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Health Reform Tax on Insurers Should Not Be Repealed

Tax Will Help Pay for Expanding Coverage

By Paul N. Van de Water

Bills introduced in the House (H.R. 763) and Senate (S. 603) would repeal the tax on health insurance providers that Congress enacted in 2010 to help pay for health reform (the Affordable Care Act, or ACA). The tax is one of a set of measures to expand health insurance coverage and slow the growth of health care costs without adding to the budget deficit. Health reform will strengthen our nation's economy and, according to the Congressional Budget Office (CBO), slightly reduce premiums for employer-sponsored health insurance in the near term.

Repealing the tax on health insurers would cost about $116 billion over the 2014-2023 period and undercut health reform in at least two ways.[1] "Pay-as-you-go" rules would require Congress to offset the cost of repeal by raising other taxes or reducing spending; one likely target would be provisions of the ACA that expand health coverage to 25 million more Americans. In addition, repealing the tax would encourage efforts to repeal other revenue-raising provisions of the ACA, which in turn would require still more painful offsets or increase the budget deficit if Congress failed to offset the cost.

How the Tax Will Work

The ACA will extend health insurance coverage to 25 million people, CBO estimates, and will help assure that Americans have access to affordable coverage. And it will do so in a fiscally responsible way. CBO estimates that health reform will *reduce* the deficit — modestly in its first ten years, and more substantially in the following decade.[2]

To pay for expanding health coverage, the ACA reduces Medicare payments and raises taxes for a wide range of industries that will directly benefit from health reform, including hospitals, home health agencies, clinical laboratories, drug companies, and manufacturers of medical devices. The fee on health insurance providers — also known as the health insurance tax — falls into this category.

[1] The Joint Committee on Taxation has estimated that the health insurance fee will raise $101.7 billion through 2022. Memorandum from Thomas A. Barthold, Chief of Staff, Joint Committee on Taxation, June 15, 2012.

[2] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010; Letter to the Honorable John Boehner, February 18, 2011; Letter to the Honorable John Boehner, July 24, 2012.

The ACA imposes an annual fee on most businesses that provide health insurance, starting in 2014. This fee is similar to an excise tax on the sale of health insurance contracts. The law specifies how much the fee is to raise each year; this total is apportioned among providers based on their share of the health insurance market (based on total premiums collected) during the previous year.[3]

The fee applies broadly to most businesses that sell private health coverage to individuals and employers, as well as to most insurers that provide coverage through Medicare Advantage, Medicare Part D, Medicaid managed care, or the Federal Employees Health Benefits Program. It does *not* apply to governmental entities or to large employers that self-insure — in other words, those that pay their employees' health costs directly rather than buy coverage from commercial insurers. This exception is reasonable since most large employers already offer health insurance and will be largely unaffected by health reform.

Small insurers and some tax-exempt and nonprofit insurers receive preferential treatment under the tax. For example, the first $25 million of a covered entity's premiums are not subject to tax, and the next $25 million are taxed at half the general rate; this disproportionately benefits smaller insurers, since a larger share of their total premiums falls below these thresholds. Also, certain insurers that are exempt from federal income tax, including public charities and social welfare organizations, are taxed on only half of their premiums *above* these thresholds.

In addition, nonprofit insurers that receive more than 80 percent of their gross revenue from government programs that target low-income individuals, seniors, and people with disabilities (including Medicare, Medicaid, and the Children's Health Insurance Program) are not subject to the tax. Nor are voluntary employee beneficiary associations established by unions to provide health benefits to their members.

Economic Effects of the Tax

As with any excise tax, supply and demand will determine how the tax's burden is ultimately split between providers and purchasers. Insurers have recently turned in strong financial results and thus are well positioned to bear some of the tax.[4] But they will likely pass a portion on to consumers. The Joint Committee on Taxation estimates that premiums subject to the fee will be 2 to 2½ percent higher than they would otherwise be.[5]

That is only part of the story, however. Health reform also contains many provisions that will *slow* the growth of premiums. The new health insurance exchanges will increase competition among plans and create economies of scale. Standardization of benefits and the prohibition of medical underwriting will reduce administrative costs. The law's individual mandate, as well as the subsidies

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[3] The fee is imposed by section 9010 of the Patient Protection and Affordable Care Act. See also Department of the Treasury, Internal Revenue Service, "Health Insurance Providers Fee: Notice of Proposed Rulemaking," *Federal Register*, March 4, 2013, pp. 14034-46.

[4] Peter Gosselin, "Despite Predictions, Health Insurers Prosper Under Overhaul," Bloomberg Government, January 4, 2012; Alex Nussbaum, "Aetna Raises Profit Forecast as Insurer Grows Enrollment," Bloomberg.com, April 30, 2013, http://www.bloomberg.com/news/2013-04-30/aetna-raises-2013-forecast-after-profit-beats-analyst-estimates.html.

