Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee

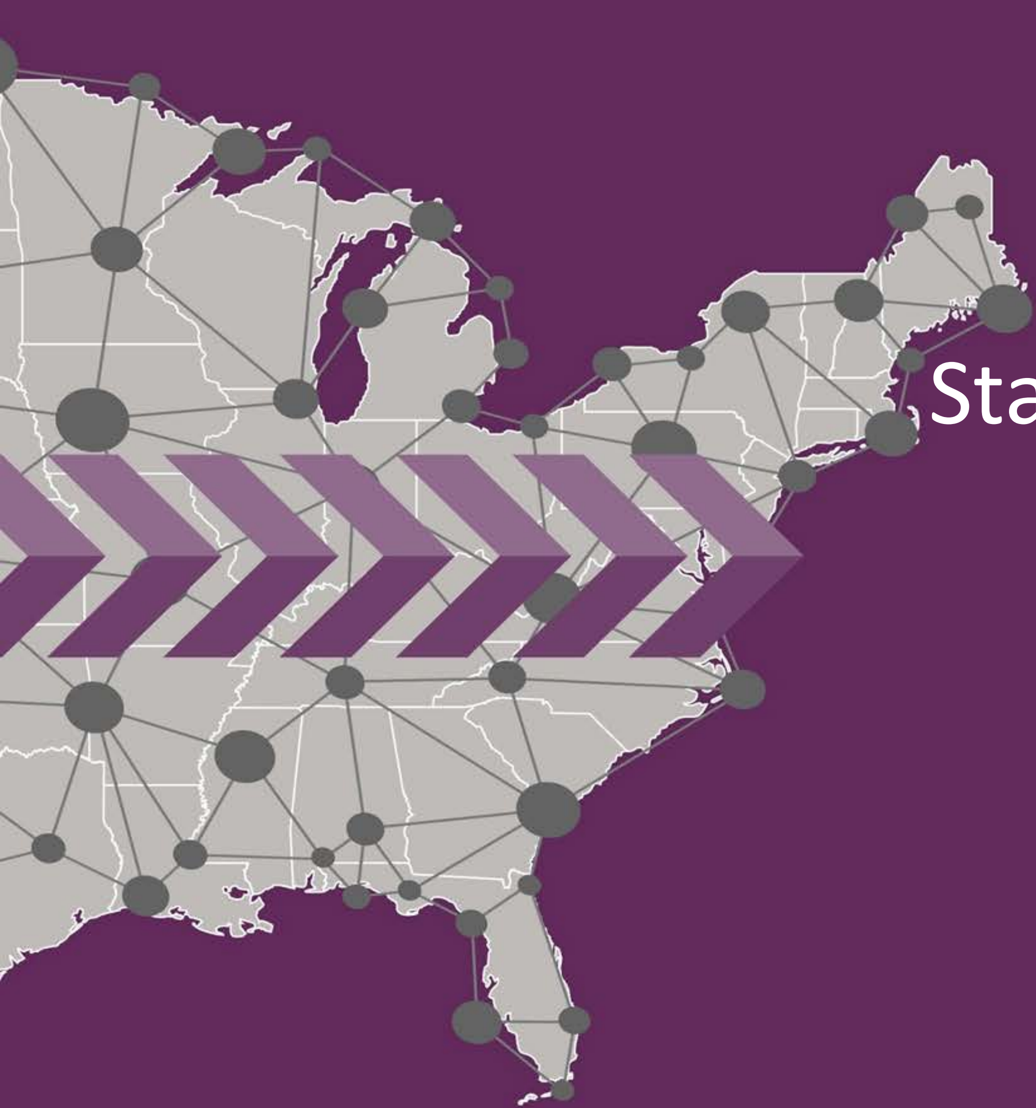
The recent repeal of the federal health insurer fee may create an opportunity for states to secure substantial funding to support health coverage, without increasing costs on consumers or the health care industry.

The government spending bill enacted in December 2019 repealed the annual fee on health insurance providers under section 9010 of the Affordable Care Act (ACA), effective in 2021. The fee, which totaled about $20 billion per year, amounted to an assessment of between two and three percent on prior-year health insurance premiums. A state fee can be designed to pick up this revenue, with little or no year-to-year market impact. Two states – Maryland and Delaware – have passed similar assessments to fund state reinsurance programs. States could also use this revenue stream to fund other affordability measures like the state subsidy program enacted last year in California.

