plans meet the other criteria for inclusion **Excludes:** • Self-insured employer sponsored group health plans • Non-profit corporations that receive more than 80 percent of their revenue from government sponsored poverty programs (Medicaid, CHIP) and that comply with certain restrictions on political activity • VEBAs sponsored by an entity other than an employer or employers • 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	• **Insured individual and group medical plans** (i.e., Guaranteed Cost or Shared Returns including Minimum Premium) • **Self-insured group medical plans** • Taft-Hartley Plans to the extent the plans meet the other criteria for inclusion **Excludes:** • Standalone pharmacy and behavioral health • Standalone dental and vision plans • Hospital indemnity and specified disease plans • Private Medicare, Medicaid, CHIP, state and federal high-risk pools and basic health plans • Health Reimbursement Accounts (HRAs) integrated with a group health plan • Health Savings Accounts (HSAs) • Flexible Spending Accounts (FSAs) • Employee Assistance Plans (EAPs), disease management programs and wellness programs • Stop-loss and indemnity reinsurance policies • Military health benefits • Indian Health Service coverage • Expatriate coverage

Frequently Asked Questions about these Fees and Taxes

WHICH PLANS DO THESE FEES APPLY TO?

This chart provides a quick overview of which fees apply to each type of plan.

	INSURED MEDICAL	SELF-INSURED MEDICAL	DENTAL AND VISION
CERF	**x**	**x**	
Health Insurance Industry Fee	**x**		**x**
Reinsurance Assessment	**x**	**x**	

Although the Health Insurance Industry Fee does not apply to self-insured group health plans, some benefits under an employer's self-insured plan (e.g., carved-out benefits) may be insured and subject to the fee.

CERF

HOW DOES MY PLAN YEAR DETERMINE WHEN THE FEE IS DUE?

The CERF became effective for plan years beginning on or after 10/2/11. For plan years beginning on 11/1/11, 12/1/11 and 1/1/12, the first fee is due July 31, 2013. The fee per average covered life *changes* on October 2nd of each year, and is payable on July 31 of the calendar year following the plan year end date.

WILL CIGNA COMPLETE A 720 FORM ON BEHALF OF ITS CLIENTS?

Excise Tax Form 720 is used to pay the fee and is currently being edited for this purpose by the government. For insured plans for which Cigna pays the fee, Cigna will complete the form and submit it with the payment. However, fully insured medical plans with an associated HRA and/or qualifying FSA are considered self-insured plans. Employers must complete the form and pay the fee for those plans. Self-insured plans will also need to pay the fee and complete the form.

WILL CIGNA BE SENDING FULLY INSURED CLIENTS A REPORT OF THE FEES PAID?

For insured plans, Cigna will calculate the fee and submit the payment and form to meet compliance. We are not preparing external reporting to make available to clients for the amounts paid.

IF MY PLAN YEAR AND ERISA YEAR ARE DIFFERENT, WHICH ONE SHOULD I USE TO CALCULATE COVERED LIVES AND DETERMINE MY PAYMENT DATE?

You must use your ERISA plan year to determine your liability and due date.

REINSURANCE ASSESSMENT

HOW WILL CIGNA CALCULATE MEMBERSHIP FOR THE REINSURANCE ASSESSMENT CALCULATION? WHAT EMPLOYEE CLASSES WILL BE INCLUDED IN THE CALCULATION?

The reinsurance assessment applies to both insured and self-insured medical plans, including plans for active employees, retirees and COBRA participants.

HOW DOES CIGNA PLAN ON HANDLING THE PAYMENT OF THE REINSURANCE ASSESSMENT FEE FOR ASO CLIENTS WHEN IT GOES INTO EFFECT IN 2014?

Cigna client managers will be asking all self-insured clients whether they want to pay the reinsurance assessment directly or whether they would like Cigna to make the payment on the plan's behalf. If a client chooses to have Cigna pay the reinsurance assessment, the fee will be added to the plan's administrative fees.