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Tax Policy Meets the Affordable Care Act: The Case of the Premium Tax

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) "premium tax" will raise $78.2 billion over the next 5 years. President Obama's premium tax has four major implications:

- It creates an uneven playing field in which the government picks winners and losers in American's health insurance through flawed tax policy,
- It threatens the doctor-patient relationship by disrupting insurance and care arrangements,
- It forces higher premiums onto patients, heavily penalizing the middle class, and
- It makes the new insurance subsidy entitlement even more expensive.

The ACA premium tax owes its roots to a debate over health insurance policy. Perhaps due to those origins, the premium tax fails to obey basic principles with regard to the tax treatment of costs, thereby tilting the playing field in favor of tax-exempt insurers. In addition, the ACA exempts from the premium tax a particular class of non-profit insurers. This serves to further tilt the playing field, as well as provide strong incentives to re-organize lines of business for tax purposes.

These design flaws suggest dramatic impacts on competition in health insurance markets, with potentially large tax-based shifting of purchase patterns and business organizational forms. These shifts would represent a pure, tax-based distortion that imposes an economic cost above and beyond the amount of tax collected.

An important and unusual feature of this tax is that the ACA specifies not a tax rate, but an aggregate amount that must be collected each year. Thus, while there will likely be tax-based churning of customers and subsidiaries, the same amount of tax will be paid. Whenever an insurer reorganizes - or even reduces - its business to avoid a dollar of tax, it must in the end be paid dollar-for-dollar by other insurers. An examination of the economics of premium taxation suggests that the burden of the tax will largely be borne by purchasers of insurance in the form of higher premiums. Strikingly, the design flaws in the tax dictate that the ultimate economic burden of the tax will exceed the value of the taxes collected. Finally, $5 billion of the 2014 tax burden will fall on the middle class.

Introduction

The Patient Protection and Affordable Care Act (ACA) is comprised of myriad policy provisions with important implications: mandates to purchase health insurance; new state-based insurance exchanges; large, new subsidies for insurance purchases; the creation of an alphabet soup of new agencies, bureaus, and panels; Medicaid expansions, and the list could go on. However, one of the least-discussed features is a new "fee" – a *de facto* premium tax – levied on U.S. health insurance companies.

The tax was intended to partially offset the budgetary impact of the new subsidies and Medicaid expansions.[1] However, viewed from the perspective of tax policy, it is a new burden on households. The tax is a new cost for insurers that will

1 The fee is one part of a careful balancing act by Congress in imposing costs on the insurance industry to balance the benefits received due to the individual mandate. See http://americanactionforum.org/sites/default/files/AAF_Severability_Amicus_Brief_FINAL.pdf

inevitably be embedded into premiums facing U.S. employers and individuals. In addition, its design flaws will exacerbate this burden and introduce distortions into insurance markets. This paper reviews the structure of the premium tax, and then turns to important issues in the design of the tax – who ultimately bears its burden and the degree to which it impedes the efficient operation of health insurance markets.

The Health Insurance Premium Tax[2]

The basic structure of the tax. The ACA imposes a "fee" on the health insurance industry that amounts to a *de facto "*health insurance premium tax" that will raise the cost of health insurance for American families and small employers, disrupt health insurance purchasing patterns, and threaten established health care relationships. Specifically, under the law, an annual fee applies to any U.S. health insurance provider, with the intent of raising nearly $80 billion over the first 5 years. The aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and rises thereafter. (See Table 1.)

To see the implications for insurance markets, one must examine how it affects individual insurers. Each insurer will be liable for a share of the aggregate fee that is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 2. For example, an insurer with net premium revenues of $10 million is unaffected. In contrast, an insurer with net premiums of $100 million will have $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder). The aggregate fee is then apportioned among the insurers based on their shares of the total affected premiums.

Because no insurer can calculate its tax liability without knowing the premium revenue of all other insurers, the ACA specifies a two-step process. The Act directs the Secretary of Health and Human Services to specify a deadline each year for insurers to report their previous year's revenue. The Secretary is then directed to calculate each insurer's share of the tax, and set a payment deadline not later than September 30 of each year. No date is set in the statute for reporting revenue or notification of the tax due, but there are penalties for late reporting, and under-reporting, of revenue.

