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# **Impact Of ACA Annual Health Insurance Tax On State Medicaid Programs**

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## Executive Summary

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, together known as ‘ACA’, primarily intends to expand health care insurance coverage to the uninsured and underinsured. In order to achieve this goal Congress has reformed health insurance laws, provided subsidies, and imposed taxes and other revenue-raising measures. One notable provision is an excise tax that applies to most health plans including Medicaid Managed Care Plans (MMCPs).

While characterized as a ‘fee’ in the text of ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax with the understanding that the tax incidence could in part be passed-on to consumers. In all likelihood this would be achieved through higher premiums. ACA included a number of other broad-based excise taxes on industries to help offset the cost of that coverage expansion.

Both the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) agreed with Congress that that ‘fee’ was in truth an excise tax, both from an operational and economic perspective, and would therefore likely be passed on to consumers in the form of slightly higher premiums. CBO appears to have accounted for the effect of the excise tax on premiums for commercial health plans and health plans in the Exchange and therefore the cost of federal premium subsidies in the Exchange. However, CBO does not appear to have explicitly accounted for the cost of the tax to the Federal Government as a consumer or payer of premiums for Medicare Advantage and MMCPs. As such Congress was not provided with an estimate of the potential cost to states and the Federal Government.

In Medicaid, capitated rates paid to MMCPs by states are required to be developed using generally accepted principles of actuarial soundness. In addition to requiring that rates reflect the populations being served, actuarial soundness requires that the full costs of doing business, such as federal and state taxes, are considered. As such, for MMCPs the excise tax may be included in part or in whole within their actuarially sound rates. To the extent the tax is included in MMCP rates, the tax will be passed through to Medicaid program payers – that is, states and the Federal Government.

As with any excise tax, the ability of the assessed to pass along the tax to the consumer depends upon the competitive nature of the market. Lax federal oversight of actuarially sound rates, budgetary constraints, and market competition could reduce the amount of the excise tax that is passed through to Medicaid programs, especially if states resist rate increases. Depending on the market, MMCPs that are subject to the tax could be at a competitive disadvantage in setting their rates if MMCPs that are exempt from the tax, and therefore do not have the expense as part of their actuarially sound rates, are in the same markets and have capacity to add to their market share. However, states select MMCP contracts based on a number of considerations, such as an MMCP’s ability to deliver quality care and broad network access, not just on premium rates.

Assuming total pass-through to Medicaid programs, Marwood’s analysis estimates that between 2014 and 2019, states could be responsible for paying up to \$4.1 billion of the



health insurance industry excise tax and the Federal Government could be responsible for paying up to \$6.4 billion of the health insurance industry excise tax.

There are a number of policy options available to MMCPs to alter the effect of the excise tax on plans, states and the Federal Government. Criteria that should be considered in analyzing each of the policy options are: 1) political dynamics; 2) effect on other plans; and 3) effect on the federal budget. It should be noted that Marwood's estimate of the state and federal cost of the health insurance industry excise tax is a maximum estimate and may differ from a CBO score. As with any legislative proposal developed by Congress CBO will estimate the savings or cost to the Federal Government based on the specifics of the policy, and other factors that CBO chooses to consider. For example, CBO could make different assumptions as to how states will determine Medicaid rate increases, which in turn will affect their estimate of how much of the tax will actually be passed on by MMCPs.



## Introduction

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act,<sup>1</sup> as amended by the Health Care and Education Reconciliation Act of 2010<sup>2</sup>, together known as ACA. The main goal of ACA is to expand health insurance coverage. Congress has reformed health insurance laws, provided subsidies, and included new taxes and other revenue measures, in addition to enacting measures to reduce federal spending to assist in financing the law. Many of these changes are specific amendments to the Internal Revenue Code (Code), while others are stand-alone provisions that are considered “off Code.”

One of the notable revenue provisions enacted under ACA is a broad-based health insurance industry excise tax, which applies to most health insurance providers, including Medicaid Managed Care Plans (MMCPs), and will be assessed annually beginning in 2014. Although this stand-alone revenue provision is referred to in law as a “fee,” Congress intends for this tax to be broad-based and act as an excise tax under the Code. Both the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) characterize the “fee” on the health insurance industry as an excise tax, in accordance with Congressional intentions.

An excise tax is a tax charged on the sale of a particular good or service. Economically speaking, excise taxes are considered indirect taxes because they are not assessed at the point of sale, but are nonetheless expected to be passed on by those directly taxed to consumers through the price of the good or service. In this case, the good or service would be health insurance coverage and the price would be health insurance premiums. The competitiveness of the market will determine whether an excise tax can be fully-passed through to consumers. For example, higher insurance premiums in a competitive market tend to dampen demand for insurance, which could lead health insurance companies to keep premiums down by passing less of the tax to consumers. In addition, individual consumers within a market may bear the burden of the tax unequally. Critics of excise taxes argue that they are regressive, disproportionately affecting individuals with low-incomes when excise taxes are passed on to consumers they function like a sales tax. Supporters of the broad-based health insurance industry excise tax argue that ACA includes other provisions that minimize or eliminate the regressive effect of this tax. Specifically, Congress includes substantial subsidies for the cost of health insurance (premiums and cost sharing) for individuals with incomes below 400 percent of the federal poverty line.<sup>3</sup> These subsidies help protect low-income consumers from the financial effect of the health insurance tax.

This white paper summarizes the legislative history and explains the details of the annual health insurance tax. This paper analyzes the impact of the tax on MMCPs as well as costs to state Medicaid programs and the Federal Government.

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<sup>1</sup> Public Law 111-148.

<sup>2</sup> Public Law 111-152.

<sup>3</sup> Roach, Brian, “*Progressive and Regressive Taxation in the United States: Who’s Really Paying (and Not Paying) their Fair Share*”, Tufts University, October 2003.



## Legislative History

The major policy goal of ACA was to expand health insurance coverage for the uninsured and underinsured. ACA seeks to achieve this goal through reforming the health insurance market, including requirements on insurers to provide coverage (guaranteed issue) and consumers to obtain it (individual mandate), and by providing subsidies. Congress imposed new revenue raising measures to assist paying for this coverage expansion.

### Senate Development

The tax-writers on the Senate Finance Committee took the lead on developing revenue provisions to help offset the increased government spending called for under ACA. In the early stages of the development of the excise tax on the health insurance industry, the tax-writers contemplated a direct premium tax on health insurance providers, similar to premium taxes currently imposed by many states. Some also contemplated a tax on the insurance industry akin to the “windfall profits tax” imposed on the oil industry in 1980, which was intended to re-coup the revenue earned by oil producers as a result of the sharp increase in oil prices. Limiting the payroll tax exclusion of employer-sponsored health insurance premiums was also considered in the early stages.

Ultimately, these options were deemed by policymakers to be either inappropriate or politically unviable.<sup>4</sup> Windfall taxes were considered inappropriate in this context because the Federal Government’s action to expand coverage was not unexpected and the added profits to insurers would not necessarily be unearned. Insurers would earn these profits through the sale of additional health insurance policies. Modifying the tax exclusion was considered politically unviable because both large and small employers as well as unions were intensely opposed.

As an alternative, policymakers coalesced around the idea of imposing broad-based industry excise taxes in order to raise revenue. Committee policymakers focused predominantly on industries that stood to benefit from the new law, with the knowledge and expectation that these industries could try to pass on these excise taxes to consumers at some level through increased market prices. The industries targeted were pharmaceutical manufacturers, medical device manufacturers, and the health insurance industry. Pharmacy Benefit Managers (PBMs) were also targeted for an excise tax, but the provision was not included in the final Senate bill.

In order to generate the necessary member support for passage of the bill in the Senate, two narrowly written exemptions of the health insurance industry excise tax were included. First, there is an exemption for health insurance providers that are required by certain states to operate as non-profit entities and have high medical loss ratios. Second, there is an exemption for insurers in states with a high prevalence of mutual insurance companies.

Also noteworthy, an early Senate version applied the health insurance industry tax to all revenues generated by health insurance providers, including revenues from fully-insured and self-insured lines of business. Prior to full Senate consideration, policymakers courting

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<sup>4</sup> The Committee discussed this and other financing options in roundtable discussions on “Financing Comprehensive Health Care Reform”, May 2009.



business-community support modified the provision to target risk-bearing insurance firms, which essentially excluded revenues from self-insured entities and administrative services organizations that serve self-insured entities from the application of the health insurance industry tax. Despite the concession, the business-community did not support the bill.

The final Senate version of the excise tax on the health insurance industry was passed by the full Senate as part of ACA on December 24, 2009.

### House of Representatives Development

The tax-writers in the House of Representatives (the “House”) crafted revenue provisions for its health care reform legislation primarily through raising income tax rates on millionaires to help finance their version of expanded coverage. The House-version did not originally consider any excise taxes. Historically, the House democrats have had an unfavorable viewpoint of excise taxes, considering them regressive.

With the election of Senator Scott Brown (R-MA) in January 2010, Democrats would no longer have a filibuster-proof majority to pass substantially new versions of a health care reform bill. It became necessary for the House to accept and pass the Senate’s version of health care reform legislation, and with it the excise taxes, if Democrats wanted to enact ACA. As a condition for approving the Senate’s version of health care reform, House Democrats wanted specific changes made to, among other provisions, the excise tax on the health insurance industry.

