Congressional Research Service
Informing the legislative debate since 1914

Patient Protection and Affordable Care Act: Annual Fee on Health Insurers

Updated December 12, 2013

Congressional Research Service
https://crsreports.congress.gov
R43225

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The Patient Protection and Affordable Care Act (P.L. 111-148) and the Reconciliation Act of 2010 (P.L. 111-152) impose an annual fee on certain for-profit health insurers, starting in 2014. The aggregate amount of the ACA fee, to be collected across all covered insurers, will be $8.0 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, the aggregate fee will be indexed to the overall rate of annual premium growth, as calculated by the Internal Revenue Service.

The annual fee will be apportioned among health insurers, based on (1) their market share and (2) their dollar value of business. The fee applies to net health care premiums written, which are defined in regulations as gross premiums from insurance sales minus refunds to enrollees under the medical loss ratio provisions of the ACA, certain commissions, and premiums ceded to reinsurers. Ceded premiums are premiums that an insurer transfers to a reinsurer, as payment for protection against defined market risks.

The ACA fee does not apply to the first $25 million of net premiums written by a covered insurer. The fee will be imposed on 50% of net premiums written above $25 million and up to $50 million, and 100% of net premiums in excess of $50 million. The regulations shield a higher level of net premiums from the fee for insurers that are exempt from federal taxes and are considered to be public charities, social welfare organizations, high-risk health insurance pools, or consumer-operated-and-oriented health plans (COOP).

The ACA fee does *not* apply to entities that fully self-insure, government-run insurance programs, or nonprofit insurers incorporated under state law that receive more than 80% of their gross revenues from government programs that target low-income, elderly, or disabled populations (such as the State Children's Health Insurance Plan [CHIP], Medicare, and Medicaid).

Some insurance issuers have informed shareholders and state insurance regulators that they intend to pass on the cost of the fee to businesses and enrollees in the form of higher premiums. Private insurers that contract with government organizations to provide Medicare and Medicaid health benefits will be subject to the fee, which could have implications for enrollee premiums and government payments to those plans. It is difficult to estimate the precise impact of the fee on the insurance industry, government programs, and consumers for several reasons, including a lack of public data on net premiums written. In addition, insurers' ability to pass on the fee will vary depending on competition in local markets, and their individual financial strategies.

Contents

Annual Fee on Health Insurers 1
Insurers Subject to the ACA Fee 1
Benefits Covered by the Fee 3
Fee Calculation 3
Insurer Reporting Requirements 4
Penalties for Noncompliance 5
Deductibility 5
Impact of the Annual Premium Fee 5
Breakdown of the Premium Fee 7
Interaction of the ACA Tax and Other Provisions 8
Issues for Congress 9
Medicaid 10
Graduate Medical Education 10
Tax Treatment of Recovered Fees 10

Tables

Table 1. Annual ACA Fee of Health Insurance Premiums 1

Contacts

Author Information 11

Annual Fee on Health Insurers

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148)[1] and the Reconciliation Act of 2010 (P.L. 111-152) impose a fee on certain for-profit health insurers, starting in 2014. The aggregate ACA fee, to be collected by the Internal Revenue Service (IRS) across all affected insurers operating in the United States, is set at $8.0 billion in 2014.[2] The fee will gradually rise to $14.3 billion in 2018, and will be indexed to the annual rate of U.S. premium growth thereafter[3] (**Table 1**).

Table 1. Annual ACA Fee of Health Insurance Premiums

Annual Fee Imposed on All Affected Insurers

Year	Aggregate Fee
2014	$8.0 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018	$14.3 billion
2019 on	Previous year's total increased by annual rate of premium growth, as calculated by IRS.

Source: Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57, *Federal Register*, March 4, 2013.

Insurers Subject to the ACA Fee

Under final IRS regulations,[4] entities subject to the ACA fee generally include health insurance issuers such as an insurance company, insurance service, or insurance organization (foreign or domestic) that are required to have a state license and are subject to the laws of such jurisdictions that regulate health insurance. Covered entities may include health maintenance organizations, multiple employer welfare arrangements[5] (MEWA) that are not fully insured, and entities offering

[1] The insurance premium tax provision is found in Sec. 9010 of the ACA and Section 1406 of the Reconciliation Act.