This opportunity is time-limited: a seamless transition generally requires states to enact their own fee before 2021 premiums are set in the middle of 2020. Since the federal fee will be collected for the last time in 2020 based on 2019 premiums, state fees should be first collected in 2021 based on 2020 premiums to ensure continuity. In addition, a state fee may be able to redeploy a one-year "windfall" that issuers would receive due to repeal of the federal fee. That's because in many cases the federal fee that was to be paid in 2021 (based on 2020 premiums) was "baked in" to 2020 premiums.

Enacting a fee to replace the federal one presents several design questions for states, including what lines of insurance to include, timing, rate, and targeted exemptions. Frequent SHVS partner and ACA tax expert Jason Levitis prepared the slides [below] to help states understand these issues. For states interested in learning more, SHVS is happy to make Jason available to provide technical assistance. In addition, experts at Manatt are available through SHVS to help understand the complex federal rules governing states taxes on Medicaid Managed Care Organizations (MCOs), as well as the related rules under the proposed Medicaid Fiscal Accountability Rule (MFAR). If you have questions or are interested in assistance, contact Heather Howard at heatherh@princeton.edu , or you can contact Jason directly at jason.levitis@gmail.com.

Support for this project was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.



Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee

Jason Levitis

John-Pierre Cardenas

Steven Costantino

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

A grantee of the Robert Wood Johnson Foundation

About State Health & Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this presentation was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. This presentation is meant to provide general guidance and should be used as a reference only. It may not take into account all relevant local, state, or federal laws and is not a legal document. While we have made every attempt to ensure that the information included in this presentation is accurate and reliable, we are not responsible for any errors or omissions, or updates that may be required due to subsequent changes in laws and regulations. Neither Princeton University nor its funder, the Robert Wood Johnson Foundation, will assume any legal liability that may arise from the use of this presentation. An attorney or tax advisor should be consulted with any particular questions related to this presentation.

About Jason Levitis

Jason Levitis is principal at Levitis Strategies LLC, a healthcare consultancy focusing on the Affordable Care Act's tax provisions and state innovation waivers. He provides technical assistance to states in partnership with State Health and Value Strategies. He's also a nonresident fellow at the Brookings Institution and a senior fellow at Yale Law School's Solomon Center for Health Law and Policy. He served as Counselor and ACA Implementation Lead at the U.S. Treasury Department until January 2017.

About John-Pierre Cardenas

John-Pierre Cardenas is an independent health policy adviser. He was the Director of Policy and Plan Management at the Maryland Health Benefit Exchange until November 2019. In that capacity, he oversaw the development and implementation of Maryland's state innovation waiver to establish a reinsurance program and health reform initiatives. He provides policy advice to states seeking to expand coverage and increase affordability under the ACA framework.

Contents

✓ Background – Why Now?

✓ Design Considerations

✓ Maryland and Delaware Experiences

✓ Resources

Background – Why Now?

Background – Why Now?

The recent repeal of the federal health insurer fee creates an opportunity for states to secure substantial funding to support health coverage without increasing costs on consumers or industry.

- The government spending bill enacted in December 2019 repealed the annual fee on health insurance providers under ACA section 9010, which raises nearly $20 billion per year.
- A state health insurance fee can capture this revenue, seamlessly picking up where the federal fee leaves off with little or no year-to-year impact on consumers or issuers.
- A state fee could also pick up only some of the revenue from the federal fee, providing a tax cut and associated premium reduction while still collecting substantial revenue.

Background – Why Now?

- Two states – Maryland and Delaware – have passed fees in response to prior suspensions of the federal fee.*
- Maryland and Delaware's fees fund state reinsurance programs. A fee could also fund other affordability measures like the premium subsidies in Massachusetts, Vermont, and (as of 2020) California, or other programs.
- ***This opportunity is time-limited***: a seamless transition generally requires states to enact their own fee before 2021 premiums are set in mid-2020.
- Without a state fee, issuers may receive a windfall, depending on how state premiums accounted for the federal fee.

* In addition, Colorado law allows a fee to be triggered for one year if the federal fee is suspended. but only in certain circumstances. It's not clear if it will be in place in 2021.