The changes sought by the majority in the House were enacted in the Health Care and Education Reconciliation Act of 2010 (the “Reconciliation Bill”), which did not require a filibuster-proof majority for passage. Key modifications made to the Senate-passed version of the provision under the Reconciliation Bill included pushing the effective date of the tax from 2011 to 2014, increasing the total annual tax, and expanding the exemption provisions to apply more broadly to non-profit plans in any state that predominantly serves low-income populations. (See Table 1)

<b>Modification</b>	<b>Description</b>
<i>Effective Date Delayed</i>	<ul style="list-style-type: none"> <li>Changed from January 1, 2011 to January 1, 2014.</li> </ul>
<i>Specified Annual Dollar Amounts Increased</i>	<ul style="list-style-type: none"> <li>Increased the annual dollar amounts to \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, \$14.3 billion in 2018, and indexed thereafter.</li> <li>Previously these amounts were \$2 billion in 2011, \$4 billion in 2012, \$7 billion in 2013, \$9 billion in 2014 - 2016, and \$10 billion in 2017 and thereafter.</li> </ul>
<i>Exemptions From Tax</i>	<ul style="list-style-type: none"> <li>Eliminated certain exemptions included in the Senate-passed version (e.g., an exemption for non-profit insurance companies with high medical-loss ratios and certain mutual insurance companies).</li> <li>Added exemptions for non-employer voluntary employees’ beneficiary association (VEBAs) and certain non-profit entities that meet specified charitable tests and receive more than 80% of their gross revenue from government programs that target low-income, elderly, or disabled persons.</li> </ul>
<i>Special Rule for Non-Profits</i>	<ul style="list-style-type: none"> <li>Added a special rule that allows certain non-profit entities to exclude 50% of the provider’s net premiums written for purposes of determining the provider’s share of the aggregate net premiums written.</li> </ul>



### Broad-Based Excise Taxes Imposed on Industries in ACA

With the enactment of ACA, Congress added to the Federal Government's existing health-related Trust Funds through new taxes. Specifically, ACA created the Patient-Centered Outcomes Research Trust Fund ("PCORTF") and dedicated to this Trust Fund revenue from a nominal excise tax imposed on group health plans.<sup>5</sup> The purpose of the PCORTF is to fund "comparative effectiveness research" conducted by the Patient-Centered Outcomes Research Institute.<sup>6</sup> ACA also included an excise tax on brand prescription pharmaceutical manufacturers and importers. This tax – referred to as the PhRMA tax – is structured in a manner similar to the excise tax on health insurance providers. The revenue generated from this excise tax will be dedicated to the Medicare Part B Trust Fund.<sup>7</sup>

In addition, ACA enacted specific excise taxes solely for the purpose of generating revenue for the Federal Government's General Fund, rather than a dedicated Trust Fund. These excise taxes include (1) the excise tax imposed on the sale of medical devices by the manufacturer or importer<sup>8</sup> and (2) the annual excise tax on the health insurance industry.<sup>9</sup>

In all cases, but especially true for the health insurance industry, some policymakers were aware that the Federal Government could indirectly be responsible for a share of the tax as a purchaser of health insurance through Medicaid, Medicare Advantage, and the Exchange through subsidies.

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<sup>5</sup> ACA section 6301(e), adding new Code section 9511 and new Code sections 4375, 4376, and 4377.

<sup>6</sup> ACA section 6301(a).

<sup>7</sup> ACA section 9008(c).

<sup>8</sup> ACA section 9009, adding new Code section 4191.

<sup>9</sup> ACA section 9010.



## Explanation of the Excise Tax on the Health Insurance Industry

Effective January 1, 2014, ACA section 9010 imposes an annual “fee” – treated as an excise tax under the Code – on certain health insurance providers, including Medicaid Managed Care Plans (MMCPs), that are licensed to bear risk in the U.S. The excise tax is a set dollar amount for a particular year. In general, this set dollar amount is apportioned among those health insurance providers subject to the excise tax based on the total amount of “net premiums written” by the particular health insurance provider for the preceding year. As discussed below in greater detail, each health insurance provider subject to the annual excise tax is required to self-report, among other things, the entity’s net premiums written for the preceding year. Based on this information and other information obtained by the Treasury, the Treasury will calculate how much of the excise tax a particular health insurance provider is required to pay to the government for that year.<sup>10</sup>

### Applicability of the Tax

In general, any health insurance provider that sells a health insurance product insuring the health risk of (1) a U.S. citizen, (2) a resident alien, or (3) a person who is located in the United States during the period of time that the person is actually present in the U.S. is subject to the annual excise tax on health insurance providers.<sup>11</sup> (Figure 1) This generally means that both for-profit and non-profit health insurance providers are subject to the tax, along with foreign insurers that insure health risks in the United States or insurers that provide health insurance under Medicare Advantage, Medicare Part D, or Medicaid.<sup>12</sup> There are a number of exceptions to this general rule, however. For example, the following entities are not subject to the excise tax:

- An employer that self-insures the health risks of its own employees (i.e., a self-insured arrangement);<sup>13</sup>
- A governmental entity;<sup>14</sup>
- A non-employer sponsored voluntary employees’ beneficiary association (“VEBA”), such as a VEBA sponsored by a union;<sup>15</sup>
- An entity that (1) qualifies as a non-profit organization, (2) meets the private inurement and limitation on lobbying provisions described in Code section 501(c)(3), and (3) receives more than 80% of its gross revenue from government programs that target low-income, elderly, or disabled populations (including Medicare, Medicaid, and the State Children’s Health Insurance Plan (“SCHIP”), and dual-eligible plans).<sup>16</sup> This exception would include non-profit Medicaid plan providers.

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<sup>10</sup> It is intended that Treasury will reconcile the amount it calculated with the actual amount paid by a health insurance provider to the government. As discussed more fully in the body of this white paper, if there is a discrepancy in these amounts, the health insurance provider must pay the assessed amount to the government and file suit in court for a refund.

<sup>11</sup> ACA sections 9010(a), (c)(1), (d).

<sup>12</sup> Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, As Amended, in Combination With the Patient Protection and Affordable Care Act*, JCX-18-10 March 21, 2010, page 90.

<sup>13</sup> ACA section 9010(c)(2)(A).

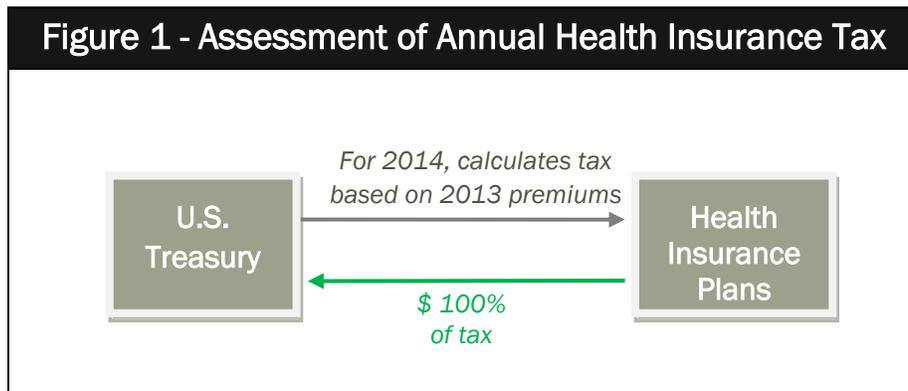
<sup>14</sup> ACA section 9010(c)(2)(B).

<sup>15</sup> ACA section 9010(c)(2)(D).

<sup>16</sup> ACA section 9010(c)(2)(C).



Entities that are under common control or part of an affiliated service group with a health insurance provider subject to this provision<sup>17</sup> will be treated as a single entity for purposes of the application of the excise tax.<sup>18</sup> In this case, if more than one entity is liable for payment of the tax by reason of being treated as a single entity, then all such entities will be jointly and severally liable for payment of the excise tax.<sup>19</sup> However, if a related entity is a non-employer sponsored VEBA or, for example, a non-profit Medicaid plan provider, the entity will not be required to pay the excise tax.<sup>20</sup>



### Annual Tax Amounts

Beginning in 2014, the total amount payable by those health insurance providers subject to the tax will equal \$8 billion.<sup>21</sup> This specified amount will increase to \$11.3 billion in 2015 and 2016, with further increases to \$13.9 billion in 2017 and \$14.3 billion in 2018.<sup>22</sup> After 2018, the tax amount is indexed to the rate of growth in premiums.<sup>23</sup> According to the Joint Committee on Taxation (JCT) and the Congressional Budget Office (CBO), the annual tax on health insurance providers is projected to generate \$60.1 billion in revenues to the Federal Government between 2014 and 2019, which is approximately 80% of the assessed value.<sup>24</sup>

### Tax Determination Methodology

In general, the specified dollar amount for a particular year will be apportioned among all health insurance providers subject to the tax.<sup>25</sup> This means that a health insurance provider subject to the tax will be responsible for a specified portion of the set dollar amount for the year. To determine this amount, the provider's net premiums written for the preceding year are divided by the net premiums written by all of the health insurance providers subject to the tax for the preceding year.<sup>26</sup> Then, the percentage of the provider's share of the aggregate net premiums written is multiplied by the specified dollar amount for the year.<sup>27</sup>

<sup>17</sup> The Code includes detailed mechanical rules for determining whether entities are under common control (under Code section 1563) or part of an affiliated service group (under Code section 414).

