Research

Impact of the Health Insurance "Annual Fee" Tax

ROBERT BOOK | FEBRUARY 20, 2014

Executive Summary

The Affordable Care Act's "annual fee on health insurance is a unique tax levied on health insurance companies as a fixed amount each year that is roughly proportional to their insurance market share, as measured by total premiums. As the tax is set at a fixed amount, insurance companies will be forced to pass the tax on to consumers in the form of higher premiums. This paper estimates the impact of this tax on individuals or, the share of the tax that will be (implicitly) paid by the average insured individual affected by it. The "annual fee" tax on health insurers will result in a premium increase of $60 to $160 per person in 2014, rising to $100-$300 by 2018, for the average insured individual — and over $260 per family in 2014, rising to over $450 in 2018, for families with employer-sponsored, fully-insured coverage.

The Health Insurance Tax

Section 9010 of the Affordable Care Act (ACA)[1] imposes a tax on health insurance that takes an unusual, perhaps unprecedented form. Instead of charging a fixed amount per policy or a percentage of the price, the tax is defined as a fixed amount each year on the health insurance industry, to be allocated across insurers roughly proportional to their market share as measured by their total premiums. Similarly structured taxes are also imposed on the medical device industry. The text of the statute calls this tax an "annual fee," but it is commonly referred to as a tax, and it really is a tax. To avoid ambiguity, we refer to it as an " 'annual fee' tax."

The logic behind this tax is that insurance companies will make money from increased enrollment due to the ACA, and therefore should pay more to the federal government. However, in order to remain in business, as well as to meet state and federal solvency and actuarial requirements, insurers will have to pass most of this tax along to policyholders in the form of higher premiums, or possibly higher average out-of-pocket costs or reduced benefits.

The form this tax takes makes it easy for the government to forecast its revenue. However, it is difficult or impossible for businesses to calculate the tax they will owe until well after the tax liability is incurred, in part because each insurer's tax liability depends not only on their own revenue, but on that of every other covered insurer in the country. In addition, certain types of health insurers are exempt from the tax.

Statutory Details of the "Annual Fee" Tax

The amount of the "annual fee" tax is $8 billion for 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2018, and $14.3 billion in 2018. Amounts for years after 2018 are set by a statutory formula. The tax is to be allocated among covered insurers based on their share of total health insurance premiums in each year. The allocation is in general proportional to each insurer's share, but for small insurers it works somewhat like a progressive corporate income tax, since the first $25 million of premiums are exempt from the tax, and only half of the next

$25 million count towards an insurer's share of the tax. In addition, certain tax-exempt, not-for-profit insurers have half their premiums excluded from the tax calculation.[2]

The tax applies to individually purchased insurance (through exchanges or otherwise), Medicare Advantage, and Medicaid managed care. There is a complete exception for employer-sponsored self-insured health plans,[3] even if they contract with an insurer to process claims and administer the health plan – but not for employer-sponsored insurance purchased from an insurance company. Voluntary employee beneficiary associations are exempt.[4] Medicare supplemental plans (such as Medigap plans), and plans that cover only accidents or only specified diseases are also exempt. There is also an exemption for non-profit insurers who derive at least 80 percent of their revenue from participation in government programs for the elderly, disabled, or poor.[5] In practice, this means that a small number of companies who participate almost exclusively in Medicare Advantage, Medicare Part D, and Medicaid managed care will be exempt; however, the vast majority of participants in these programs also sell "standard" insurance, and thus will not qualify for this exemption even if they are non-profit – and will owe the tax on their Medicare Advantage revenue in addition to their standard insurance revenue.

One might ask, since each insurer's tax liability depends in part on the premiums collected by all other covered insurers, how is each insurer supposed to know how much to pay? The answer is found in Section 9101(b)(3): they will report their covered premiums to the Secretary of Health and Human Services, who will calculate each insurer's share of the tax on the "basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary." It is unclear how, if at all, a covered insurer could challenge a calculation they believe to be incorrect, since the calculation would be based on the proprietary business records of many other entities.