[2] The ACA imposes other fees on the insurance industry, including the (1) transitional reinsurance program, (Section 1346); (2) excise tax on high-value plans (Section 9001); and (3) Patient Centered Outcomes Research Institute (PCORI) fee (Section 6301). These fees are outside the scope of this report.

[3] See Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57, *Federal Register*, p. 14034 -14046, March 4, 2013, https://federalregister.gov/a/2013-04836; and Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee; Correction," 26 CFR Part 57, *Federal Register*, p. 17612, March 22, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-03-22/pdf/2013-06701.pdf. The regulations state that the IRS will determine overall net premiums written based on reports submitted by covered insurers and "any other source of information available to the IRS;" and Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, p. 71476-71493, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

[4] 26 CFR 57.2. Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

[5] 26 CFR 57.2. Multiple employer welfare arrangements (MEWA) provide health and welfare benefits to employees of two or more unrelated employers that are not parties to bona fide collective bargaining agreements. MEWAs are

Medicare Advantage (Part C) or Medicare prescription drug plans (Part D), or Medicaid managed care plans.

The parent organization for a group of subsidiaries that offer health coverage generally would calculate the net premiums written of all its affected subsidiaries for the purpose of applying the fee.[6]

Certain types of health insurers or insurance arrangements are not subject to the fee. These generally include the following:

- Self-insured plans, in which an employer assumes the financial risk for providing health benefits to its employees. In 2010, about 60% of enrollees with work-based coverage were in self-insured plans.[7]
- Voluntary employees' beneficiary associations (VEBAs)[8] organized by entities other than employers, such as unions.
- Federal, state, or other governmental entities, including Indian tribal governments.
- Nonprofit entities incorporated under state law that receive more than 80% of their gross revenues from government programs that target low-income, elderly, or disabled populations (such as the State Children's Health Insurance Plan [CHIP], Medicare, and Medicaid). The nonprofits may not engage in substantial lobbying, nor engage in political campaign activities.[9]
- Student health insurance coverage that educational institutions purchase through a separate, unrelated insurer. The insurer would be the covered entity for the purpose of applying the fee.

designed to give small employers access to low cost health coverage on terms similar to large employers." See Department of Labor, "Fact Sheet: MEWA Enforcement," March 2013, http://www.dol.gov/ebsa/newsroom/fsMEWAenforcement.html. Under the proposed IRS regulations, the fee will apply to MEWAs that are not fully insured, whether or not they are subject to regulation under state insurance law. The fee will apply to the extent that a MEWA uses enrollee premiums to pay for services that it provides, rather than using the premiums to pay for services provided by an outside insurer. A fully insured MEWA will not be subject to the fee even though it receives premiums, if it uses those premiums to pay an insurance company to provide the coverage being purchased. In that case, the insurance company is the covered entity because it, not the MEWA, is providing coverage. The regulations cite the example of a MEWA that receives a $10,000 premium payment from an employer providing medical and separate vision coverage. The MEWA uses $9,000 to pay the premium for coverage under a group policy and $1,000 in direct reimbursements under the vision plan. The MEWA would be treated as a covered entity only on the $1,000 used to pay for vision coverage.

[6] If the controlled group is not an affiliated group that files a consolidated federal income tax return, it would select a person as the designated entity to report on behalf of the group.

[7] Beth Levin Crimmel, "Self-Insured Coverage in Employer-Sponsored Health Insurance for the Private Sector, 2000 and 2010," Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, September, 2011, http://meps.ahrq.gov/mepsweb/data_files/publications/st339/stat339.pdf.

[8] A VEBA is a tax-exempt trust fund used to pay insurance benefits, including health insurance, to an association of members or their dependents. A VEBA that is part of a self-insured employer plan is also not a covered entity.