<sup>18</sup> ACA section 9010(c)(3)(A).

<sup>19</sup> ACA section 9010(c)(4).

<sup>20</sup> ACA section 9010(c)(3), flush language.

<sup>21</sup> ACA section 9010(e)(1).

<sup>22</sup> *Id.*

<sup>23</sup> ACA section 9010(e)(2).

<sup>24</sup> Joint Committee on Taxation, *Estimated Revenue Effects of the Amendment in the Nature of a Substitute to H.R. 4872, the "Reconciliation Act of 2010," As Amended, in Combination With the Revenue Effects of the "Patient Protection and Affordable Care Act" As Passed By the Senate, and Scheduled for Consideration By the House Rules Committee*, JCX-17-10, March 20, 2010.

<sup>25</sup> JCT Technical Explanation, page 89.

<sup>26</sup> ACA section 9010(b)(1).

<sup>27</sup> *Id.*



**Example:** Health insurance provider A's net premiums written in 2013 amounted to \$40 billion, and the net premiums written by all health insurance providers subject to the tax was \$200 billion in 2013. In this case, provider A's share of the aggregate net premiums written for 2014 is 20%. In 2014, if health insurance provider A's share of the aggregate net premiums written is 20%, the portion of the \$8 billion annual tax amount for the year that provider A would owe to the government would be \$1.6 billion (\$8 billion multiplied by 20%).

It is important to note that the amount of the net premiums written used for this calculation do not represent the total net premiums written by the provider. For example, the first \$25 million of net premiums written are not taken into account for purposes of determining the amount of the tax owed.<sup>28</sup> In the case where the insurer has \$25 million or less in net premiums, the provider would not be subject to the tax. If a provider's net premiums written are more than \$25 million but less than \$50 million, 50% of the provider's net premiums written above \$25 million are used to determine the applicable tax.<sup>29</sup>

**Example:** Health insurance provider B's net premiums written for the preceding year amounted to \$35 million. The first \$25 million of provider B's net premiums are not taken into account. This leaves \$10 million of net premiums. The law only allows 50% of the \$10 million in net premiums to be used in tax calculations. Thus, in this case, provider B's net premiums written for purposes of determining the amount provider B owes would be \$5 million.

Finally, if a provider's net premiums written exceed \$50 million, the first \$25 million will not be taken into account, 50% of the net premiums written between \$25 million and \$50 million will be considered, and 100% of the provider's net premiums in excess of \$50 million will be taken into account.<sup>30</sup>

**Example:** Health insurance provider C's net premiums written for the preceding year amounted to \$100 million. Here, the first \$25 million of C's net premiums are not taken into account, 50% of the premiums written between \$25 million and \$50 million will be considered (\$12.5 million), and 100% of the remaining \$50 million of net premiums written will be taken into account. Thus, in this case, insurance provider C's net premiums written for purposes of determining the amount of the tax that provider C owes would be \$62.5 million (\$50 million plus \$12.5 million).

A separate special rule is also applied for purposes of determining the provider's share of the aggregate net premiums written. However, this special rule – which allows the provider to effectively discount its net premiums written by 50% – only applies to certain entities.<sup>31</sup> Specifically, a health insurance provider that is considered a “public charity,”<sup>32</sup> a “social

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<sup>28</sup> ACA section 9010(b)(2)(A).

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> ACA section 9010(b)(2)(B).

<sup>32</sup> Under Code section 501(c)(3).



welfare organization,”<sup>33</sup> a “high-risk pool,”<sup>34</sup> or a “Consumer Operated Oriented Plan (otherwise known as a “CO-OP”)<sup>35</sup> may reduce its net premiums written by 50%.<sup>36</sup>

**Example:** Assume health insurance provider C in the above example is a social welfare organization (i.e., a 501(c)(4) organization). On account of this special rule, insurance provider C would only be required to take into account roughly \$36 million (\$62.5 multiplied by 50%) of its net premiums written for purposes of determining the amount of the tax provider C would owe.

Net written premiums are intended to mean premiums written, including reinsurance premiums, reduced by reinsurance ceded and by ceding commissions.<sup>37</sup> Premiums generated from certain HIPAA-excepted benefits (e.g., accident, disability income insurance, coverage for a specified disease or illness, or hospital indemnity or other fixed indemnity insurance), long-term care, or any Medicare supplemental health insurance are not taken into account under this provision.<sup>38</sup>

### Operational Aspects of the Health Industry Excise Tax

Although described as a “fee”, the Treasury, JCT and CBO treat the annual health insurance tax as an excise tax for purposes of assessing and enforcing payment.<sup>39</sup> The statute provides, however, that the rules relating to procedure and administration of assessing and enforcing the excise tax shall only include civil actions for refunds under these rules.<sup>40</sup> This means that if a health insurance provider disputes the amount of the excise tax it is otherwise required to pay – because, for example, the Treasury calculated a greater amount of the excise tax owed than the provider reported – the provider must pay the assessed amount to the government and file for a refund for the overpayment in federal court. The Treasury is directed to establish a date on which the excise tax must be paid to the government. ACA states that this date can be no later than September 30<sup>th</sup> of each year.<sup>41</sup>

Each health insurance provider subject to the excise tax must submit a report to the Treasury indicating the amount of its net premiums written for the preceding year.<sup>42</sup> The Secretary of the Treasury will specify the date on which the report must be filed in a particular year.<sup>43</sup> If a health insurance provider fails to submit a report to the Treasury by the specified date, the provider will be subject to a penalty equal to \$10,000 plus the lesser of (1) \$1,000 per day while the failure continues or (2) the amount of the tax imposed for which the report was required, unless the failure to report was due to reasonable cause.<sup>44</sup> An accuracy-related penalty will also apply. In the case that a health insurance provider understates its net premiums written on the report filed with the Treasury, the provider will

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<sup>33</sup> Under Code section 501(c)(4).

<sup>34</sup> Under Code section 501(c)(26).

<sup>35</sup> Under Code section 501(c)(29).

<sup>36</sup> ACA section 9010(c)(2)(B).

<sup>37</sup> JCT Technical Explanation, page 89.

<sup>38</sup> See ACA section 9010(h)(3).

<sup>39</sup> See ACA section 9010(f)(1). The statute cross-references the rules under Subtitle F of the Code which sets forth the procedures for tax administration and includes rules ranging from setting filing dates and the collection of penalties for late tax filers to criminal offenses and judicial proceedings.

<sup>40</sup> *Id.*

<sup>41</sup> ACA section 9010(a)(2).

<sup>42</sup> ACA section 9010(g)(1).

<sup>43</sup> *Id.*

<sup>44</sup> ACA section 9010(g)(2)(A).



be required to pay a penalty equal to the difference between the amount of the excise tax that the Treasury determines should have been paid in the absence of the understatement and the amount of the excise tax determined based on the understatement.<sup>45</sup>

The new law directs the Secretary of the Treasury to calculate the amount of the excise tax owed by each health insurance provider subject to the new provision.<sup>46</sup> The statute provides that for purposes of performing the calculation, the Secretary will rely on the information submitted to the Treasury in the reports described above.<sup>47</sup> The law also indicates that the Treasury can draw from other sources of information.<sup>48</sup> It is intended that the Treasury may rely on published aggregate annual statement data (presumably filed with a state's Department of Insurance), and may use publicly available annual statement data and filed annual statements to verify or supplement reports submitted by the insurance provider.<sup>49</sup>

The amount of the excise tax owed by a health insurance provider in a particular year is not deductible for corporate income tax purposes.<sup>50</sup>

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<sup>45</sup> ACA section 9010(g)(3)(A).

<sup>46</sup> ACA section 9010(b)(3).

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> JCT Technical Explanation, page 89.

<sup>50</sup> ACA section 9010(f)(2).



## CBO and JCT Consideration of the Annual Health Insurance Fee as an Excise Tax

Excise taxes are imposed under the Tax Code for two primary reasons: 1) to generate revenue for the Federal Government; and 2) to affect behavior.<sup>51</sup>

In the case of revenue generation, the Code imposes a number of excise taxes on goods and services in particular industries, and dedicates those revenues to a Trust Fund or otherwise specified purpose to finance certain activities related to the respective industry. A notable example is the excise tax on the sale of fuel (gasoline). Receipts from the fuel tax are dedicated to transportation projects (i.e., road and highway construction) so that the fuel tax is considered by many as a user fee.

The Code also imposes excise taxes to affect behavior. Arguably the most notable excise tax intended to affect behavior is the excise tax imposed on tobacco products, including cigarettes, cigars, and smokeless tobacco.<sup>52</sup>

Both JCT and CBO expect excise taxes to be indirectly assessed on consumers, usually through higher prices. Specifically to the broad-based health industry excise tax, JCT and CBO analyzed the effect on private health insurance premiums. CBO accounted for the effect of the excise tax on premiums in the Exchange and therefore on the cost of federal premium subsidies in the Exchange. However, it is not clear that CBO accounted for the cost of the tax to the Federal Government as a consumer or payer of premiums for Medicare Advantage and Medicaid plans. As such, Congress was not provided with an estimate of the potential cost of the tax to states and the Federal Government.