Design Considerations

Administrative Structure

- The federal health insurer fee has a complex structure: a fixed total tax amount is allocated among issuers by their share of aggregate premiums collected (modified by certain exemptions and exclusions).
  - As a result, changing any one issuer's tax bill changes every issuer's tax bill
  - Sorting it out takes time, so the federal fee is due September 30 following plan year
- States do not need to adopt this approach.
- Instead, they can collect an equivalent amount through a more typical structure, where premiums are taxed at a fixed rate.
  - Can be collected earlier, like the spring after the plan year, or even quarterly
- Many states have premium taxes in place, and a new tax can likely leverage the existing administrative apparatus.

Deductibility

- Another potential complicating feature of the federal fee is that it is non-deductible for income tax purposes.
- A non-deductible fee costs income-tax-paying issuers more than the amount of the fee itself.
- Sales and excise taxes are typically treated as normal business expenses and therefore deductible.
  - Usually, only penalties for bad behavior are non-deductible
- Again, states do not need to adopt this feature.
- A state fee established under normal rules will be deductible for both federal and (if applicable) state income tax purposes.

What's Taxed – Federal Fee

The federal fee is broad-based but with targeted exemptions and reductions:

- Premiums < $25M threshold are exempt; premiums $25M-$50M are 50% exempt
- Issuers that (1) get 80% of revenue from Medicare, Medicaid, and CHIP and (2) are incorporated as nonprofits under state law are exempt
- Other issuers exempt from income tax under sec. 501 get a 50% premium haircut
- Medicare supplemental (Medigap) plans are exempt
- Self-insured employer plans are exempt

What's Taxed – State Fees

- States generally cannot match the federal structure exactly:
  - States cannot tax Medicare Advantage, Part D, and FEHB plans
  - Taxes on Medicaid Managed Care Orgs. (MCOs) must be broad-based and uniform
    - CMS's proposed Medicaid Fiscal Accountability Rule (MFAR) would extend this requirement to other insurance
- Also, state taxes on MCOs are generally limited to 6% of premiums in total and must otherwise comply with Medicaid provider assessment regulations.
  - Again, MFAR would generally extend these requirements to other insurance
- Maryland's fee generally includes everything subject to the federal fee that it legally can; it does not adopt federal exemptions and reductions.
- Delaware's fee is narrower, excluding MCOs and stand-alone vision & dental plans

What’s Taxed

	Federal Fee	Maryland	Delaware	Notes
Individual, group, & other fully-insured markets	Included	Included	Included	
Stand-alone vision, dental	Included	Included	Excluded	
Medicaid MCOs	Excludes state-ID’d nonprofits with 80% of revenue from these programs	Included	Excluded	Taxes on MCOs generally must be broad-based, uniform, & ≤ 6% total
Medicare Adv. & Part D		Excluded	Excluded	States may not tax
FEHB	Included	Excluded	Excluded	States may not tax
Medicare Supplemental	Excluded	Excluded	Excluded	
State & local gov’t entities	Excluded	Excluded	Excluded	
Fixed indemnity, LTC, etc.	Excluded	Excluded	Excluded	
Self-insured plans	Excluded	Excluded	Excluded	ERISA constraints apply
Premiums below threshold	Excludes 1st $25M and 50% of $25M-$50M	No exclusion	No exclusion	Consider MCO rules
Tax-exempt issuers	50% haircut	Included	Included	Consider MCO rules

What's Taxed

- Considerations for states:
  - Revenue
  - Continuity with federal fee
  - Level playing field
  - Maximizing federal funds
  - Legal constraints – current and proposed
  - Leveraging existing state administrative structure
- Potential approach:
  - As a starting point, tax entities that are subject to existing state premium tax
  - Consider adding or removing specific lines to conform to federal fee
  - Including MCOs increases revenue and federal funds but may reduce continuity
  - To minimize MFAR risk, consider complying with broad-based, uniform, and 6% cap rules regardless of whether MCOs are included
    - Applying these regulations requires a state-specific analysis

Size of Fee

- Federal fee often estimated at 2.75% to 3% of premiums
  - Varies due to special rules – e.g., tax-exempt issuers
  - Oliver Wyman says lower after federal corporate income tax cut
- Maryland’s fee was 2.75% in 2019 to collect revenue during moratorium, then changed to 1% when it appeared federal fee would be in place.
- Delaware’s fee has a trigger: 1% when federal fee is in place, 2.75% when not (so 2.75% going forward)
- Representative options:
  - 2.75% maximizes revenue but may increase taxes on tax-exempt firms that receive 50% haircut under federal fee
  - 1% collects less revenue but avoids increase on tax-exempt firms