[9] Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, p. 71476-71493, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

Benefits Covered by the Fee

Health insurance is outlined in the IRS rules as "benefits consisting of medical care (provided directly through insurance or reimbursement or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." Health insurance includes limited-scope dental and vision benefits and retiree health insurance.[10]

Certain insurance benefits that are not considered health insurance for purposes of the fee include accident or disability insurance; liability coverage; workers' compensation benefits; automobile medical coverage; credit-only insurance; coverage for certain on-site medical clinics; coverage for a specific disease or illness; long-term nursing home, home health care, and community-based care, or any combination thereof; hospital indemnity or other fixed indemnity insurance;[11] Medigap[12] policies; some types of travel insurance; and some reinsurance.[13]

Fee Calculation

The ACA fee will be based on net health care premiums written by covered issuers during the year prior to the year that payment is due. IRS regulations[14] define net health care premiums written as gross premiums from insurance sales (including reinsurance premiums written), reduced by ACA medical loss ratio rebates[15] to enrollees, reinsurance ceded, and ceding commissions.[16] (Ceded premiums are premiums paid by an insurer to a reinsurance firm for protection against defined market risks.)

Each year the IRS would apportion the fee among affected insurers based on (1) their net premiums written in the previous calendar year as a share of total net premiums written by all covered insurers, and (2) their dollar value of business.[17]

Covered insurers are not subject to the fee on their first $25 million of net premiums written. The annual ACA fee would be imposed on 50% of net premiums above $25 million and up to $50 million, and 100% of net premiums in excess of $50 million.

---

[10] Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

[11] Indemnity insurance protects businesses and workers in cases where they are found to be at fault in an accident or incident. Malpractice insurance is one example of indemnity coverage.

[12] CRS Report R42745, *Medigap: A Primer*, by Carol Rapaport.

[13] The IRS definition does not include major medical plans that provide broad coverage to travelers on trips lasting six months or longer. Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, p. 71476-71493, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

[14] 26 CFR 57.4. Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, p. 71476-71493, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

[15] CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, by Suzanne M. Kirchhoff.

[16] A ceding commission is a payment to an insurer/reinsurer by an assuming reinsurer providing compensation for various business expenses.

[17] Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

For example, the IRS would not take into account the first $37.5 million of net premiums written for a covered insurer with total net premiums above $50 million.

- No tax on first $25 million.
- Tax levied on 50% of premiums above $25 million and up to $50 million ($12.5 million).
- Taxable base on first $50 million is $12.5 million ($50 million - $25 million - $12.5 million).

The proposed rules provide differing treatment for certain tax-exempt insurers such as public charities, social welfare organizations, high-risk health insurance pools, or consumer-operated-and-oriented plans (COOP). After applying the fee adjustments (see above) a covered insurer that is exempt from federal taxes would have the ACA fee applied to only 50% of its net premiums that are subject to the fee, so long as the premiums are attributable to the insurer's tax-exempt activity.

The IRS would calculate each insurer's actual, annual fee/share of the premium tax based on the ratio of the insurer's net premiums written (after adjusting for the above disregards) as a share of the total net premiums written by all covered entities (after adjustment for the disregards). (See "Insurer Reporting Requirements.")

Insurer Reporting Requirements

Insurers would be required to report annual premium data to the IRS by April 15 of the following year.[18] While entities with less than $25 million in net premiums written are not subject to the fee, they are still required to submit premium information. The IRS will determine the amount of each firm's net premiums written based on the annual reports, along with any other source of information the IRS has available.[19] Insurers are to report the information on Form 8963, "Report of Health Insurance Provider Information."

After reviewing the available financial information the IRS would notify each covered insurer or other entity of its:

1. Preliminary fee allocation.
2. Net premiums written for health insurance, both before and after IRS regulatory adjustments.
3. Aggregate net premiums written for U.S. health insurance from all covered entities.
4. Information regarding the process for correcting any errors in the IRS findings.

Insurers would be required to review their preliminary fee calculation and, if they believe there are errors, to submit a correct form to the IRS in a timely fashion. The IRS would provide each covered entity with its preliminary fee calculation by June 15 each year.[20] If an insurer believes

[18] 26 CFR 57.3. Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee. If an entity is not in the business of providing health insurance for any United States health risk in the fee year, it is not a covered entity and does not have to report.