### JCT Analysis of the ACA Excise Tax on the Health Insurance Industry

On June 3, 2011, JCT provided an in-depth analysis of the impact of the health insurance industry excise tax on private coverage premiums.<sup>53</sup> In its analysis, JCT likened the fee to “an excise tax on the sales price of health insurance contracts.”<sup>54</sup> JCT analysis of who would ultimately bear the cost of the excise tax suggested that the bearer of excise tax costs (consumers) does not depend on the original entity upon which the excise tax is levied (health insurance plans).

JCT provided analysis of the excise tax in the context of competitive or not perfectly competitive markets. In the case of perfectly competitive markets, an excise tax is borne entirely by consumers in the form of higher prices in the long-term. This is a direct result of the general principles that (1) an excise tax increases the cost of a good and (2) in a competitive market, firms are less likely to pass on more than the full cost of tax (because their competitors may under-price the good), and they are similarly less likely to absorb the tax (because they would lose money by under pricing a taxed good).

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<sup>51</sup> Joint Committee on Taxation, “Present Law and Background Information on Federal Excise Taxes”, JCS-1-11, January 2011, (hereinafter referred to as “JCT Information on Federal Excise Taxes”), page 1.

<sup>52</sup> JCT Information on Federal Excise Taxes, pages 33-35.

<sup>53</sup> On June 3, 2011, JCT responded to a request from Senator Jon Kyl (R-AZ) to estimate the impact repealing the annual fee on health insurance providers would have on health insurance premiums. It is important to note that this estimate is not available to the public.

<sup>54</sup> June 3, 2011 letter to Senator Kyl.



In the case of markets that are not perfectly competitive (like the insurance industry), JCT estimates that the price of the good could increase by (1) more than the amount of the tax, (2) exactly the amount of the tax, or (3) less than the amount of the tax. In this context, JCT suggested that the full cost of the tax may not be entirely passed on to the consumer, depending on the circumstances.

Based on this analysis, JCT concluded that a “very large portion of the tax on health insurance providers will be passed forward to purchasers of insurance in the form of higher premiums.”<sup>55</sup> In the case of health insurance products sold by providers subject to the health industry excise tax, JCT estimated that the premiums would be 2-2.5% greater than they otherwise would have been, amounting to a \$350 to \$400 increase for an average family health insurance policy in 2016.

#### CBO Analysis of the ACA Excise Tax on the Health Insurance Industry

At this time, the only publicly available CBO analysis of the health industry excise tax is embedded within an analysis on the impact of the Senate’s version of the health care reform legislation – in the aggregate – on general health insurance premiums.<sup>56</sup> The general structure of the excise tax did not substantively change from Senate passage to the date that the excise tax was ultimately enacted into law. Therefore, Marwood believes that the CBO analysis continues to be relevant regardless of changes to the overall size of the tax and some exemptions.

In its analysis, CBO assumed that the premium for a health insurance policy equals the average amount that an insurer expects to pay for services covered under the plan plus a loading factor that reflects the insurer’s administrative expenses and overhead (including any taxes or fees paid to the government) and profits (for private plans). With respect to the excise tax on health insurance providers, CBO assumed that the “fees would be largely passed through to consumers in the form of higher premiums for private coverage,” thereby “increasing premiums slightly.”<sup>57</sup>

CBO considered the effect of the pass-through relative to federal subsidies in the Exchange, though CBO does not appear to have explicitly estimated the impact to the Federal Government relative to Medicare Advantage or Medicaid managed care plans.

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<sup>55</sup> June 3, 2011 letter to Senator Kyl.

<sup>56</sup> CBO, “An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act”, November 30, 2009.

<sup>57</sup> *Id.*



## State Medicaid Managed Care Programs and the Health Insurance Industry Excise Tax

When analyzing the impact of the excise tax on health insurance premiums, CBO and JCT characterized the annual tax on health insurance providers as an excise tax that would be passed through to consumers in the form of higher premiums. Regarding the case of Medicaid managed care (and other public programs delivered through insurance), state Medicaid programs along with the Federal Government are considered consumers because they pay the plans' premiums. Therefore, to the extent that insurers raise premiums in order to pass on the tax, states and the Federal Government pay the tax.

### Medicaid Managed Care Arrangements

State Medicaid agencies can enter into managed care arrangements with CMS under a number of authorities, including research and demonstration waivers, freedom of choice waivers, or State Plan Amendments. Medicaid managed care service models include case management and coordination of care in fee-for-service, non-risk contracts, and capitated risk-based contracts. Specifically, these arrangements are often Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management (PCCM) programs. Currently, 43 states, including the District of Columbia, have some form of Medicaid managed care.

Both Medicaid managed care enrollment and expenditures have been increasing as a share of the overall program for the past several decades. Managed care encompasses a significant portion of Medicaid enrollment, but only approximately 18-21% of overall expenditures.<sup>58</sup> Medicaid managed care enrollees currently are predominantly children, pregnant women, parents, and childless adults. However, the population mix will change as more states enroll the aged, blind, and disabled population in managed care. Additionally, ACA-related Medicaid coverage expansion will mostly add male, childless adults to the program. According to the June 2011 Medicaid and CHIP Payment and Access Commission (MACPAC) report, over 70% of Medicaid enrollees are enrolled in some type of managed care arrangement nationwide, with 47% enrolled in comprehensive risk-based MCOs.<sup>59</sup>

### Application of Health Insurance Excise Tax to Medicaid Managed Care Plans

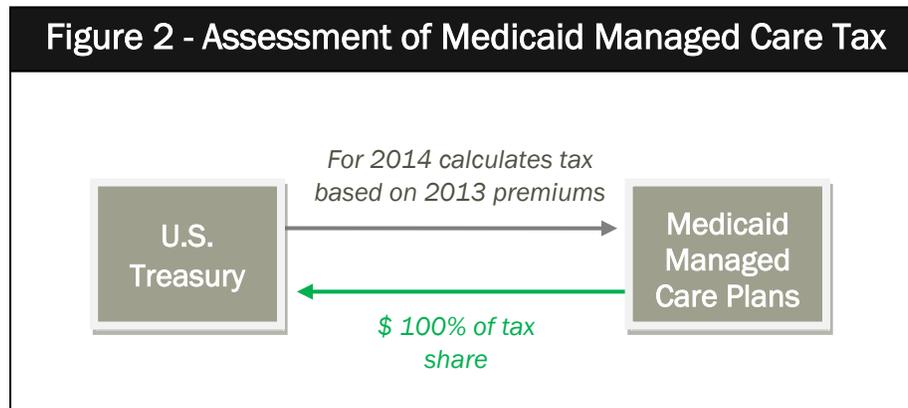
The ACA excise tax on health insurance providers would apply to risk-bearing MMCPs (MCOs, PIHPs, PAHPs), except for those meeting the exemption criteria. (Figure 2) Approximately 80% of MMCP enrollees receive their benefits from an MMCP subject to the tax.<sup>60</sup>

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<sup>58</sup> Marwood analysis of MSIS data.

<sup>59</sup> Medicaid and CHIP Payment and Access Commission, "Report to Congress", June 2011

<sup>60</sup> The Association of Community Affiliated Plans, which represents Medicaid plans likely exempt from the excise tax, estimates their plans to enroll approximately 7.2 million members of approximately 34 million Medicaid managed care enrollees in 2010



### Pass-Through of Excise Tax by MMCPs to Consumers: State Governments

MMCPs are typically reimbursed per member per month (PMPM) rates determined through either a negotiated-rate or competitive bid process between MMCPs and the states. When a Medicaid agency enters into a contract with a managed care plan, CMS must review and approve the contract prior to service delivery. One of the components of the contract review process involves ensuring that the principles of actuarial soundness were used to set the premium rates in Medicaid.

The actuarial soundness requirement is intended to ensure that the rates paid to MMCPs are sufficient for the plans to provide the contracted benefits and services while remaining financially solvent. In essence, the actuarial soundness requirement is a protection both for Medicaid beneficiaries as well as for the MMCPs that provide services.<sup>61</sup> CMS has developed a checklist, with input from the American Academy of Actuaries, to guide the contract review and approval process.

Costs related to providing services, such as administrative and financial overhead, are included within the actuarial soundness calculation.<sup>62</sup> Similarly, a 2005 practice note from the American Academy of Actuaries provided guidance to MMCPs, states, and CMS on actuarial soundness calculations and the inclusion of taxes. Specifically, the practice note provided the following guidance definition:

**Actuarial Soundness:** Medicaid plan premiums are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes [emphasis added], and the cost of capital.<sup>63</sup>

<sup>61</sup> Lewin Group, “Rate Setting and Actuarial Soundness in Medicaid Managed Care”, 2006

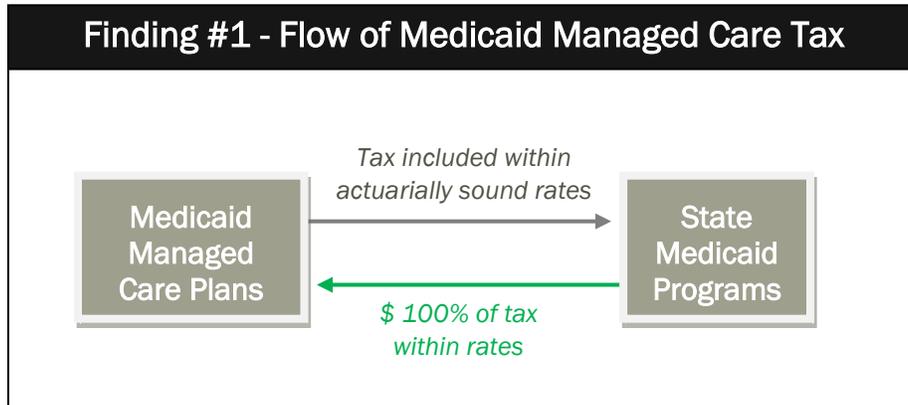
<sup>62</sup> 42 CFR 438.6.

