

# **ESTIMATED PREMIUM IMPACTS OF ANNUAL FEES ASSESSED ON HEALTH INSURANCE PLANS**

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## Executive summary

A critical component of a sustainable health care system is affordable coverage. While an increasing amount of discussion about health care spending and affordability rightly focuses on underlying medical costs, less attention has been paid to the impact of regulatory fees and taxes on health care costs. In particular, one significant provision under the Affordable Care Act (“ACA”) that has received relatively little coverage is the imposition of fees on health insurance providers offering fully insured coverage beginning in 2014. Both the non-partisan Congressional Budget Office (“CBO”) and the Joint Committee on Taxation (“JCT”) have concluded that these fees will increase insurance premiums. This report quantifies the impact of the insurer fees on private and public sector coverage. Our analysis estimates that the insurer fees will increase premiums in fully insured coverage markets by an average of 1.9% to 2.3% in 2014. The impacts generally increase over time such that we estimate by 2023, the fees will ultimately increase premiums by an average of 2.8% to 3.7%. For small group coverage, this will on average increase the cost to cover an individual by about \$2,800, and a family by about \$6,800 over a 10-year period, beginning in 2014.

As noted, the fees generally apply to all fully insured coverage, including coverage offered in the individual and small group markets (whether offered inside or outside an ACA health insurance exchange), the large group market, and under public programs such as Medicare Advantage, Medicare Part D, and Medicaid Managed Care. The potential result of these increases will be:

- An increase in the cost of fully insured health care coverage, impacting individuals and smaller firms in particular, across both the commercial and public sectors.
- Further incentive for employers to self-insure their health benefits coverage as a means of avoiding these fees – increasingly shifting the burden of the fees to smaller employers and individuals who continue to purchase fully insured coverage and must shoulder the cost of a statutorily fixed level of fees no matter the relative size of fully insured coverage markets.
- Increased costs facing the Medicare Advantage and Part D programs that, following basic economic and actuarial principles, will result in increased cost-sharing and premiums for Medicare Advantage and Medicare Part D enrollees.
- Greater pressure on state budgets to address increasing costs for Medicaid managed care plans.
- A potential exacerbation of concerns related to “adverse selection” in the individual and small group markets as younger, healthier individuals forego coverage leading to a less stable risk pool and higher premiums.

The opinions and conclusions expressed herein reflect technical assessments and analyses, and do not reflect statements or views with respect to public policy.

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## Background

The Patient Protection and Affordable Care Act (Pub L. 111-148) (“PPACA”) and the Health Care and Education Reconciliation Act (Pub L. 111-152) (“HCERA”), which we will refer to collectively as the Affordable Care Act (“ACA” or “the law”), establishes an annual fee on the health insurance sector – effective in 2014. The new fee applies with some exceptions to any covered entity engaged in the business of providing health insurance (including private plans that participate in public programs), but does not include self-insured employer-provided health plans. The amount of the fee will be \$8 billion in 2014, increasing to \$14.3 billion in 2018, and increased based on premium trend thereafter.<sup>1</sup> The fees are non-deductible for federal tax purposes. As we explain later, this feature implies that for each dollar assessed and paid in fees, more than a dollar in additional premium amounts must be collected (e.g. \$1.54 for every \$1.00 in fees, assuming a 35% federal corporate income tax rate). In total, on a statutory basis, between 2014 when the fees are first imposed and 2019, the total amount assessed (and actually collected from health insurers) will be at least \$73 billion. Net revenues to the federal government, however, will increase by a lesser amount as reflected in revenue effect estimates by the Joint Committee on Taxation (“JCT”) which show federal revenues increasing by \$60.1 billion over 10 years (2010-2019).<sup>2</sup> As highlighted below, both the JCT and Congressional Budget Office (“CBO”) conclude that the new fee on health insurance plans would increase premiums.

The Congressional Budget Office (“CBO”) prepared an estimate of the impact of the market reforms required by the ACA in a letter to Senator Evan Bayh on November 30, 2009. However, in this document, the CBO made no explicit calculation of the impact of the insurer fees on average premiums in the market. Instead, they stated “these fees would largely be passed through to consumers in the form of higher premiums for private coverage.”<sup>3</sup>

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<sup>1</sup> PPACA Section 9010. The statute provides that after 2018 the amount of the tax is the applicable amount for the preceding year increased by the rate of premium growth (as defined in the Internal Revenue Code) the preceding calendar year.

<sup>2</sup> 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 H.R. 3590, the Patient Protection and Affordable Care Act, as Passed by the Senate, and Scheduled for Consideration by the House Committee on Rules on March 20, 2010. Joint Committee on Taxation. March 20, 2010. The difference between the statutory amount assessed and the lesser change in federal revenues likely reflects a traditional offset JCT imposes with respect to excise taxes. See *Overview of Revenue Estimating Procedures And Methodologies Used by the Staff of the Joint Committee on Taxation* pages 14-15 JCX-1-05 (February 2, 2005).