Design flaws of the premium tax. From a tax policy perspective the premium tax has two potential design flaws. First, the premium tax is not considered a business expense for purposes of calculating corporate income tax. That is, it is not tax-deductible. Other costs – claims paid, employee compensation, business services, supplies, and so forth are deducted from revenues to yield a sensible measure of taxable income or profit. By precluding the deductibility of the premium tax, the ACA deliberately overstates income and distorts the computation of corporation income taxes.

The second design flaw is the potential unequal treatment of insurers. To begin, note that tax-deductibility is only an issue for taxable insurers.[3] Not-for-profit insurers account for approximately half the market share in health insurance.[4] Put differently, by disallowing deductibility, insurers subject to corporate income tax will effectively pay income tax on their ACA premium tax. Tax-exempt insurers will not, effectively tilting the playing field in their favor.

A final issue is the notion of "gross revenue exemption" for a non-profit insurer. The ACA says that non-profits that earn 80 percent or more of their gross revenue from government programs for the low-income, elderly, or disabled are exempt from the tax. (This would include Medicare Advantage and Medicaid managed care plans.) Notice that this

2 This section draws heavily on previous research http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf
3 In practice, the distinction is less distinct, as many "non-profit" insurers are taxed on business income not related to their tax-exempt purpose.
4 For example, most of the Blue Cross-Blue Shield affiliates are not-for-profit. According to the Alliance for Advancing Nonprofit Health Care, 61 percent of health insurers with at least 100,000 enrollees are nonprofit, and these nonprofit account for 48 percent of enrollees. http://www.nonprofithealthcare.org/resources/BasicFactsAndFiguresNonprofitHealthPlans9.9.08.pdf

option is not available to for-profit insurers, even if their *entire* business derives from government programs for the low-income, elderly, or disabled. Perhaps ironically, a non-profit with less than 20% of its revenue from commercial business would be exempt from the premium tax even on its commercial business, but a for-profit doing only government low-income and elderly business would be liable for the premium tax on its entire revenue.

As an example, a non-profit insurer with only Medicare Advantage (MA) plans would be exempt from the tax. Suppose, however, that the same insurer also participates in the under-65 market? Specifically, assume the non-profit fully insures their MA plans and also is in the business of claims processing for self-insuring employers.

What is the gross revenue of the latter line of business? Is it the total amount they collect from employers to pay claims? Or is it more narrowly just fees charged for processing claims? If it is just the processing fees, it will be much more likely that the MA plan dominates the revenue stream and the firm is exempt.

The statute alone does not resolve the issue; rather market participants must await a rulemaking process to resolve the uncertainty as to what "80 percent or more of revenue" means.

The flip side of these impacts on insurers are harms to consumers. Insurance will be driven more by tax considerations than by the quality and value proposition of each policy. As existing insurance relationships are upset, the disruption will potentially threaten doctor-patient relationships and other patterns of provider care.

The Economics of Premium Taxation

A fundamental tenet of policy is that taxes distort economic activity, to some extent sapping market vitality and growth. At the same time, taxes must be effectively borne by *somebody* – not a business – in the form of reduced compensation (workers); lower dividends or capital gains (owners); or higher prices (consumers); or some combination of these. The art of tax policy is to keep the negative distortions as small as possible and the tax burden appropriately distributed. How does the premium tax fare by these metrics?

Impact of the premium tax on insurance market competition. The differential impacts of the premium tax on taxable, non-taxable, and exempt non-profit insurers have clear implications for insurance market competition. Recall that taxable insurers will not be able to deduct the premium tax when computing their income taxes. The importance of this non-standard tax treatment cannot be overstated. If an insurance company passes along $1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another $0.35 in corporate income taxes. Accordingly the impact on the insurer is $0.65 in net revenue *minus* the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by $1/(1-0.35) or $1.54 per dollar owed under the premium tax. If it does this, the after-tax revenue is the full $1 needed to offset the premium tax. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of $78.2 billion in fees over the first 5 years, the upward pressure could be as high as $120.3 billion. That is a $120.3 billion burden borne by owners, consumers and workers.