<sup>63</sup> American Academy of Actuaries, “Actuarial Certification of Rates for Medicaid Managed Care Programs”, 2005.



While the definition focuses on “state-mandated assessments and taxes,” the imposition of additional Federal fees would likely meet the definition of “reasonable, appropriate and attainable costs.” Since the excise tax is mandatory, actuaries would likely define it as a reasonable cost of doing business. MMCPs will likely have the excise tax included within their actuarially sound rates, and therefore the cost of the tax will pass-through to the states.

**Finding #1: Medicaid Managed Care Plans will pass-through the cost of the tax to states as part of their actuarially sound rates.**



From an operational perspective, oversight and enforcement of actuarially sound rates varies. A 2010 report by the Government Accountability Office (GAO) concluded that CMS “has been inconsistent in ensuring that states are complying with the actuarial soundness requirements and does not have sufficient efforts in place to ensure that states are using reliable data to set rates.”<sup>64</sup>

CMS concurred with GAO’s findings and subsequent recommendations, and has been developing policies and procedures to improve rate-setting oversight. CMS is currently operating workgroups tasked with examining state, federal, and MMCP practices related to managed care rate-setting; focus will be on developing policy recommendations to improve the consistency and accuracy of CMS’ contract review and approval process as well as updating the review checklist, though the actual effect on policy is to be determined.

In addition, MMCPs must consider that they are competing with other plans for the states’ Medicaid managed care business; not only with other MMCPs subject to the excise tax, but also with MMCPs exempt from the excise tax. In developing competitively negotiated rates or bids, individual MMCPs will have to determine whether passing-through all or some of the excise tax to the states as part of the actuarially sound rates could impede their ability to compete on price for Medicaid managed care contracts.

<sup>64</sup> Government Accountability Office, “Medicaid Managed Care, CMS’s Oversight of States’ Rate Setting Needs Improvement”, 2010. <http://www.gao.gov/new.items/d10810.pdf>



In many states, the ability of MMCPs exempt from the tax to achieve greater market share may be limited as their provider networks are often geographically defined. Therefore, price competition with MMCPs exempt from the tax would be limited in these states.

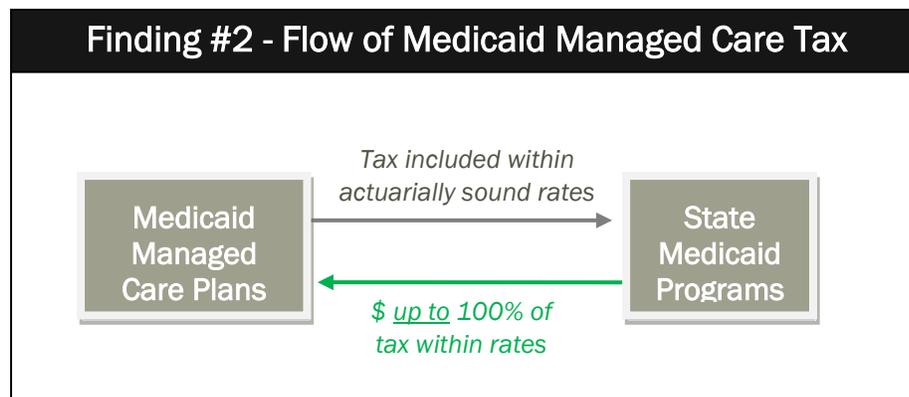
As with any excise tax, the ability of the assessed (MMCPs) to pass along the tax to the consumer (state Medicaid programs) depends upon the nature of the market. In this case, the direct consumers are the state governments who will be influenced by state budgetary constraints.

Currently, most states continue to face consistent budgetary shortfalls that have required spending reductions and/or revenue increases. Medicaid budgets, which are usually the second or third largest portion of state budgets, are under pressure due to the expiration of additional federal Medicaid funding provided through the American Recovery and Reinvestment Act (ARRA) on June 30, 2011, eligibility maintenance of effort requirements included in ACA, and higher than expected enrollment due to the recession.

In addition, state governments must contend with discussions at the federal level as part of debt ceiling or future deficit reduction legislation to potentially readjust federal Medicaid matching funds or to restrict state utilization of provider taxes, which have historically been used by states to draw down additional federal funds for their Medicaid programs. There is some question as to the level at which state governments, as consumers, will be willing or able to absorb the excise tax burden from a budgetary point of view.

Higher premium rates as a result of the excise tax being included within actuarial sound rates could diminish the savings states often seek from their Medicaid managed care programs. At some future point, states' decisions to implement, continue, or expand Medicaid managed care programs in an environment with increased rates due to the excise tax pass-through could come into conflict with states' goals of achieving Medicaid program savings unless states push back on the rate increases.

**Finding #2: Medicaid Managed Care Plans will pass-through the cost of the tax to states as part of their actuarially sound rates; however, state fiscal constraints or market competition may prevent full pass-through.**





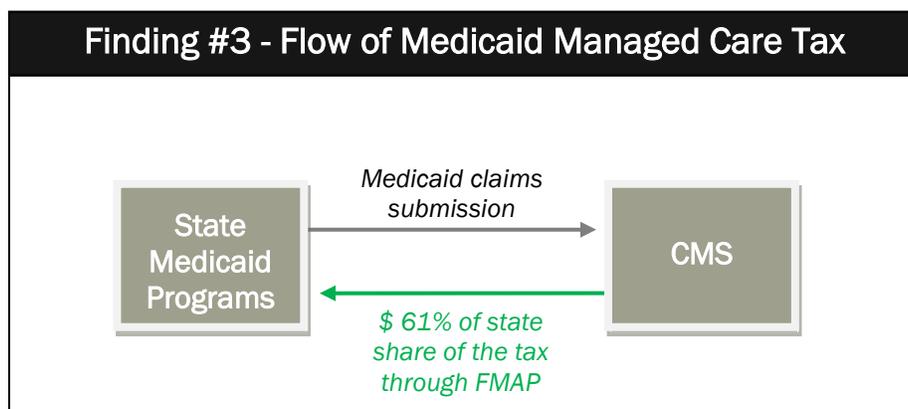
### Federal Government Is Also a Medicaid Managed Care Consumer

The Medicaid program is a partnership between states and the Federal Government. The Federal Medical Assistance Percentage (FMAP) is calculated for each state to determine the amount of federal matching funds for state Medicaid expenditures. In total, the Federal Government currently pays for approximately 57% of all Medicaid expenditures. According to CBO, when ACA enrollment increases go into effect, the Federal Government share of all Medicaid expenditures is estimated to be approximately 61%, according to CBO.

State Medicaid programs submit claims and payment information to CMS, including premiums paid to MMCPs, in order to receive their federal matching funds. To the extent that actuarially sound rates are approved with the tax included, states will pass through part of the cost of the tax equal to their FMAP percentage to the Federal Government. The Federal Government currently has little mechanism, other than in cases of fraud, by which to deny states their right to this FMAP payment. In essence, the Federal Government is a passive Medicaid managed care consumer with states.

In the Medicaid managed care context, the Federal Government imposed a portion of the health insurance industry excise tax assessment on itself. This is also true in other contexts as well, including the Medicare Advantage program and the newly created state-based health insurance exchanges where the Federal Government subsidizes a portion and in some cases all of the premiums. Some policymakers may be unaware of this nuance given that the JCT and CBO do not appear to have estimated the explicit effects of the excise tax on federal spending for Medicare and Medicaid.