[19] Other sources of information that may be used by the IRS include the Supplemental Health Care Exhibit (SHCE) required by the ACA, the Medical Loss Ratio annual report form, or similar statements filed with the National Association of Insurance Commissioners (NAIC), states, or the federal government.

[20] Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee; Procedural and

that the IRS preliminary fee calculation contains errors, it must provide the IRS with a corrected report by July 15.

The IRS would notify each covered entity of its final fee calculation on or before August 31 each fee year.[21] The IRS would give each covered entity a final fee determination, based on the same criteria as the preliminary fee. The final fee may differ from the preliminary fee, however, based on any error correction, additional information uncovered during the review process, or a change in the calculation of overall net written premiums for the United States. Insurers must pay the final fee will by September 30 each year.

Insurer information submitted on both original and corrected Forms 8963 is not confidential and will be open for public inspection or available upon request, according to the IRS.[22]

Penalties for Noncompliance

Insurers that fail to file required reports in a timely manner would face a penalty equal to $10,000 *and* the lesser of (1) an amount equal to $1,000 multiplied by the number of days the firm is out of compliance, or (2) the amount of the covered entity's fee for which the report was required. The penalty will be waived in cases where insurers can demonstrate reasonable cause for not reporting the information on time.

Insurers would also face penalties for filing inaccurate information that understates net premiums written. The penalty will be equal to the excess of:

1. The amount of the annual fee the insurer would have paid had the premium data had been reported accurately, over
2. The amount of the annual fee imposed on the insurer, which was based on faulty reporting that understated the amount of net premiums written.

Deductibility

Because the ACA premium fee is considered an excise tax by the IRS, the proposed regulations state that companies cannot deduct the fee from their annual taxes.[23]

Impact of the Annual Premium Fee

While the federal ACA premium fee is new, states for many years have imposed premium taxes on insurance products. In 2012, states collected $16.7 billion in premium taxes on a broad range of insurance (including property and casualty, life, and health products).[24] Insurers' ability to pass on the new ACA tax, in the form of higher premiums to consumers, will vary based on factors such as the degree of market competition or a firm's specific business strategy. Government

Administrative Guidance," Notice 2013-76, November 29, 2013, http://www.irs.gov/pub/irs-drop/n-13-76.pdf.

[21] Ibid.

[22] Ibid and Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57 and 602, *Federal Register*, November 29, 2013, https://www.federalregister.gov/articles/2013/11/29/2013-28412/health-insurance-providers-fee.

[23] Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57, *Federal Register*, p. 14040, March 4, 2013, https://federalregister.gov/a/2013-04836.

[24] U.S. Census Bureau, *2012 Annual Survey of State Government Tax Collections, Detailed Table*, April 11, 2013, http://www.census.gov/govs/statetax/.

programs such as Medicare and Medicaid that contract with private insurers to deliver health benefits consider an insurer's tax payments, along with other costs, when setting annual program reimbursement levels.

The Congressional Budget Office (CBO) has estimated that insurers may pass on the ACA insurer fee to consumers in the form of "slightly" higher premiums for coverage. According to CBO, prior to the ACA's passage, because self-insured plans would largely be exempt from the fee, and because large firms are more likely to self-insure than small firms, the net result would be a smaller percentage increase in average premiums for large firms than for small firms and for nongroup coverage.[25]

The Joint Committee on Taxation has estimated that legislation to repeal Section 9010 of the ACA would result in a 2% to 2.5% reduction in the premium prices of insurance plans offered by the covered entities.[26] The Joint Committee said it expected a very large portion of the fee to be passed on to purchasers of insurance in the form of higher premiums. The analysis found that eliminating the fee could reduce annual premiums for a family of four in 2016 by $350-$400.[27]

Some insurance companies have released estimates regarding the impact of the fee. For example, Blue Shield of California has forecast the impact of the 2014 insurer fee will equal about 2.3% of premium.[28] Kaiser Permanente has told business clients the insurer fee will amount to roughly 0.65% of premium in 2014.[29] Some insurance companies plan to increase premiums or have asked state regulators to include the impact of ACA costs, including the premium tax, in their annual rate requests.[30] Horizon Blue Cross Blue Shield of New Jersey, for example, estimates that the tax will increase its costs by $125 million in 2014, spurring an increase in premiums.[31] The company had $9.4 billion in revenues in 2012, with net income of $200 million.