Timing

The federal fee will be collected for the last time in September 2020 based on 2019 premiums collected. Key timing considerations for states:

- **Continuity**:
  - For seamless transition, collect state fee for the first time in 2021 based on 2020 premiums
  - Legislation should be passed by mid-2020 so fee can be baked into 2021 premiums
- **Possible windfall**: If federal fee to be paid in 2021 was baked into 2020 premiums, issuers may receive a windfall without a new state fee
  - Incentive was to bake 2021 fee into 2020 premiums, since was it based on 2020 premiums
  - But in some states, 2020 premiums may include ***2020*** fee. In that case, there's no windfall
  - Any windfall would be partially returned to consumers through MLR rebates, but three-year averaging limits responsiveness, and some issuers have a cushion

Important*: The windfall issue is separate from continuity. Regardless of which year's fee is reflected in which year's premiums, continuity requires a state fee to be collected for the first time in 2021 based on 2020 premiums.*

Timeline of Existing Fees

Fee Payment Year (Based on Prior-Year Premiums)

	2014-2016	2017	2018	2019	2020	2021+
Federal fee	✓	✗	✓	✗	✓	✗
Maryland Fee	✗	✗	✗	2.75%	1%	1%
Delaware fee	✗	✗	✗	✗	1%	2.75%

Using the Revenue

- Options include:
  - Reinsurance program through Section 1332 waiver
  - Subsidy for individual market coverage (premiums and/or cost-sharing)
  - Supporting a public option or Medicaid buy-in program
  - Other programs to support coverage
- May impact reactions of issuers and other stakeholders. Consider:
  - Which issuers benefit (market segment, risk profile)
  - Which consumers benefit
  - Leveraging federal dollars

Maryland and Delaware Experiences

Maryland and Delaware Experiences

- Need for funding
- Value proposition for issuers
- Stakeholder engagement
- Key stakeholder concerns
- Legislative coalition-building

Resources

Potential Data Sources

- A good starting point is Oliver Wyman's analysis of the impact of the federal fee on 2020 premiums:
  - Table 10 ("Additional premiums to be paid as a result of section 9010 taxes in 2020") provides a proxy for aggregate revenue by state.
  - To estimate state revenue, remove the "Medicare Advantage" and "Medicare PDP" columns given the prohibition on states taxing those lines.
- For more accurate and issuer-specific information, the best source is likely rate filings, which generally show the amount of federal fee built in.
  - Rate filings for some states can be found at the SERFF Filing Access portal
- The IRS's sec. 9010 page provides issuer-specific premium data for the federal fee, but it is not broken down by state.
- CMS's MLR reporting files include section 9010 payments, but the data appear incomplete.

Other Resources

- Section 9010
  - IRS section 9010 page, with links to regulations and other information
  - IRS FAQs on section 9010 suspensions and repeal
- Maryland fee
  - Legislative language
  - Fiscal note
  - Administrative bulletins here and here
- Delaware fee
  - Legislative language
  - Administrative bulletin
- Rules regarding state taxation of health insurance
  - Medicare Advantage: 42 CFR § 422.404
  - Medicare Part D: 42 CFR § 423.440
  - FEHB: 5 USC § 8909(f)(1)
  - MCOs: 42 CFR § 433.55; 42 CFR § 433.68
  - Proposed rule (MFAR) extending MCO-like rules to other insurance: 84 FR 63722

SHVS Technical Assistance

For states interested in learning more, Jason Levitis is available to provide technical assistance. In addition, experts at Manatt Health are available through SHVS to help understand the complex federal rules governing states taxes on Medicaid Managed Care Organizations (MCOs) and assist states in conducting state-specific analysis.

Jason Levitis
Principal, Levitis Strategies LLC
jason.levitis@gmail.com
203-671-2609

John-Pierre Cardenas
Independent Health Policy Adviser
johnpierre.cardenas@gmail.com
443-799-6223

Patti Boozang
Senior Managing Director, Manatt Health
PBoozang@manatt.com
(212) 790-4523

Steven Costantino
Director of Health Care Reform, Delaware Department of Health and Human Services
Steven.Costantino@delaware.gov

Heather Howard
Director, State Health and Value Strategies
heatherh@Princeton.edu
609-258-9709
www.shvs.org

Dan Meuse
Deputy Director, State Health and Value Strategies
dmeuse@Princeton.edu
609-258-7389
www.shvs.org