However, not all insurers will be taxable entities. A tax-exempt insurer would have incentives to pass along only $1; not $1.54 per dollar owed under the premium tax. On top of this, the ACA exempts from tax altogether (see above) certain non-profit insurers with 80 percent of their gross revenue from government programs. In this instance, there will be no upward premium pressure on whatever private insurance plans they may offer.

The upshot is that as premiums rise by $1.54 (taxable insurers), $1 (non-exempt non-profits), and $0 (exempt non-profits) – per dollar of premium tax – there will be clear incentives for buyers to shift their insurance purchases toward cheaper sources. Obviously, disadvantaged insurers will either find other cost reductions or be less able to compete. If they fail to adequately adapt, those insurers run the risk of being forced out of the health insurance business.

Of course, if insurers are unable to make core economic adjustments, they may resort to legal restructuring to try to avoid the tax. Non-profits, in particular may attempt to create subsidiaries to carry their employer-sponsored insurance business while remaining exempt on their other business.

There are two important implications of these impacts on market competition. The first is that because the overall fee is fixed it is impossible for all market participants to simultaneously avoid the tax. Every dollar of tax avoided by one insurer is completely shifted to other insurers, including tax "avoided" because a company goes out of business. Thus, market shifts and adjustments may be continuous. Second, and most important, these adjustments are an economic cost. Because they shift consumers away from their preferred products and firms away from their preferred business structures they represent a worsening of outcomes strictly in response to the tax.

Who will bear the burden of the tax? An interesting feature of the premium tax is that a fixed amount will be collected each year (see Table 1) regardless of the tax-based churning of customers and business organization discussed above. Thus, taken at face value, insurers as a whole have to pay this new "health insurance premium tax."

This line of reasoning ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the annual fee. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. And as with any excise tax, firms don't really pay taxes; they are shifted to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

Given that insurance companies will have to send the premium tax payments to the Treasury, the statutory incidence is quite clear. However, a basic lesson of tax policy is that people pay taxes; firms do not. Firms may send tax payments to the Treasury, but they can only get those resources from somebody in the economy. Accordingly, the economic burden of the $78.2 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income, or exacerbating losses. Some might argue that the firms will simply "eat the tax" – that is, accept the reduction in net income, in effect placing the burden of the tax on owners and employees. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies' abilities to make investments in health IT programs, wellness initiatives, and disease management tools. Ultimately, this hurts individuals and small employers who will lose the opportunity to access the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Importantly, these impacts also apply to not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue to serve policyholders effectively.

In short, all insurers – for profit and non-profit alike – that are subject to the tax will seek to restructure in an attempt to recover their costs, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth in the form of raises or bonuses, squeeze labor expansion plans and possibly lay off workers, or both. However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the cost of the tax is onto customers. If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive markets for equity capital and hired labor are, the greater the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, the same problem arises if insurance is obtained through one's employer. As employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus, the health insurance premium tax will have the effect of lowering personal income and payroll taxes, thereby shifting the ultimate burden to those individuals.

Who will be affected; that is, who purchases health insurance? Tables 3 and 4 outline a *rough* sketch of the likely burdens of the tax. Table 3 uses information from the Joint Committee on Taxation for tax year 2008 to identify the number of tax returns (column 2) and average tax benefit for employer sponsored insurance (ESI, column 3) to compute the total tax benefit of ESI (column 4) by income class.[5] Column 5 contains an estimate of the average tax rate for each income class.[6] Since the tax benefit is simply the value of insurance (the untaxed compensation) times an individual's tax rate, column (6) contains an estimate of the value of ESI by income class obtained by dividing (4) by (5). The final column shows the fraction of overall insurance that is obtained by each income group.