**Finding #3: States will pass-through approximately 61% of their share of the excise tax to the Federal Government through the FMAP.**

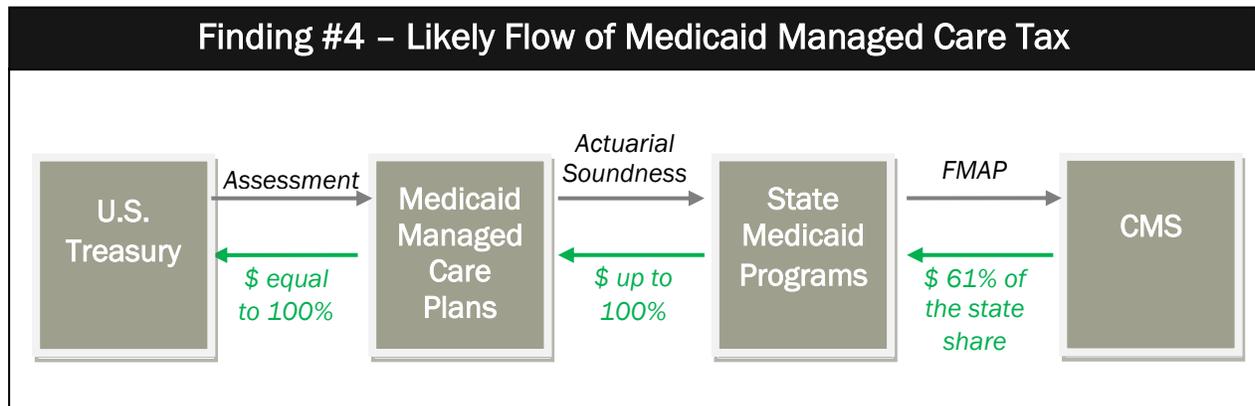




### Flow of the Excise Tax Relative to Medicaid Managed Care Plans

Marwood analysis shows that the health insurance industry excise tax, when applied to MMCPs, will result in a transfer of liability from the MMCPs to consumers, which in the case of Medicaid are the states and Federal Government. Given the various budget and market dynamics in each state, some level of shared liability among all three entities is more likely.

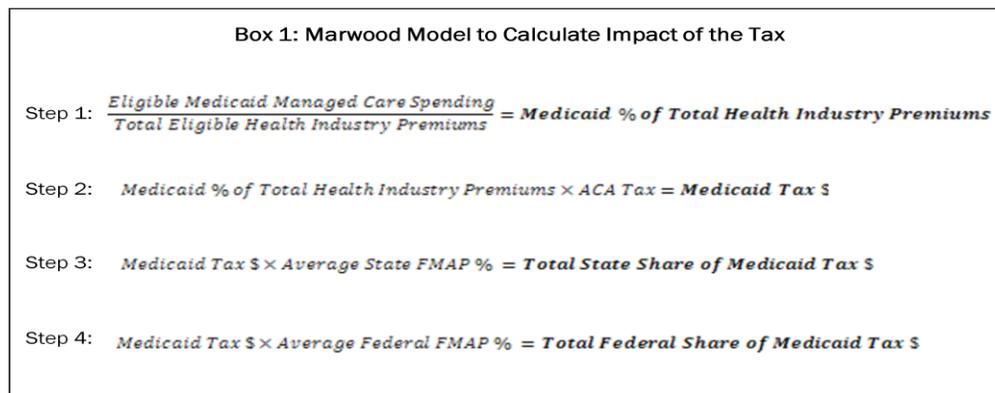
**Finding #4: The excise tax will be passed-through by MMCPs to states and the Federal Government. Depending upon the market, shared liability between MMCPs, states and the Federal Government is likely.**





## Marwood Analysis of Impact of Health Insurance Industry Excise Tax

Marwood developed a model to assess the impact of the health insurance industry excise tax on Medicaid Managed Care Plans and any pass-through effects to states or the Federal Government (See Box 1 and Appendix for greater explanation). Marwood utilized data from the CMS Medicaid Statistical Information Summary (MSIS), National Health Expenditures (NHE), CBO, Kaiser Family Foundation, and the Association of Federal Health Organizations to estimate spending within Medicaid and other health insurers. Marwood adjusted spending to account for medical cost growth as well as enrollment increases due to ACA or state Medicaid managed care program expansions. Additionally, Marwood took into account plans and enrollees exempt from the tax. Marwood assumes that the tax will be passed on to states through actuarially sound rates and then partially paid by the Federal Government through FMAP funding paid to the states; for this analysis, Marwood utilized an annual average federal FMAP share of 61%. In practice, this percentage will differ by state.



### Impact of Health Insurance Industry Tax on MMCPs

Marwood calculated the total MMCP share of the health insurance industry excise tax to be 13.73% in 2014 and 14.16% in 2015, which translates to approximately \$1.1 billion and \$1.6 billion, respectively.<sup>65</sup> (Table 2) As a percentage of Eligible Medicaid Managed Care Spending (EMMCS), the total tax on MMCPs would have translated to additional EMMCS spending of 1.2% in 2013 and 1.5% in 2014.<sup>66</sup>

The House’s broadening of the application of exemptions from the excise tax has potentially distorted the competitiveness of the Medicaid managed care marketplace and given a significant advantage to non-profit MMCPs. MMCPs subject to the tax must now compete with non-profit MMCPs that are not subject to the tax, regardless of whether contracts are determined through negotiations or a bidding process. Exempt MMCPs do not have to worry about covering the cost of the excise tax. Therefore, MMCPs subject to the tax face a competitive disadvantage as the cost of the tax is reflected in their actuarially sound rates, creating a potentially higher rate than they would have offered otherwise or could be offered by an exempt MMCP.

<sup>65</sup> As the excise tax assessments are based on premiums from the prior year, the effect of ACA coverage expansion can be seen in comparing the Medicaid share between 2014 and 2015.

<sup>66</sup> Based upon 2013 MMCS and 2014 MMCS, respectively.



The design of the excise tax to exclude the application on certain non-profit plans could similarly distort competitive dynamics in other markets, like Medicare Advantage, where non-profit and for-profit plans have historically competed. Non-profit plans that predominately enroll low-income beneficiaries and offer plans in an Exchange will be similarly advantaged over for-profit entities.

Some states could be discriminating consumers of Medicaid managed care. To avoid the tax, states could seek to contract with MMCPs that are exempt from the tax. The more lives that are covered through exempt MMCPs, the lower the states' spending on the tax will be, as EMMCS and the share of Total Eligible Health Industry Premiums (TEHIP) are reduced.

However, it should be noted that price is not the only consideration for states when choosing an MMCP. In many instances, non-profit plans that serve Medicaid, which currently represent between 15% and 20% of the Medicaid managed care market, cannot greatly expand their market share because their provider networks are often geographically limited. States often place value in the breadth of an MMCP's network as well as demonstrated ability to coordinate care and quality measures. In addition, the extent of competition depends on how close exempt and non-exempt MMCP rates are, and whether the exempt MMCPs are in a position to significantly increase their share of the MMC market.

Nonetheless, to the extent that individual MMCPs cannot pass-through the tax, either due to states pushing back or competitive market considerations, the assessment is large enough to significantly diminish and possibly eliminate MMCP Medicaid profits.

Year	Medicaid Managed Care Spending	Total Health Industry Premiums	Medicaid % of Total Health Industry Premiums	ACA Tax*	Medicaid MMCP Tax \$	State FMAP	Total State Share of Medicaid MMCP Tax \$	Federal Share of Medicaid MMCP Tax \$
2014	\$88.3 billion	\$643 billion	<b>13.73%</b>	\$8 billion	<b>\$1.1 billion</b>	39%	<b>\$428 million</b>	<b>\$670 million</b>
2015	\$103.4 billion	\$730 billion	<b>14.16%</b>	\$11.3 billion	<b>\$1.6 billion</b>	39%	<b>\$624 million</b>	<b>\$976 million</b>

\*Based upon excise tax levels assessed in ACA. JCT and CBO actual revenue collections to be lower.

### Impact of Health Insurance Industry Tax on States

Assuming total pass-through of the excise tax by MMCPs, the states' collective share of the tax will be up to \$428 million in 2014 and up to \$624 million in 2015. (See Table 2) The cost of the paying tax to states will be more than \$4 billion from 2014 through 2019 and more than \$8 billion over the ten-year window that begins in 2014.

The state share will be apportioned to each of the 43 states, including the District of Columbia, with Medicaid managed care spending, depending upon each state's share of Medicaid managed care spending. For example, the California Medicaid program (Medi-Cal) could be responsible for as much as an additional \$42 million in 2014. Individual state shares will fluctuate over time as states expand or modify their Medicaid managed care programs.



As discussed earlier, there is some question as to whether the entire cost of the excise tax will be passed-through from the MMCPs through actuarially sound rates to the states and Federal Government. Marwood expects states will focus their attention on the aggregate rate presented by MMCPs, as opposed to specific line-items within the rate calculation. If the MMCPs' actuarially sound rates should be increased due to the tax, states may dispute other parts of the rate calculation in order to reduce the overall rates requested by MMCPs. One way states have found to push back on Medicaid managed care rates is to pass a law that prohibits Medicaid agencies from increasing premiums over the prior year or that limits increases to an arbitrary amount. This may allow states to effectively ignore actuarial soundness to meet budgetary goals. As a result, there is the scenario where the aggregate rate may not reflect the total pass-through cost of the tax and therefore MMCPs will share the burden of the tax with states and the Federal Government. The actual MMCPs' financial liability will depend on the budgetary environment and Medicaid managed care market in each state.

States that heavily rely on Medicaid managed care view see a 1-2% (see page 19) increase on rates as fiscally cumbersome, depending upon their budgetary environment, and could impose greater pressure on MMCP rates. Some states with small managed care programs may not view a 1-2% effect on managed care premiums as substantial.

#### Impact of Health Insurance Industry Tax on the Federal Government

Assuming total pass-through of the excise tax by MMCPs, the Federal Government share through FMAP payments will be \$670 million in 2014 and \$976 million in 2015. (See Table 2) The cost of the tax would be more than \$6 billion from 2014 through 2019 and more than \$12 billion over the ten year window that begins in 2014. The Federal Government share will only be reduced if MMCPs opt not to pass-through the entire tax or states are able to push-back on MMCP rate increases.