<sup>3</sup> CBO’s Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act; November 30, 2009. CBO’s statement in this regard applied both to the insurer fees which are the subject of this analysis, and fees applied to importers and manufacturers of medical devices, which are not addressed here.

In a June 2011 letter to Senator Jon Kyl, the JCT explained that the fee on health insurance providers is similar to an *excise tax* based on the sales price of health insurance contracts. They estimated that repealing the health insurance industry fee would reduce the premium prices of plans by 2.0 to 2.5 percent, and that eliminating this fee could decrease the average family premium in 2016 by \$350 to \$400.<sup>4</sup>

Oliver Wyman was engaged by America's Health Insurance Plans to analyze the insurer fees. In this report we have quantified the impact of the insurer fees on premiums in marketplaces that are impacted by these fees. Consistent with the estimates from JCT and other experts, we believe that the fees will have a material impact, which is amplified by the non-deductibility of the insurer fees for the purposes of calculating a health insurer's federal income tax.

Overall, we estimate that the insurer fees will increase premiums in the insured market on average by 1.9% to 2.3% in 2014, and further increase such that by 2023, we estimate that the fees will increase premiums by 2.8% to 3.7%.<sup>5</sup> In addition to providing an estimated aggregate impact, we also provide estimates of the effect of these fees on different insurance market segments, including the individual, small group, and fully-insured large group markets, as well as on public programs such as Medicare Advantage, Medicare Part D, and Medicaid Managed Care.

Our analysis reviewed the impact of the fees and contributions as outlined in the ACA under which statutory annual fees amounts are specified over the period of 2014 through 2018, and increase annually thereafter based on premium trend (as noted above and in footnote 1). The percentage rates that we project for 2019 (based on the 2018 statutory fee amount) are expected to remain constant beyond 2019. To help readers better understand what this means over time, we have projected out the effects of the fee on premiums over a ten-year period.

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<sup>4</sup> See JCT Letter to Senator Jon Kyl (June 3, 2011).

<sup>5</sup> As noted, our estimates appear to reflect the same general magnitude as those estimated by JCT. In addition, other estimates have found similar impacts to ours. For example, in paper prepared by Doug Holtz-Eakin, former director of the Congressional Budget Office, the fee was estimated to raise premiums from between 2.4% in 2014 to over 3% in 2015, adding \$475 to the cost of coverage per family or nearly \$5,000 per family over a decade. See Holtz-Eakin, Douglas. "Higher Costs and the Affordable Care Act: The Case of the Premium Tax." American Action Forum. March 9, 2011. <http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf>.

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## Data

The health insurance fees that will be collected beginning in 2014 will be allocated to each insurer based on their applicable net premiums during the year. The portion of the fee to be paid by each insurer will be based on the proportion of their premiums to total premiums for all covered entities. In order to determine the applicable fee to be paid by each insurer relative to their premiums, we need to calculate the total premiums for entities that will be charged the fees. To get there, we start with base premiums for 2009 and project forward to the beginning of the implementation of the fees in 2014.

There are three main components to our analysis. The first component is an estimation of current health insurance premiums that would be eligible to be assessed the insurer fees. The next component is the expected increase in per capita costs due to such factors as the underlying health care trend, benefit changes either required by the ACA or in the general course of business, and changes in the demographics of the insured population. The final component is the expected change in enrollment counts. We discuss each of these items in further detail below. Additional technical detail regarding the methodology for our estimates is provided in the technical Appendix to this report. As indicated, our assumptions relating to these estimates reflect estimates from CBO and other governmental sources.

### Base premiums

We used two different methods for the calculation of the base premiums. The first method represents a high estimate of total base premiums and primarily is based on financial statement data. All insurance companies are required to annually file financial statements with the applicable state regulatory agencies. These data are publicly available and represent the experience for insurers during the preceding calendar year. We accumulated all of the financial statement data for 2009.<sup>6</sup> Our understanding is that the insurer fees will be allocated based on net premium subject to certain exclusions. Using the accident and health supplemental exhibits that are part of the financial statements health insurers submit, we estimated the amount of the exclusions for the health products that are not applicable to the insurer fees. These exclusions include amounts for hospital indemnity type plans, critical illness, long- and short-term disability, Medicare supplement and long-term care.

As part of the first method, we also used the supplemental exhibits from the financial statements to identify the net premiums by line of business, splitting premium into individual, small group,

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<sup>6</sup> Our data collection effort included review of financial statement filings with the California Department of Managed Health Care (“DMHC”) – managed care organizations regulated by the DMHC typically do not file financial statements in the form provided by the National Association of Insurance Commissioners (“NAIC”).

large group, Medicare and Medicaid. In total, this method generated net premiums of \$555 billion in 2009 over which the insurer fee would be spread.

