Frequently Asked Questions on State Adoption of the Health Insurer Fee

Center on Budget and Policy Priorities

States have a new opportunity to raise revenue from health insurance companies just by continuing a fee that already exists. Late last year Congress repealed the Affordable Care Act's (ACA) insurer fee, starting in 2021. If they act soon, states can capture these funds by enacting their own fee in place of the federal one. They can use the revenue to make individual market coverage more affordable, as Maryland and Delaware have done and as New Mexico has proposed.[1]

State policymakers may have questions about the health insurer fee. Here are some answers:

How much could it raise? The federal law will raise $15.5 billion in 2020 and was expected to raise $13.7 billion in 2021 and $151 billion through 2029. States could collect a large portion of that, somewhat less than the federal fee because some categories of health plans can't be taxed by states. Individual states' collections would be roughly proportional to their share of aggregate health insurance premiums.[2] Maryland anticipated raising nearly $380 million from the fee it put in place during a moratorium on the federal fee in 2019.

Who would pay? The federal fee applies to most types of insurance, except self-insured plans; plans with aggregate premiums below a certain threshold; plans from certain nonprofit insurers whose primary revenue was from Medicare, Medicaid, or the Children's Health Insurance Program; and Medigap plans. Some other tax-exempt insurers pay a reduced rate. States don't have the authority to reach some of the plans included under federal law, such as the Federal Employee Health Benefits Plan, Medicare Advantage, and Medicare Part D plans. But even with those exclusions, that still leaves a broad market of individual and group insurance and stand-alone benefits, like vision and dental coverage.

Who would benefit? States could use the new revenue to fund a state reinsurance program, which lowers premiums by essentially insuring health insurance companies against high-cost claims. Maryland and Delaware used the state health insurer fees to fund some or all of their state contribution toward reinsurance programs, while drawing down the federal premium tax credit savings through a Section 1332 waiver. Maryland's 2.75 percent fee on insurers achieved a 13.2 percent average premium reduction and contributed to a 32,000 gain in individual marketplace enrollment in 2019.[3] Delaware enacted a 1 percent fee beginning in 2020 for reinsurance, which it credits with decreasing premiums by 19 percent in 2020, after the insurer proposed to raise them by 6 percent.

But reinsurance generally only benefits higher-income people who are not subsidy eligible, since low- and moderate-income consumers who are eligible for subsidies pay a set percentage of income toward coverage, regardless of sticker price premiums. And across states, lower-income people are more likely to be uninsured.

States could also use funds from a health insurer fee to reduce costs for lower-income people, such as by supplementing the federal subsidies that help them afford individual market coverage. New Mexico, for example, has proposed a 3.25 percent premium surtax that would be used partly to create an insurance affordability fund designed to boost enrollment. As we've explained, enhanced subsidies are key to increasing coverage. One study of Massachusetts' premium subsidies found that reducing premiums by about $40 per month increases take-up of individual market coverage among eligible people by 14 to 24 percentage points, with larger effects at lower income levels.

Would a state fee raise premiums? Since the fee is already embedded in 2020 premiums, extending it at the state level shouldn't result in additional premium increases in 2021. If states don't impose their own fee, repeal of the federal fee

[1] Colorado also has a law that allows a state fee to be triggered in certain circumstances, but it's unclear if that will apply in 2021.

[2] States can get a rough estimate of the potential revenue raised by type of insurance by looking at Table 10 here: https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf.

[3] Maryland's fee was reduced to 1 percent in 2021 and beyond.

could lead to modest premium reductions. But some insurers are anticipating windfall profits from repeal, which indicates that they don't plan to pass all the savings through to consumers. And if states dedicate the revenue raised by the fee toward premium-reducing measures — direct subsidies or reinsurance — then the net effect would be to make coverage more affordable.

How would it be structured? States could simplify the federal fee's complexities. Federal law set a revenue target then allocated that amount across insurers based on their aggregate premiums. States could instead implement a flat fee based on insurers' premium revenue, to raise a similar amount (2.75 to 3 percent of premiums in 2020).

Also, federal law designated the payment as a "fee" and not a "tax." The key distinction is that federal fees are not tax deductible against income taxes, whereas taxes are.[4] States could make their own decisions about whether to make a state fee tax deductible.

When should states act? There are benefits to swift action. Insurance companies will pay the federal fee for the last time in 2020. State action by mid-year, before 2021 rates are set, would allow insurers to budget for continuing the fee and begin paying the state in 2021.

[4] Disallowing the deduction likely increases premiums, if insurers price to compensate for both the fee and the tax paid on the fee. If states enacted a deductible tax instead of a fee, they may be able to maintain the full federal fee and still see a small rate reduction.