Section 9010(f)(2) specifies (by reference to Section 275(a)(6)) of the Internal Revenue Code, that this "fee" should be considered a "tax" for which no deduction shall apply for the purpose of federal income (corporate profits) tax. This means, in effect, that for-profit insurers will have to include this tax – paid directly to the federal government – as part of their "profit" on which they have to pay further tax. For most for-profit insurers, this means they will pay an additional 35 percent income tax on the annual fee tax.[6] An insurer losing money will not have to pay this additional amount; however, since the annual fee tax is counted as "profit" for tax purposes, it is possible that an insurer near the break-even point would have to pay income tax on these "profits" even if they are actually losing money. Not-for-profit insurers will not be affected by this provision since they do not pay corporate income tax.

Data and Methodology

The goal is to estimate the additional amount the average insured person will pay as a result of this tax, and to the extent possible, calculate averages for sub-populations with different categories of insurance (for example, employer-sponsored insurance, individually purchased coverage, Medicare Advantage, and Medicaid managed care). The statutory total tax amount is allocated to each type of insurance, and divided by the number of persons covered by each type (and in the case of employer-sponsored insurance, employees and families as well). The result will be the estimated impact per person in each category of insurance.

For data on employer-sponsored insurance (ESI), including both average premiums, the percentage of employees covered by fully-insured ESI plan (subject to the tax) and employer self-insured plans (exempt), and estimates of the number insured, we use the latest Kaiser Family Foundation's annual Employer Health Benefits Survey,[7] as well as a report from the Robert Wood Johnson Foundation.[8]

For Medicare Advantage and Medicare Part D, we use data from the Center for Medicare and Medicaid Services (CMS). Enrollment data is from the December 2013 monthly enrollment file; premiums are based on published rates for 2014. For Medicaid managed care (through Medicaid Managed Care Organizations, or MCOs), we use the estimates in the Milliman Baseline Expansion Scenario.[9]

Estimates for the individual market via the ACA exchanges are necessarily highly speculative at this point. CMS has published premiums for selected example enrollees (individuals of two sample ages and families of three structures), but has not published formulas; furthermore, with enrollment still in progress as of this writing, it would not be possible to calculate total or average premiums because the age and geographical distribution of the enrollees is not yet determined. As a rough estimate, we have assumed that the average premium per enrolled life is the unweighted average of premiums for the two sample ages given (27 and 50), and we have assumed that enrollment will match the administration's initial prediction of 7 million enrollees in 2014. As of this writing, enrollment is far behind the administration's projection. If this remains true, average tax amounts for all categories of insured people will be slightly higher than estimated, since the fixed tax burden will be spread over fewer insured persons.

To estimate the additional effect of the corporate income tax, we note that for-profit insurers will have to increase their premium revenue by approximately $1.54 for each $1.00 of “annual fee” tax owed (0.54 is 35 percent of 1.54, so they will have to pay $1.00 in annual fee tax, plus $0.54 in income tax).

Not-for-profit insurers are not subject to corporate income tax; in addition, as noted above, not-for-profit insurers are subject to the annual fee tax calculated on the basis of only half their premiums. The overall impact of the profits tax effect has to be adjusted for both of these effects. Approximately 16.6 percent of total premiums are collected by not-for-profits;[10] this implies that on average, premium revenue must increase approximately $1.49 for each $1.00 of “annual fee” tax owed.[11] (The corresponding figures for Medicaid MCOs are 42% from non-profits, and $1.32 total impact per $1.00 of “annual fee” tax.)

Because both premium estimates and enrollment beyond 2014 are highly speculative due to the effects of other ACA provisions, we will for the most part use 2014 and (where those are unavailable) 2013 premiums – in effect calculating what impact the tax would have been in each of the years 2014-2018 if it had been in effect in 2014.

Results & Sensitivity Analysis

Based on the methodology above, the average impact of the tax is given in Table 1.