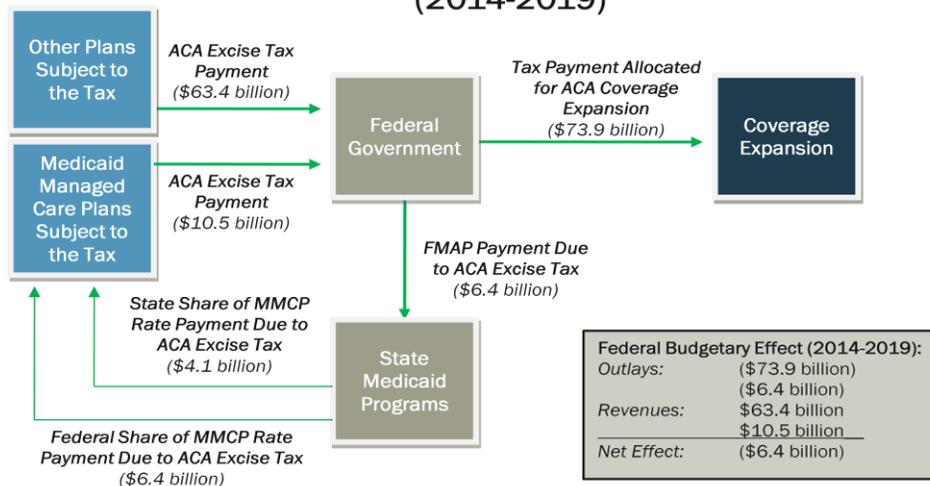
As noted, the initial policy rationale for the excise tax was to help raise the necessary revenue to achieve the goal of expanding health insurance coverage. Many within Congress were well aware that the structure of the excise tax on the health industry, from an economic theory perspective, could result in the burden of the tax being passed-on to the consumer, presumably through health insurance premiums. In assessing the cost of ACA, CBO and JCT do not appear to have considered the interaction of the tax with state actuarial soundness laws and FMAP payments or that the Federal Government is a Medicaid consumer and therefore liable for a portion of the excise tax.

Certainly Committee members who drafted the provision are aware that the Federal Government will pay some of the tax assessed because it subsidizes premiums in Medicaid (as well as Medicare Advantage and the newly created Exchange). However, as CBO does not appear to have indicated the cost to Congress, some policymakers may be unaware that the Federal Government is effectively paying for some of the tax, which could be up to ~\$6.4 billion of the amount assessed on MMCPs over the first six years (2014-2019), according to Marwood's estimate. At the same time states are collectively paying up to ~\$4.1 billion of the amount assessed on MMCPs over the same time period depending upon the Medicaid managed care market and how much of the tax is actually passed through by MMCPs.



Illustratively, revenues to the Federal Government may be up to -\$6.4 billion over six years (non-CBO analysis) from the application of the tax to MMCPs due to the FMAP related outlay from the Federal Government. As the excise tax was intended to help pay for expanding health insurance coverage under the ACA, and despite revenues accruing to the General Fund and not a Trust Fund to explicitly pay for coverage, in theory, additional revenues will need to be made available from somewhere else in the federal budget to pay for this shortfall as shown in the illustrative model in Figure 3.

**Figure 3 – Illustrative Flow of ACA Health Insurance Industry Excise Tax (2014-2019)**



**Factors Affecting Future MMCP Medicaid Share of the Excise Tax**

After 2014, there are four major variables that could impact Medicaid's MMCP share of the tax: 1) Medicaid growth; 2) Exchange growth; 3) Medicaid managed care expansion; and 4) change in the percentage of self-insured employers.

It should be noted that Marwood’s estimate of the state and Federal cost of the health insurance industry excise tax is a maximum estimate and may differ from a CBO score. CBO’s score of a proposal to change the excise tax will depend on the details of the policy proposal and other factors that could determine the savings or cost to the Federal Government. For example, CBO could make different assumptions as to how states will determine Medicaid rate increases, which in turn will affect their estimate of how much of the tax will actually be passed on by MMCPs.

Following the 14% initial projected rate of growth in Medicaid in 2014, Medicaid enrollment is projected to grow in 2015 and 2016 by a rate of 5-6% each year before tapering off at a projected growth rate of 1-2% in 2017 and beyond.<sup>67</sup>

Comparatively, following the initial projected rate of growth increase in applicable private health insurance in 2014 of approximately 11%, applicable private health insurance

<sup>67</sup> CBO, “Spending and Enrollment Detail, March 2011 Baseline”, March 2011.



enrollment is projected to grow by approximately 3.6% in 2015 and 7% in 2016, later flattening out in 2017.<sup>68</sup>

Overall, Medicaid and applicable private health insurance enrollment growth will be approximately 11% between 2014 and 2016. Most of the projected growth in 2014-2016 will be predominantly in the adult population that has historically been enrolled in Medicaid managed care. However, 59% of the growth in private health insurance enrollment could be through self-insured plans exempt from the tax.<sup>69</sup> Taken together, directionally, the comparative growth in Medicaid enrollment will increase the Medicaid share of the tax, assuming the uptake rate of Medicaid managed care remains the same.

If states continue to shift fee-for-service beneficiaries to Medicaid managed care - for quality of care or budgetary purpose - by expanding to new geographic areas or eligible populations such as the Aged, Blind, and Disabled (ABD) there will be an increase in the Medicaid share of the tax. Currently, the ABD population is estimated to be responsible for 75-80% of Medicaid costs.<sup>70</sup> Medicaid share of premiums would likely increase due to more lives and the potential for higher premium rates associated with the ABD population utilizing a higher amount of hospital and long-term care services. On the other hand, if states were to decide to award contracts solely based on price and not breadth of network or quality of care, some states could decide to selectively award contracts to non-profit plans potentially exempt from the tax.

The last major variable relates to the self-insured uptake rate as self-insured employers are exempt from the tax. Over the past ten years, the number of employers covered through a self-insured benefit plan has increased from 49% in 2001 to 59% in 2010. (Table 3) As of 2010, 93% of the largest employers (5,000 or more workers) provide health insurance coverage through self-funded plans. More employers, particularly small- to medium-sized employers, who currently have relatively low self-insured rates (15% and 58% in 2010, respectively) may opt to self-insure in order to avoid fees and requirements created by ACA. However, the increased rates within these two cohorts will likely have a minimal overall effect. Nonetheless, as the number of employees covered through self-insurance increases, so will the MMCP share of the tax.

**Table 3 - Firms Providing Employees with Self-Insured Plans, By Firm Size**

# of Workers	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3-199	17%	13%	10%	10%	13%	13%	12%	12%	15%	15%
200-999	52	48	50	50	53	53	53	47	48	58
1,000-4,999	66	67	71	78	78	77	76	76	80	80
5,000+	70	72	79	80	82	89	86	89	88	93
<b>ALL</b>	<b>49%</b>	<b>49%</b>	<b>52%</b>	<b>54%</b>	<b>54%</b>	<b>55%</b>	<b>55%</b>	<b>55%</b>	<b>57%</b>	<b>59%</b>

\*Kaiser Family Foundation, "Employer Health Benefits Annual Survey, 2010"

<sup>68</sup> CBO, "Analysis of the Major Health Care Legislation Enacted in March 2010", March 2011.

<sup>69</sup> Kaiser Family Foundation, "Employer Health Benefits Annual Survey, 2010", 2010.

<sup>70</sup> Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2007 MSIS and CMS64 data, July 2010.



Other variables that may have some effect on the MMCP share of the excise tax:

- Medicaid constrained rates through negotiations due to the budget environment or as part of a competitive bid could have the effect of marginally decreasing the state Medicaid share as Medicaid premiums are reduced.
- The shifting of Medicaid lives under a competitive bid environment to more exempt MMCPs could also reduce the Medicaid share of the premium.
- Additionally, a significant increase or decrease in Medicare Advantage plans, which are subject to the tax, could result in a decrease or increase, respectively, in the Medicaid share of the tax.



## Conclusion

The annual health insurance tax included in ACA was intended to be a broad-based industry excise tax. Economists, including those at the JCT and CBO, expect that the tax is largely passed-through to consumers, even if CBO did not explicitly estimate the Medicaid and Medicare costs to the Federal Government. The Federal Government, in partnership with states' Medicaid programs, could be responsible for a portion of the tax as a direct Medicaid managed care consumer.

The level of Federal Government and state responsibility for the tax depends upon the portion of the tax MMCPs are able to pass-through to consumers in each individual Medicaid managed care market. State budget constraints and the competitive nature of the rate negotiation or bid process are the biggest factors. In addition, the structure of the tax, wherein certain non-profit Medicaid managed care plans are exempt from the tax, could distort the competitive dynamics of the Medicaid managed care market towards non-profit plans.