[5] Thomas A. Barthold, Letter to the Honorable Jon Kyl, June 3, 2011, http://www.ahipcoverage.com/wp-content/uploads/2011/11/Premium-Tax-JCT-Letter-to-Kyl-060311-2.pdf.

to help people buy coverage, will bring more relatively healthy workers into the insurance pool; for example, the mandate will likely increase participation in employer-sponsored insurance. Premium increases of 10 percent or more will be subject to state or federal review, and insurers must provide rebates to their customers if they spend less than 80 percent of premium income on medical care. The ACA also includes a large number of initiatives to identify and implement more efficient ways to deliver medical services.

All things considered, CBO estimates that health reform will slightly reduce premiums for employer-sponsored health insurance in the near term. For employers with more than 50 workers, CBO estimates that the law will reduce average premiums by up to 3 percent in 2016, compared to where they would otherwise be. For small employers, the estimated change in premiums ranges from an increase of 1 percent to a reduction of 2 percent. For workers in firms that can benefit from the ACA's tax credit for small employers, the cost of insurance will drop by 8 to 11 percent.[6] These figures all take into account the effect of the health insurance tax.

Claims that the health insurance tax — or health reform in general — will "kill" jobs are unfounded. CBO foresees a small net reduction in labor supply under health reform, primarily because some people who now work mainly to obtain health insurance (a situation known as "job lock") will choose to retire earlier or work somewhat less, not because employers will eliminate jobs.[7] That effect could be partly offset by increased incentives to work for people who now face the loss of Medicaid, without any insurance to replace it, if they work more.

Over the longer run, health reform will have many positive impacts on the economy. The lower budget deficits stemming from health reform will hold down interest rates and free up capital for private investment. Health reform will increase labor market flexibility, since the need for health coverage will no longer lock workers into a job. Expanding coverage will also improve health outcomes by helping people obtain preventive and other health services and improving continuity of care. Most important, the ACA includes a wide array of policies to improve health care quality and reduce costs. These factors will enhance the nation's economic productivity.

Criticisms of Tax Are Off-Base

The health insurance industry's trade association, America's Health Insurance Plans (AHIP), has leveled several criticisms against the health insurance tax that are exaggerated or inaccurate.[8]

AHIP says that it is "deeply concerned . . . that the health insurance tax will put greater pressure on state Medicaid budgets" by raising the costs that private insurers charge to provide managed care for Medicaid beneficiaries. This concern is overblown. Managed care accounts for only about 20 percent of Medicaid spending, and about one-fifth of the Medicaid beneficiaries enrolled in managed care are enrolled in a plan that isn't subject to the tax. If insurers passed the full amount of the tax through to state Medicaid programs, that would — by one estimate — cost states a total of about

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[6] Douglas W. Elmendorf, Letter to the Honorable Evan Bayh, November 30, 2009.

[7] Congressional Budget Office, "Box 2-1: Effects of Recent Health Care Legislation on Labor Markets," *The Budget and Economic Outlook: An Update*, August 2010, pp. 48-49.

[8] America's Health Insurance Plans, *Comments to the House Ways and Means Committee Work Groups Urging Repeal of the ACA Health Insurance Tax,* April 12, 2013.

$600 million in 2015, spread over the 50 states and the District of Columbia. But since budgets are tight, states will likely be tough negotiators and are unlikely to allow Medicaid managed care plans to pass through the entire amount.[9]

AHIP also alleges that the ACA places a larger burden on the health insurance industry than on the prescription drug and medical device industries, but this claim is incorrect. AHIP notes that the expected revenue from the health insurance tax is more than three times as large as that from health reform's medical device tax and the ACA's fee on brand-name prescription drugs. But AHIP fails to point out that the health insurance industry earns several times the revenue of the medical device and drug industries, and that the ACA also requires drug manufacturers to provide discounts on brand-name drugs for Medicare beneficiaries in the coverage gap (also called the "donut hole") and pay increased rebates under Medicaid. Relative to the size of the industry, the fee charged to health insurers is no greater than that faced by drug companies and medical device manufacturers.[10]

It's also important to note that health insurers will gain tens of millions of additional customers as a result of health reform. CBO expects 24 million people to enroll eventually in private health insurance plans offered through the exchanges and 13 million more people to participate in Medicaid and CHIP — many of whom will enroll in managed care plans contracting with states — compared to enrollment *without* the ACA.[11]

Finally, AHIP complains that the tax is "particularly burdensome . . . because it is not deductible for income tax purposes." What matters, however, is the net amount of revenue it raises; if the tax were deductible but the nominal tax rate were correspondingly higher (in order to raise the same amount of revenue), its overall effect would be much the same.

The tax on health insurers is a small price to pay for helping to extend health coverage to 25 million more Americans without increasing the deficit.

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[9] Marwood Group, *Impact of ACA Annual Health Insurance Tax on State Medicaid Programs*, October 2011.

[10] Rick Newman, "How Big Pharma Wins from Healthcare Reform," *U.S. News*, September 25, 2009, http://money.usnews.com/money/blogs/flowchart/2009/09/25/how-big-pharma-wins-from-healthcare-reform.

[11] Congressional Budget Office, *CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*, May 2013.