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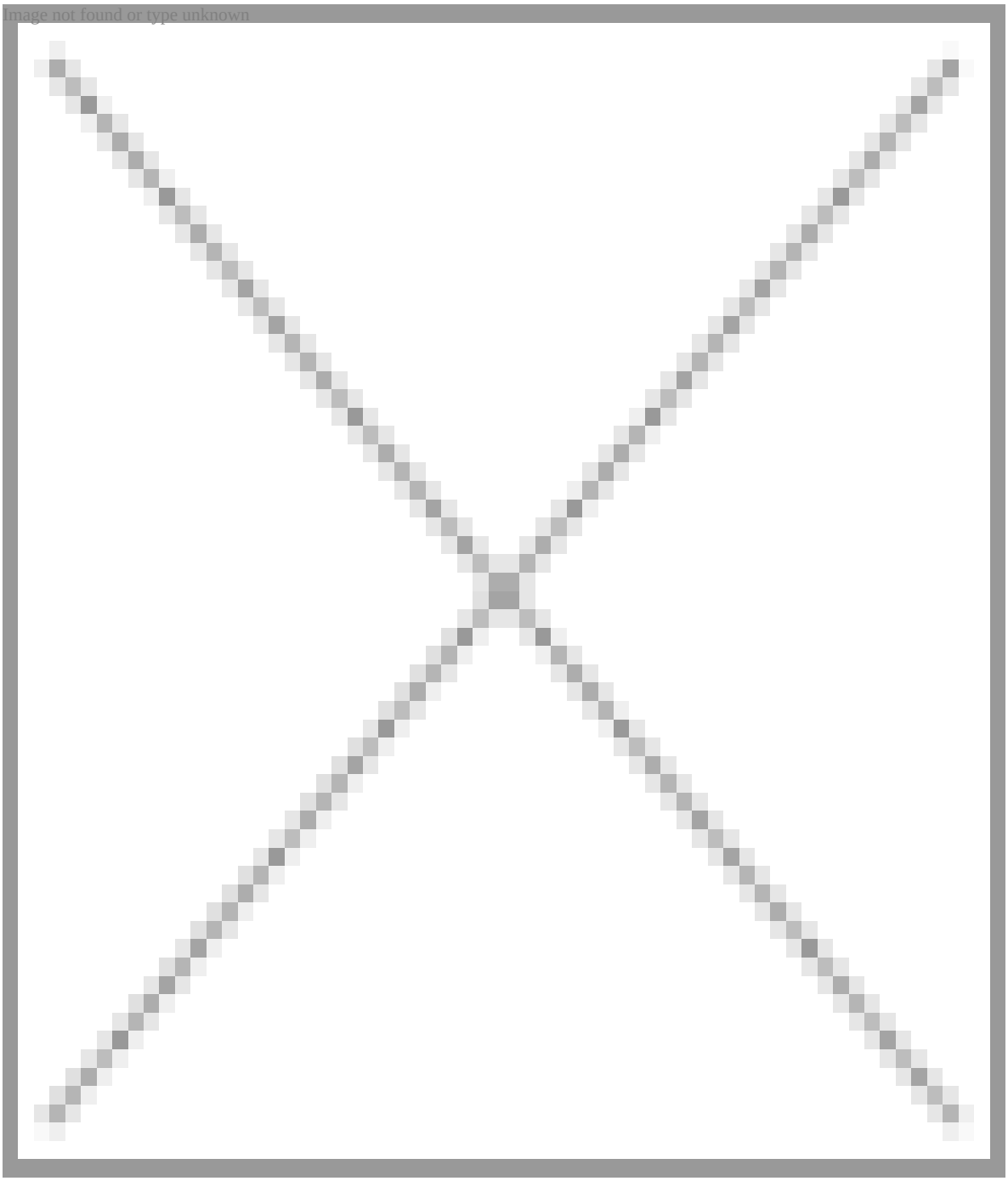

Sensitivity Analysis

In any projection for which some assumptions need to be made because underlying data is unavailable, it is appropriate to ask how sensitive the projections are to these assumptions.

For example, the above projections include generous assumptions about the level of exchange enrollment. If actual enrollment turns out to be much less, the average tax per ESI family and per employee will increase by no more than 5 percent, and the average tax over all non-Part D covered lives will increase by no more than 7 percent.[12]

In addition, we assumed that Medicare Advantage enrollment in 2014 would be comparable to December 2013 enrollment. However, changes made to the Medicare Advantage program in the ACA are expected by the CMS Actuary to significantly reduce enrollment.[13] We have previously made an estimate of this reduction[14] in enrollment. If we assume that our estimated enrollment is correct, the average tax per ESI family increases by less than 5 percent and the average tax per Medicare Advantage enrollee also increases by less than 5 percent.