In addition, an April 2013 study by the actuary/consulting firm Milliman estimated that the fee would result in premium increases of 1.7% to 2.4% in 2014, rising to 2.0% to 2.9% in following

---

[25] Congressional Budget Office, Letter to Senator Evan Bayh, "An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act," November 30, 2009; p. 15; http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf.

[26] Joint Committee on Taxation, Letter to Senator Jon Kyl, June 3, 2011, http://www.ahipcoverage.com/wp-content/uploads/2011/11/Premium-Tax-JCT-Letter-to-Kyl-060311-2.pdf.

[27] Ibid.

[28] Blue Shield of California, "Upcoming Affordable Care Act Taxes Effective 2014," https://www.blueshieldca.com/bsca/documents/about-blue-shield/health-reform/ACA_Taxes_20Fact_Sheet_final.pdf.

[29] Kaiser Permanente, "Affordable Care Act: New Insurer Fees and Their Impact on Your Business." PDF is available at Read the Q&A at http://info.kaiserpermanente.org/html/hcr_ca/taxes-fees.html.

[30] UnitedHealthGroup, *2012 Annual Report*, p. 32, http://www.unitedhealthgroup.com/2012-annual-report/. "This tax will first be paid and expensed in 2014; however, because our policies are annual, we have included the tax and other Health Reform Legislation cost factors in our 2013 rate filings relating to 2014 rate periods and any related premium increases for 2013 policies that have coverage into 2014 will increase the amount of premium recognized in 2013."

[31] Horizon Blue Cross Blue Shield of New Jersey, *2012 Annual Report*, p.5; http://www.horizonblue.com/about-us/our-company/company-reports; and Horizon Blue Cross Blue Shield of New Jersey "Affordable Care Act Imposes Insurer Fee on Premiums," http://www.horizonblue.com/sites/default/files/pdf/BB%202013%20Premium%20Tax.pdf. The firm notes that state minimum loss ratio requirements, which require a certain percentage of premiums to be spent on enrollee benefits, affect its ability to build in the fee in its individual and small group premiums. In addition, the ACA imposed a national medical loss ratio requirement. Issuers are allowed to exclude ACA assessments or fees from the federal MLR calculations for a reporting year only if such assessments or fees were incurred in that reporting year. Issuers may not exclude ACA assessments or fees they expect to incur in future MLR reporting years. See CMS, CCIIO Technical Guidance (CCIIO 2013—0003): Question and Answer Regarding the Medical Loss Ratio Reporting and Rebate Requirements," July 2, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mlr-guidance-7-02-2013.pdf

years. The firm said that the fee gives nonprofit insurers a competitive advantage, because many nonprofits are exempted or are subject to a lower fee than the for-profit insurers' fees.[32]

Breakdown of the Premium Fee

Estimating exactly how the federal premium fee will affect the insurance industry, and existing government programs such as Medicare and Medicaid, is complicated by a number of factors, including a lack of detailed data on net premiums.

The National Association of Insurance Commissioners (NAIC) has developed a system for uniform financial reporting by insurance companies. Currently, the NAIC collects premium data on *direct* premiums earned and written, rather than on *net* premiums written.[33] As noted earlier, the ACA defines net premiums written as gross premiums from insurance sales, minus ACA MLR rebates, certain commissions, and premiums ceded to reinsurers.

The difference between direct and net premium written is largely reinsurance activity. Any estimate of the distribution of the ACA fee based on direct premiums earned will most likely overestimate the size of the market subject to the ACA insurer tax. The NAIC will begin collecting data on net premiums written via future insurer financial statements. In addition, companies are to provide information to the IRS as part of their annual reporting requirements under the ACA.