According to the Marwood analysis, the health insurance industry excise tax could result in a federal revenue shortfall of up to -\$6.4 billion between 2014 and 2019; or expressed another way, the creation of \$6.4 billion in additional FMAP spending. There are a number of policy options that can be considered to remove the effects of the excise tax on state and Federal budgets and on plan competition. Criteria that should be considered in analyzing each of the policy options are: 1) political dynamics; 2) effect on other plans; and 3) effect on the federal budget. As with any legislative policy introduced in Congress, CBO will come to an estimate as to the savings or cost to the Federal Government based on the specifics of the policy, and other factors that CBO chooses to consider.



## Appendix - Methodology Explained

### Step 1 Explained

In order to determine Medicaid's share of the tax in 2014, first Marwood had to calculate Medicaid's % of Total Health Industry Premiums by dividing Eligible Medicaid Managed Care Spending (EMMCS) by Total Eligible Health Industry Premiums (TEHIP).

$$\frac{(\text{Eligible Medicaid Managed Care Spending})}{(\text{Total Eligible Health Industry Premiums})} = \text{Medicaid \% of Total Health Industry Premiums}$$

Marwood used data from the 2008 Medicaid Statistical Information System (MSIS), which was then adjusted (detailed below), to project EMMCS spending through 2014. States have been required to submit eligibility and claims data electronically through the MSIS to CMS since the Balanced Budget Act of 1997. After reviewing the data for validation edits, CMS makes the data publically available and accessible through the State Summary DataMart.<sup>71</sup> The DataMart includes annual eligibility, utilization, and spending summary information for a number of dimensions, including state, eligibility, service category, and plan type. MSIS is preferred over other CMS datasets, such as the Data and Study Group Medicaid Managed Care Report or the Financial Management Reports, since these datasets contain only enrollment or spending data, respectively.

More specifically, Marwood used MSIS data on 'Capitated Care Enrollment and Spending,' which accounts for state payments for enrollees in MCOs, PIHPs, and PAHPs. The non-inclusion of PCCMs in this data allowed Marwood to isolate risk-based premium payments that would be subject to the tax. Payments for PCCM enrollees are usually made to providers primarily for care coordination.

Marwood selected 2008 as a base year primarily since full MSIS data was not available beyond 2008. That the preferred data source for TEHIP used 2008 data as a base year was an added factor. In order to project MMCS beyond 2008, Marwood projected enrollment and Per Member Per Month (PMPM) premium growth.

Relative to enrollment, Marwood used CBO enrollment figures from 2008 through 2014, adjusted by the estimated percent of the population that would enroll in MMCP.<sup>72</sup> Marwood used a factor of 65% for MMCP enrollment, which is the 2008 MSIS unduplicated percentage of 'Capitated Care Enrollment' divided by overall Medicaid enrollment. Marwood reduced MMCP enrollment by 7,200,000 beginning in 2010 to account for those enrolled in non-profit Medicaid managed care plans that are exempt from the annual tax.<sup>73</sup>

For 2013, Marwood adjusted enrollment by 3,000,000 to estimate for expansions of MMCP to beneficiaries previously covered through Medicaid fee-for-service over the next two years.<sup>74</sup> Next, Marwood applied the MMCP enrollment factor of 65% to the newly eligible Medicaid population that will receive coverage in 2014 as a result of the passage of ACA

<sup>71</sup> Accessible through <http://msis.cms.hhs.gov/>.

<sup>72</sup> CBO Medicaid Spending and Enrollment Data from 2008 through 2014.

<sup>73</sup> As per the Alliance for Community Affiliated Plans, whose membership is predominantly Medicaid managed care plans that are likely to be exempt from the tax.

<sup>74</sup> Marwood primary research.



and further reduced the enrollment figure by 20% to reflect current enrollment in exempt Medicaid managed care plans.<sup>75</sup>

For the second half of the projection equation (PMPM), Marwood took the average annual growth in MMCP PMPM from 2004-2008 (6.16%) and applied it for each year after 2008. The MMIS growth in MMCP was consistent with growth in National Health Expenditures over the same time period. For individual states with MMC enrollment expansions from FFS predominantly tied to the Aged, Blind, and Disabled population (ABD), Marwood did not adjust the PMPM to reflect the likely higher cost of this population<sup>76</sup> when determining average premium per state and average national. Marwood did not find it necessary to adjust the PMPM for ACA-related newly eligible Medicaid enrollees, who are mostly representative of the current MMC population.<sup>77</sup>

Once all enrollment and PMPM adjustments were made, EMMCS for each year equaled (Adjusted Enrollment X Adjusted PMPM) X 12 months.

Estimated Eligible Medicaid Managed Care Spending (2008-2014)						
2008	2009	2010*	2011	2012	2013**	2014
\$68,130,059,558	\$77,172,771,599	\$67,436,039,992	\$72,878,721,856	\$77,368,051,123	\$88,289,838,586	\$103,410,645,933

\*First year Marwood adjusted Medicaid managed care enrollment for lives (7.2 million) exempt from the tax  
 \*\*Marwood added in additional Medicaid lives to account for expected shifts from FFS to Medicaid managed care

To develop the TEHIP figure Marwood used data from a November 2009 report done by the Association of Federal Health Organizations (AFHO) assessing the impact of the proposed managed care tax on the Federal Employees Health and Benefit Program (FEHBP). AFHO used a 2008 total industry health premium estimate from Barclays Capital.<sup>78</sup> CBO estimates little change in commercial insurance and Medicare Advantage enrollment between 2008 and 2014. However, Marwood adjusted TEHIP in 2014 to account for enrollment expansions from ACA (positive for non-self-insured employer, exchanges and Medicaid; negative for non-group and other) of approximately 8.5 million individuals.<sup>79</sup> Marwood did not reduce TEHIP to account for shifts in enrollment that would have little overall impact, such as change in percentage of self-insured workers; Medicaid managed care shifts; or other exemptions. Marwood used the estimated growth rate of National Health Care Expenditures for 2008 through 2014.<sup>80</sup> Marwood did not account for the threshold tests in ACA that could exclude some managed care plans from the tax or reduce their liability.

Estimated Total Eligible Health Industry Premium (2008-2014)						
2008	2009	2010	2011	2012	2013	2014
\$492,000,000,000	\$519,256,800,000	\$548,023,626,720	\$578,384,135,640	\$609,848,232,619	\$643,023,976,474	\$730,119,860,856

As per law, EMMCS and TEHIP data from the prior year are used to determine the proper share of a tax in a given year. So, for 2014, the Treasury will use 2013 EMMCS and TEHIP

<sup>75</sup> CBO, "Spending and Enrollment Detail, March 2011 Baseline".

<sup>76</sup> Kaiser Commission on Medicaid and the Uninsured estimates based on 2007 MSIS and CMS64 data.

<sup>77</sup> CBO, "Spending and Enrollment Detail, March 2011 Baseline".

<sup>78</sup> Association of Federal Health Organizations (AFHO), "Impact of the Insurer Fee and the Excise Tax on the Federal Employees Health Benefits Program, Prepared for the U.S. Office of Personnel Management", November 25, 2009.

<sup>79</sup> Marwood adjusted the CBO estimate for an increase in employer-sponsored coverage by adjusting for the percentage of those that will be self-insured, using the current rate of 59%.

<sup>80</sup> National Health Expenditures Data, Historical and Projected.



premium data. Marwood calculated the Medicaid share of the tax for 2014 and 2015 in order to observe the effect of the ACA enrollment increase.

Estimated Medicaid % of Total Eligible Health Industry Premium (2008-2014)						
2008	2009	2010*	2011	2012	2013**	2014
13.85%	14.86%	12.31%	12.60%	12.69%	13.73%	14.16%

\*First year Marwood adjusted Medicaid managed care enrollment for lives (7.2 million) exempt from the tax  
 \*\*Marwood added in additional Medicaid lives to account for expected shifts from FFS to Medicaid managed care

### Step 2 Explained

Once the MMCP share of TEHIP is determined, the next step was to multiply that figure by the statutorily specified ACA Tax for the given year.

$$\text{Medicaid \% of Total Health Industry Premiums} \times \text{ACA Tax} = \text{Medicaid Tax \$}$$

ACA sets the tax amount for 2014-2018, with the 2019 tax to be indexed to the growth in premiums. Marwood utilized the NHE growth rate from 2008-2014 of 5.44% to project the 2019 tax amount. In total, Marwood estimates the 2014-2019 tax level will be \$73.9 billion.

JCT and CBO estimate that \$60.1 billion will actually be collected, but neither explained specifically how the reduced level would be determined or whether the effect would be proportionally applied across all those assessed the tax. As such, Marwood decided to utilize the statutory level.

### Step 3 and 4 Explained

Finally, Marwood believes that the tax could be entirely passed through by MMCPs to the states as part of their actuarial sound Medicaid managed care rates and Marwood believes that states will only be actually responsible for a portion of the passed-through tax. States will pass-through a large portion of the cost to the Federal Government through the Federal Medical Assistance Percentage (FMAP).

$$\text{Medicaid Tax \$} \times \text{Average State FMAP \%} = \text{Total State Share of Medicaid Tax \$}$$

On average, CBO estimates that the Federal Government will pay 60-62%<sup>81</sup> of state Medicaid expenditures in 2014 through federal matching funds. Marwood used 39% to account for the actual state share of the Medicaid tax.

Individual states will be impacted based on their FMAP rate and budgetary constraints.

<sup>81</sup> CBO March 2011 Baseline.



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