Furthermore, another estimate of the tax impact was prepared by Chris Carlson of Oliver Wyman more than two years ago, using a substantially different method, different assumptions, and (of necessity) premium and enrollment estimates that are not as up-to-date as those available now.[15] Despite these differences, his results for 2014 were, by the standards of such forecasts, similar those reported here – and generally within 15 percent for the ESI sector.[16]

Economic and Budgetary Impact

In most cases, a tax on a particular product is borne partially by the seller and partially by the buyer. The reason for this is that a per-unit or percentage-of-price tax alters the impact of the transaction on both parties, and leads to a reduction in purchases that mitigates the effect of the tax. If less is sold, less tax is due. In the case of the health insurance tax, however, the total amount of the tax is fixed, regardless of sales volume. This means that it is not possible for insurance companies to reduce their tax liability by increasing prices and reducing sales.

The economic impact of the tax is harder to gauge. Clearly, the tax provides a significant incentive for employers to switch from full-insured to self-insured plans – a switch that not only reduces their tax liability, but also (because the total amount of the tax is fixed) increases the tax liability of fully-insuring employers, as well as individuals purchasing insurance on their own (including through the exchanges).

However, there is another effect not widely recognized. Most people enrolling through exchanges will receive a premium subsidy based on the difference between a specified percentage of their income, and a standard insurance plan (the second-lowest-priced silver plan available in their location for their family size). If the premiums are increased to pay the health insurance tax, the subsidies will automatically increase by the same amount – in effect, the federal government will be paying the tax to itself in the case of subsidized exchange customers.

This effect will partially apply in the case of those with fully insured employer-sponsored health plans. Because the premiums for employer-sponsored insurance are a form of compensation not counted as taxable income (regardless of whether they are allocated to the employer or the employee), the federal government will not collect personal income tax or FICA (payroll) tax on this amount. When the premiums increase to pay the health insurance tax, collections of income and payroll taxes will be reduced, on average, by the amount of the health insurance tax times the marginal tax rate of affected workers. This means that the federal government will be paying a portion of this tax (ranging from about 15 percent to about 40 percent, depending on the worker's income) to itself, though not the full amount as in the case of subsidized exchange enrollees.

In the case of Medicaid, CMS regulations[17] require that states pay premiums to Medicaid Managed Care Organizations (MCOs) that are “actuarially sound.” Because taxes and fees are necessary costs incurred by MCOs, they must be included in the determination of actuarially sound rates. As a result, MCOs will be fully reimbursed by the state and federal governments for the cost of this tax.[18]

In short, a substantial portion of this tax is simply transferred from the insured customer to the government, and back to the insured customer – and in the case of Medicaid, from government to government – with the

insurance company serving as an intermediary in both directions. However, even in cases where there is no direct tax or budgetary impact, there will be administrative costs associated with the tax borne by both the government and the insurance companies. These particular administrative costs represent complete and unambiguous waste, as they benefit neither patients, providers, insurers, other taxpayers, nor the government.

The "annual fee" tax will, however, have its full impact on exchange enrollees without subsidies. This includes those not eligible for exchange subsidies – either because their employer offers individual coverage only,[19] or because their income exceeds four times the federal poverty level for their family size.

Conclusion

The "annual fee" tax on health insurers will result in a premium increase of $60 to $160 per person in 2014, rising to $100-$300 by 2018, for the average insured individual — and over $260 per family in 2014, rising to over $450 in 2018, for families with employer-sponsored, fully-insured coverage. This amount will increase over time with the amount of the tax, even before taking into account the increased incentives for employers to switch to self-insurance, and the possibility that the higher premiums will induce some customers to forgo insurance. Both of these factors will increase the average tax paid by those who remain insured.

[1]The Patient Protection and Affordable Care Act (Public Law 111–148) was enacted on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), enacted on March 30. For convenience, most people refer to the final amended legislation as the Affordable Care Act (ACA), even though there was no actual legislation by that name..