Existing NAIC data provide some general guidance regarding the possible, proportional breakdown of the insurance fees. In general, for-profit health insurers in the United States (excluding California) wrote about $295 billion in direct premiums in 2012.[34] Comprehensive group and health policies accounted for more than half the total, with Medicare (MA and Part D) accounting for about 24%[35] and Medicaid accounting for up to about 19%.[36]

Medicare and Medicaid

One outstanding question is the potential impact of the premium fee on the Medicare and Medicaid health care programs. The premium tax does not apply to direct government programs, so does not apply to Medicaid and Medicare fee-for-service plans, where the government administers and pays for services. (See "Insurers Subject to the ACA Fee.")

However, the federal government contracts with private insurers to offer Medicare Advantage and Medicare Part D insurance plans. In addition, a growing share of state-federal Medicaid insurance plans, mainly managed care plans, are offered by outside issuers, as are some CHIP plans. For-profit insurers are subject to the ACA premium fee on their Medicare and Medicaid business. (Nonprofit entities are exempt from the tax if they are incorporated under state law and receive more than 80% of gross revenues from government programs that target low-income, elderly, or disabled populations.)

---

[32] Mathieu Doucet and Julia Yahnke, Milliman, *ACA health insurer fee: Estimated impact on the U.S. health insurance industry*, April 2013, http://www.milliman.com/uploadedFiles/insight/healthreform/pdfs/ACA-health-insurer-fee.pdf.

[33] The NAIC defines an earned premium as the portion of the total premium amount corresponding to the coverage provided during a given time period. Direct written premiums are premiums received by an insurance company without adjustments for ceding of a portion of these premiums to reinsures.

[34] Data are from SNL Financial and NAIC.

[35] The total does not include Medigap policies, which are not covered by the fee.

[36] CRS analysis of 2012 NAIC data using SNL database.

The share of the Medicare and Medicaid market held by private insurers is significant. For-profit companies served 71% of Medicare Advantage enrollees in 2011, with not-for-profit insurers accounting for about 29%.[37] About 74% of Medicaid beneficiaries were in some kind of managed care plan in 2011, according to the Centers for Medicare & Medicaid Services.[38] According to the CMS data and a 2010 survey by the Kaiser Commission on Medicaid and the Uninsured, more than half of Medicaid managed care enrollees are enrolled in managed care organizations on a risk-payment basis.[39]

Because the ACA premium tax will be factored into the rates that states pay insurers to offer managed care plans, insurance companies and others have warned that it could increase state and federal costs for the program.[40]

Government regulations could limit how much of the fee is passed on to Medicare beneficiaries. For example, Medicare Advantage plans each year are subject to a cap, or maximum increase, in total beneficiary costs. The premium fee is not a cost factor that will be used to adjust maximum beneficiary costs, which will effectively limit insurers' ability to pass on the fee.

How much of the overall fee will be borne by outside insurers, and how much by the federal and state governments depends in part on how many states expand their Medicaid programs. Milliman in its April 2013 study estimated that under a status quo scenario, commercial plans would be responsible for about 61% of the fee over a 10-year period, with the Medicare paying 25% and Medicaid 14%. Under a nationwide full Medicaid expansion scenario, the Medicaid portion of the fee would increase by about 12%, with corresponding reductions to the share paid by commercial plans and Medicare.[41]

Interaction of the ACA Tax and Other Provisions

There are concerns about the potential for the ACA premium tax to increase costs to insurers, businesses, and consumers. The ACA premium tax is not occurring in isolation, however, but as part of the ACA's broad series of taxes and fees, and consumer and business insurance subsidies, and other health delivery reforms designed to expand the number of Americans with insurance and slow the rate of government and private market health care spending. The ultimate impact of the premium fee will depend on how these changes play out.

---

[37] Gretchen Jacobson, Tricia Neuman, Anthony Damico, and Jennifer Huang, Kaiser Family Foundation, "Medicare Advantage Plan Star Ratings and Bonus Payments in 2012," November 2011, p. 6, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8257.pdf.

