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In the Spotlight: ACA Taxes and Fees

The Congressional Budget Office estimates that the Affordable Care Act (ACA), when fully implemented, will expand coverage to up to 29 million more people in the United States. Primarily, this is done through a combination of a potential expansion of Medicaid and a subsidization of coverage for low- and middle-income individuals and families. While promoting better access to health care is something everyone can support, someone has to pay the tab. With this in mind, ACA contains several new fees and taxes – many that directly impact insurers – in an effort to have the law pay for itself. While a previous Spotlight addressed the insurer tax (commonly known as the Health Insurance Tax, or "HIT"), this Spotlight will give an overview of many of the fees throughout the law.

Taxes and Fees

Health Insurer Tax Fee

Beginning in 2014, health insurers will be assessed new federal taxes in the form of an annual fee. The ACA requires the health insurance industry to pay the amounts shown in the table below.

ACA Insurer Taxes

Year	Fee Paid by Insurers
2014	$8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018*	$14.3 billion

**These aggregate insurer fees will increase by an indexed amount each year after 2018.*

Each insurer's portion of the fee will be determined annually based on its "net premiums written" - its share of the U.S. insurance market. Put simply, as an insurer's market-share rises, so too will its portion of the new fee. These fees are not deductible for tax purposes, but the additional premiums needed to cover them *are* taxable. As a result, health insurers will need to collect premiums greater than the fee in order to have sufficient funds to pay the taxes and the fee.

Reinsurance Fee

The reinsurance fee is a part of a complex risk assessment system put in place to stabilize premiums. It is temporary (2014-2016) and the funds are intended to help stabilize the premiums in the individual market. However, the majority of health plans, not just individual but also fully- and self-insured plans, are responsible for funding the program through an assessment via their health insurer or third party administrator. The fees are collected based on a national uniform contribution rate (a flat fee per member for fully-insured and self-insured plans). In aggregate, ACA dictates the amount of the assessment as $25 billion over the three years ($12b in 2014; $8b in 2015; and $5b in 2016). The proposed annual fee per enrollee in a plan for 2014 is $63.00.

Comparative Effectiveness Research Fee (PCORI)

ACA establishes a Patient-Centered Outcomes Research Institute (PCORI) that is charged with identifying the effectiveness of various forms of medical treatment. The Comparative Effectiveness Research Fee (PCORI Fee) is another temporary fee (2012-2019) imposed on insurers and self-insured. The monies collected from the fees are used to fund research on the effectiveness of medical treatments and prescription drugs. For fiscal year 2013 the law imposes a fee of $1 per covered life. In fiscal year 2014 the fee increases to $2 per covered life and for fiscal year 2015 through 2019 the fee will be indexed.

Individual Coverage Requirement

Starting in 2014, ACA requires that most individuals have a comprehensive health insurance policy or be faced with paying a penalty. In 2014, the penalty is the greater of $95 or 1% of income annually. The penalty rises to the greater of $695 or 2.5% of income in 2016. For many, the mandate will be a non-issue because they get insurance through an employer or government programs like Medicare or Medicaid. Millions more will benefit from generous federal subsidies to help pay for insurance. Certain exemptions to the mandate will exist for religious reasons, financial hardship and more but generally, those who are uninsured will face a choice: carry health insurance or pay a penalty levied by the federal government.

Employer Shared Responsibility Requirement

Beginning in 2014, to encourage employers to continue offering affordable minimum essential health insurance coverage, large employers (with 50 or more full-time equivalent employees) will either have to offer employees coverage that meets certain requirements or be charged a penalty. ACA defines "affordable" as consuming no more than 9.5% of an employees' income. If employers do not offer coverage and at least one full-time equivalent employee receives a tax credit, the penalty is $2,000 per employee (excluding the first 30 employees). If the employer offers coverage but at least one employee receives a tax credit and the coverage does not meet the definition of affordable, the penalty is the lesser of total number of full-time employees – less 30, times $2,000 or $3,000 times the number of employees receiving a credit. The hours of part-time employees are taken into account to determine whether an employer has 50 or more "full-time equivalent" employees, but the penalty only takes into account the number of full-time employees and not part-time employees.

High Cost Employer-Sponsored Coverage Excise Tax

Looking down the road, in 2018, employers who offer health insurance coverage that has premiums in excess of $10,200 for individuals and $27,500 for families will be taxed 40%. For retirees and employees with high-risk jobs, the minimum is increased to $11,850 for individuals and $30,950 for families.

Exchange User Fee

Although there have been many federal grants for establishing different types of Health Benefit Exchanges, eventually these Exchanges are expected to be self-sustained. For Exchanges that are run primarily by the federal government (approximately 32 states will likely have some federal involvement in running their Exchange), the federal government is proposing an Exchange user fee which will apply to insurers in order to help the funding of the Exchanges. The amount of the user fee is still being determined.

Device Tax

Beginning in 2013, a 2.3% medical device tax will be implemented on all medical device companies. This tax applies to all medical device sales beginning on January 1, 2013. The Congressional Budget Office has estimated that, over 10 years, the tax would amount to about $29.1 billion in revenue.

Pharmaceuticals

The largest impact to pharmaceuticals is a deal reached to close the coverage gap in Medicare Part D plans. Pharmaceutical industry impacts include:

- In 2011, pharmaceutical companies now subsidize brand name drugs 50% and Medicare beneficiaries are responsible for the remaining 50%.
- Pharmaceutical companies will have an annual fee to help fund the ACA, divided among the brand name companies, based on their previous year's sales to government programs (such as Medicare, Medicaid, CHIP, and TRICARE). The fee totals $2.5 billion in 2011 and will increase each year until 2018 when it peaks at $4.1 billion. For years 2019 and on, the fee is $2.8 billion.

BCBSNC Views

Blue Cross and Blue Shield of North Carolina has long supported access to quality health care for all North Carolinians. However, we recognize that coverage comes at a price and if that price disproportionately affects one sector of the economy, it can harm consumers. The new fees on insurers, as well as those on medical devices, pharmaceuticals, and the fee associated with the Exchanges, will add up - affecting the affordability of health insurance coverage for many individuals and families. For example, we estimate that our share of the health insurance tax in 2014 will be approximately $69.7 million and because the tax is non-tax deductible, BCBSNC will have to use an estimated **$109.4 million of premiums in 2014** to cover the amount for which we are responsible.[1] This increase in premiums will increase costs to consumers.

[1] Based on 2011 data. Internal estimates.