The computations in Table 3 give a rough idea of the distribution of insurance holders, and thus the distribution of those ultimately bearing the burden of the premium tax. They are subject, however, to a number of caveats. First, the data are from 2008, roughly pre-dating the Great Recession and the ACA itself. The distribution in 2014 will likely be quite different.[7] Second, Table 3 relies on employer-provided insurance. Those who choose the individual market tend to be higher income, thereby skewing the results modestly. Finally, the income measure in Table 3 is adjusted gross income for tax purposes. The use of tax data misses those who are the poorest, and not captured by the income tax.

Nevertheless, Table 4 provides a rough guide to the future impacts. It shows the aggregate premium impacts by income class for the first 5 years of the tax. To be specific, in 2014 the aggregate fee of $8 billion (bottom row) is estimated to translate into a premium increase of $10.6 billion in the aggregate.[8] Of this $10.6 billion, $2.8 billion of the burden is borne by those with incomes between $10,000 and $30,000; and $2.2 billion is borne by those with incomes between $30,000 and $50,000. Only a small fraction, $41 million, will be felt by the most affluent. The message is clear: the premium tax is a middle class tax.

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5 See http://finance.senate.gov/imo/media/doc/JCT1.pdf

6 Author's computations based on Internal Revenue Service, *Statistics of Income* data for 2008 individual returns.

7 It is difficult to anticipate just what will be the differences. The legacy of the recession is likely a greater erosion of employer-sponsored insurance; some would argue the same impact of the ACA itself. However, if the ACA individual mandates survives legal challenge, the distribution of overall insurance holdings will be much more equal.

8 This assumes that roughly 60 percent of the insurers are taxable and 40 percent are not.

Impact on Entitlement Spending

An implication of higher premiums is that it will become necessary to provide larger subsidies for the ACA entitlement. Those with income less than four times the Federal Poverty Level (FPL) are eligible for subsidized coverage through the exchanges. The subsidy declines as income rises, but is calculated based on second lowest cost "silver-level" health plan available to that household.[9] The premium tax will make that plan more expensive, raising subsidy costs.

Table 5 shows rough estimates of the amount of the premium tax that will be immediately spent because of the subsidy costs, based on CBO estimates of the number of exchange enrollees who will receive premium subsidies. This rough estimate at over 20 percent ($1.8 billion) in 2014, and rises to over 35 percent ($5.3 billion) in 2018.

Conclusions

The Patient Protection and Affordable Care Act (ACA) "annual fee premium tax" will raise $78.2 billion over the next 5 years. The ACA premium tax owes its roots to a debate over health insurance policy. Perhaps due to its origins, it fails to pass muster from the perspective of tax policy.

The premium tax fails to obey basic principles with regard to the tax treatment of costs, thereby tilting the playing field in favor of tax-exempt insurers. In addition, the ACA exempts from the premium tax a particular class of non-profit insurers. This serves to further tilt the playing field, as well as provide strong incentives to re-organize lines of business for tax purposes.

These design flaws suggest dramatic impacts on competition in health insurance markets, with potentially large tax-based shifting of purchase patterns and business organizational forms. These shifts would represent a pure, tax-based distortion or economic cost.

An important feature of the premium tax is that the ACA dictates an aggregate amount that must be collected each year. Thus, while there will likely be tax-based churning of customers and subsidiaries, the tax *will* be paid. An examination of the economics of premium taxation suggests that the burden of the tax will largely be borne by purchasers of insurance in the form of higher premiums. Strikingly, the design flaws in the tax dictate that the ultimate burden of the tax will exceed the value of the taxes collected. Finally, the vast majority of the burden will be fall on the middle class.

9 The household is then free to select any exchange plan it wishes, paying more of its own income for a more expensive plan, or less for a lower-cost plan.