[38] Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment Report*, As of July 11, 2011, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf. See also: MACPAC, Report to the Congress: The Evolution of Managed Care in Medicaid, June 2011, p. 2 and 108, https://docs.google.com/viewer?a=v&pid=sites&srcid= bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJlNjdkMDZiYw; and Michael McCue and Michael Bailit, The Commonwealth Fund, "Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide," June 2011, p. 3, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/ 2011/Jun/1511_McCue_assessing_financial_hlt_Medicaid_managed_care_plans_ib_FINAL.pdf.

[39] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Managed Care: Key Data, Trends, and Issues," February 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf.

[40] Chris Carlson, Oliver Wyman, *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans*, October 31, 2011, http://www.mhpa.org/_upload/OliverWyman-ImpactofPremiumTax.pdf.

[41] Mathieu Doucet and Julia Yahnke, Milliman, *ACA health insurer fee: Estimated impact on the U.S. health insurance industry*, p. 8, April 2013, http://www.milliman.com/uploadedFiles/insight/healthreform/pdfs/ACA-health-insurer-fee.pdf.

Federal subsidies will mitigate the impact of higher premiums for some consumers. Under the ACA health exchanges must be established in every state by January 1, 2014, either by the state itself or the Secretary of Health and Human Services (Secretary). The exchanges will not be insurers, but will provide qualified individuals and small businesses with access to health plans offered by private insurers that meet set, federal standards.[42] Individuals and small businesses that purchase health plans through the exchanges may qualify for federal subsidies and tax credits, which could reduce their costs and soften some of the impact of the ACA insurer tax.[43] The CBO has estimated that 22 million people will purchase coverage through the exchanges once they are fully established in 2016, and that roughly 19 million (87%) will receive exchange subsidies.[44]

In addition, certain small employers are eligible for an ACA tax credit, provided they contribute a uniform percentage of at least 50% toward their employees' health insurance. By 2014, for-profit employers will be eligible for a maximum credit equal to 50% of the employer's contribution toward employee premiums, while nonprofit organizations will be eligible for a maximum credit of up to 35% of employer contributions. The maximum small business tax credit is available for two consecutive tax years, beginning with the first year the employer offers coverage through an exchange.[45]

In addition to premium and small business tax credits, the ACA requires increased regulation and oversight of insurance costs. The federal government will provide grants to states to review insurance rates, and will require health insurance companies to provide justifications for any proposed rate increases that the federal government determines to be unreasonable.[46]

Issues for Congress

Legislation has been introduced in Congress to repeal the ACA fee on health insurance providers, and to require fuller consumer reporting regarding the fee. The bills are in addition to other legislation to repeal the ACA. Among the bills that have been introduced are:

- **H.R. 763**, To repeal the annual fee on health insurance providers enacted by the Patient Protection and Affordable Care Act by striking Section 9010.
- **S. 603**, To repeal the annual fee on health insurance providers enacted by the Patient Protection and Affordable Care Act.
- **H.R. 1558**, Section 104 of the bill would repeal Section 9010 of the ACA.
- **S. 24**, Section 104 of the bill would repeal Section 9010 of the ACA.

Related:

[42] CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[43] CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

[44] Congressional Budget Office, "CBO's May 2013 Estimated of the Effects of the Affordable Care Act on Health Insurance Coverage," http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

[45] CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (ACA)*, by Manon Scales and Annie L. Mach.

[46] CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

- **H.R. 1205**, To require health plans to disclose in their annual summary of benefits ACA-imposed taxes and fees.
- **S. 764**, To require health plans to disclose in their annual summary of benefits ACA-imposed taxes and fees.

In addition to formal legislation, there has been debate regarding other, possible changes to the ACA insurer premium fee.

Medicaid

A number of state governors caution that the premium fee will result in higher costs to states that offer fully capitated Medicaid managed care plans under contract with insurers. Federal regulations require that premiums paid to Medicaid managed care plans be "actuarially sound."[47] To make that determination, state licensing entities consider insurers' costs, including health benefits, marketing and administrative expenses, and taxes.[48] Because of cost-sharing limitations in Medicaid, the fees may not be passed on to enrollees. Instead, if premium rates go up, states and the federal government, which jointly fund Medicaid, could pay more to operate the program. The federal government will collect the insurer premium fee, but states will not have new, offsetting revenues to defray any new costs.

The Republican Governors Association has asked Congress to exempt Medicaid and CHIP managed care plans from the insurance tax.[49] Some analysts say that states will be able to negotiate with insurers to control premium costs, meaning that the full impact of the fee is unlikely to be passed along.[50]

Graduate Medical Education

The Association of American Medical Colleges has proposed using a portion of the premium tax to help fund U.S. graduate medical education.[51] Health policy experts are concerned about the current size, specialty mix, and geographic distribution of the healthcare workforce. Some experts forecast a shortage of physicians, a situation that will be made more acute when millions of previously uninsured consumers obtain coverage under the ACA.[52]

Tax Treatment of Recovered Fees

Another outstanding issue involves tax treatment of ACA fees "recovered" by affected insurers. Some large health care providers have indicated that they plan to recoup the cost of these excise taxes by levying fees or raising insurance premiums on those enrolled in their plans. In other words, although the excise tax is levied on health insurance providers, the economic impact of the

[47] Balanced Budget Act of 1997 (P.L. 105-33), and 42 CFR 438.6.

[48] American Academy of Actuaries, Practice Note, "Actuarial Certification of Rates for Medicaid Managed Care Programs," 2005, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

[49] GOP governors Bobby Jindal (LA) and Scott Walker (WI), March 22 letter to Congressional Leaders, http://www.mhpa.org/_upload/2013-03-22-RGA%20Jindal%20Walker%20tax%20Letter%20to%20Hill.pdf.

[50] Paul Van De Water, Center on Budget and Policy Priorities, "Health Reform Tax on Insurers Should Not Be Repealed: Tax Will Help Pay for Expanding Coverage," July 25, 2013, http://www.cbpp.org/cms/?fa=view&id=3995.

[51] Association of American Medical Colleges, Comment Letter to the Treasury Secretary Jacob Lew, June 3, 2013, http://www.regulations.gov/#!documentDetail;D=IRS-2013-0011-0068.

[52] CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Elayne J. Heisler.

excise tax might be borne by consumers. Under current law, increased insurer fees and premiums that are imposed to compensate, at least in part, for the imposition of the excise tax will contribute to the health insurers' calculations of their gross income for tax purposes. Therefore, these fees will be subject to corporate income tax (just like ordinary revenues earned through the sales of products and services).

A coalition of insurers has submitted comments to the IRS requesting that extra fees and higher premium costs be *excluded* from calculations of gross income. The insurers argue that they are effectively being "double-taxed": once through the ACA's fees/excise taxes, and next based on income earned from new fees and higher premiums instituted to offset any reduction in profits due to the tax. In the insurers' view, the fees should be interpreted by the IRS as a "recovery" for past excise taxes paid.[53] Opponents could argue that such an exclusion would amount to a tax preference for health insurers, and would also reduce the amount of revenue expected to be raised through the ACA fee. The IRS in its proposed regulation asked for comments on the issue.[54]

Author Information

Suzanne M. Kirchhoff
Analyst in Health Care Financing

Acknowledgments

This report includes the work of Janemarie Mulvey, a former CRS Specialist in Health Care Financing.

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

[53] According to formal comments submitted by the Health Working Group, a trade association representing some large health care insurers, their rationale for this interpretation is based on past legal precedent called the "tax benefit rule." For more information on this interpretation, see Healthcare Working Group /Skadden Arps, Comments on Proposed IRS Rule, http://www.regulations.gov/#!documentDetail;D=IRS-2013-0011-0069.

[54] Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee," 26 CFR Part 57, *Federal Register*, p. 14034 -14046, March 4, 2013, https://federalregister.gov/a/2013-04836.