Table 1: Aggregate Insurance Fees[10]	
Year	**Fee**
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [11]	$14.3 billion
2014-2018	$78.2 billion

Table 2: Fraction of Premiums Counted	
Annual Net Premiums	**Fraction**
Less than $25 million	0
$25 million to $50 million	50 percent
$50 million or more	100 percent

Table 3: The Distribution of Premium Payments, 2008						
Adjusted Gross Income	**Total Tax Returns (Thousands)[12]**	**Average ESI Tax Expenditure Per Return ($)[13]**	**Total ESI Tax Expenditure (Thousands $)[14]**	**Average Tax Rate (Percent)[15]**	**Value of ESI (Thousands $)[16]**	**Share of ESI (Percent)[17]**
<$10,000	5,698	$635	$3,618,230	3.0%	$121,137,240	4.2%
$10,000-$29,999	17,631	$1,952	$34,415,712	4.6%	$745,378,570	26.1%
$30,000-$49,999	17,369	$2,457	$42,675,633	7.1%	$598,976,942	21.0%
$50,000-$74,999	14,879	$3,095	$46,050,505	8.5%	$541,770,647	19.0%
$75,000-$99,999	9,502	$3,900	$37,057,800	9.3%	$398,470,968	14.0%
$100,000-$199,999	10,726	$4,481	$48,063,206	12.7%	$378,450,441	13.3%
$200,000-$499,999	2,463	$4,728	$11,645,064	19.6%	$59,413,592	2.1%
>$500,000	600	$4,467	$2,680,200	24.3%	$11,034,762	0.4%

[10] The non-deductibility of the Insurance fees raises their economic impact. See text for discussion.
[11] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.
[12] http://finance.senate.gov/imo/media/doc/JCT1.pdf
[13] http://finance.senate.gov/imo/media/doc/JCT1.pdf
[14] [Author's calculation]
[15] [Author's calculation based on SOI data]
[16] [Author's calculation]
[17] [Author's calculation]

Table 4: Premium Tax Burden by Income and Year						
	Premium Tax Burden (Millions $)					
Adjusted Gross Income	**2014**	**2015**	**2016**	**2017**	**2018**	**2014 - 2018**
<$10,000	$452	$638	$638	$785	$807	$3,319
$10,000-$29,999	$2,779	$3,925	$3,925	$4,828	$4,967	$20,425
$30,000-$49,999	$2,233	$3,154	$3,154	$3,880	$3,992	$16,414
$50,000-$74,999	$2,020	$2,853	$2,853	$3,510	$3,611	$14,846
$75,000-$99,999	$1,486	$2,098	$2,098	$2,581	$2,656	$10,919
$100,000-$199,999	$1,411	$1,993	$1,993	$2,452	$2,522	$10,371
$200,000-$499,999	$222	$313	$313	$385	$396	$1,628
>$500,000	$41	$58	$58	$71	$74	$302
Addendum						
Aggregate Premium Burden	$10,643	$15,033	$15,033	$18,492	$19,024	$78,225
Premium Tax	$8,000	$11,300	$11,300	$13,900	$14,300	$58,800

Table 5: Additional Entitlement Costs				
Year	**Subsidized Exchange Enrollees[18] (millions)**	**Insured Population Subject to Tax[19] (millions)**	**Percent Subsidized[20]**	**Estimated Tax Used for Subsidies[21] (billions)**
2014	7	32	22%	$1.8
2015	10	38	26%	$3.0
2016	16	46	35%	$3.9
2017	18	48	38%	$5.2
2018	19	51	37%	$5.3
2019	18	50	36%	$5.1[22]
2020	17	49	35%	$5.0[23]
2021	18	51	35%	$5.0[24]
2022	17	50	34%	$4.9[25]

[18] Congressional Budget Office and the staff of the Joint Committee on Taxation, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012, at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf
[19] CBO, March 2012, assuming that ESI coverage will be self-insured, and thus not subject to the premium tax.
[20] Authors' calculations based on CBO, March 2012.
[21] Authors' calculations based on CBO, March 2012, assuming that average premiums are similar for both subsidized and non-subsidized coverage. If non-subsidized households choose lower-cost plans, this share would be higher (and *vice versa*).
[22] Figures for 2019 and beyond will be actually increased by the rate of premium growth from the preceding year; figures shown do not take that increase into account.
[23] Ibid
[24] Ibid
[25] Ibid