The second method, representing a lower estimate of total base premiums, is developed using data from the National Health Expenditures (“NHE”) prepared by the Centers for Medicare and Medicaid Services (“CMS”).<sup>7</sup> We started with total expenditures for private health insurance and reduced this amount for exclusions for health products to which the annual fees do not apply, including Medicare supplement and long-term care. Finally, we split this amount between insured and self-insured using the MEPS<sup>8</sup> data. The Medicare and Medicaid premiums are unchanged from the financial statement analysis, as the results for these products are consistent between the two sources. Overall, the NHE data show that the applicable premiums accumulate to \$501 billion for the insurer fees, with an additional \$462 billion in the self-insured market.

The final exclusion from the premium is for certain tax-exempt organizations. Under the statute, the premium for these organizations is reduced by one-half before any allocation of the insurer fees. Therefore, using financial statement data, we estimated the amount of net premiums that we expect would be subject to this partial exclusion, with the aggregate amount representing roughly \$92 billion of the \$555 billion insured market. Therefore, we reduced the base premiums by \$46 billion under both methods, or half of the total net premium earned by these exempt organizations. For simplicity, we did not factor in the impact of two other exclusions addressed in the statute. The first of these addresses certain non-profit plans that predominantly serve low-income and elderly Americans through publically-funded health insurance programs such as Medicare, Medicaid and CHIP. The second exclusion we did not address concerns the fractions of premiums counted for purposes of determining a carrier’s annual net premiums.<sup>9</sup> Factoring in these exclusions would tend to raise estimates of the impact of the annual fee on premiums. Similarly, it is worth noting that the introduction of any additional or new exclusions would likewise have the effect of increasing the burden of the fees on the remaining base of fully insured coverage (thereby increasing the impact of the fees on those enrolled in such coverage) because the fees reflect statutorily fixed collection amounts.

## Per capita costs

The projections of the premium rates require us to estimate changes to the cost to provide health care between now and 2014, and beyond. This is because as noted the fee reflects a statutorily fixed collection amount (that differs by year), as opposed to a specified percentage rate, such that its impact on premiums is highly dependent on the size of the market measured in premium dollars against which the fee is applied in any given year. For the commercial

<sup>7</sup> <https://www.cms.gov/NationalHealthExpendData/>

<sup>8</sup> [www.meps.ahrq.gov](http://www.meps.ahrq.gov)

<sup>9</sup> Under the statute, carriers with annual net premiums of less than \$50 MM have a fraction of their premiums counted toward the calculation of their net premiums for purposes of determining their share of the fee. It is not clear whether the reduced percentages for the first \$50 MM apply to all firms or just to those with less than \$50 MM in annual net premiums.

market, we calculate this estimate using data provided by the CBO. Our reliance on these data does not suggest an endorsement of these estimates, but provides a convenient reference point for estimating the impact and incidence of the annual fee.

First, the CBO prepared a letter to Senator Evan Bayh on November 30, 2009 that estimated the effect of the then Senate proposal on average premiums in 2016. We interpret this to represent the changes in cost due to the implementation of the market reforms required by the ACA, and recent correspondence from the CBO indicates that these effects hold true with the law that was actually passed. The effect that the CBO measured is a 10% to 13% increase in average premiums in the non-group market, a 1% increase to 2% decrease in the small group market, and a 0% to 3% decrease in the large group market. For simplicity, our projections use the mid-point of these estimates.

Second, the CBO provided an addendum to this letter on December 5, 2009 that estimated the average premiums under the current law. These amounts are shown in Table 1 below.

**Table 1: Average premiums under current law based on CBO estimates**

Current law	Type	2009	2016	Annual increase
Individual	Single	\$3,800	\$5,500	5.4%
	Family	\$9,000	\$13,100	5.5%
Small group	Single	\$5,400	\$7,800	5.4%
	Family	\$13,300	\$19,300	5.5%
Large group	Single	\$5,100	\$7,400	5.5%
	Family	\$13,900	\$20,300	5.6%

In the last column of the table we show the average annual trend in premiums (reflecting e.g. growth in underlying medical costs) imputed from the CBO data, given CBO's estimates for premiums in 2009 and 2016. We used these values to project changes in premiums due to health care trend for each market in addition to the changes due to the ACA described above.

## Enrollment estimates

The final step in establishing the premiums in 2014 is to estimate the changes in enrollment by line of business between 2009 and 2014. The ACA provides two significant expansions of coverage. First, Medicaid is expected to grow substantially in 2014, as individuals and families with annual incomes up to 138% of FPL (including the mandatory 5% income disregard) will be eligible for coverage under the expanded Medicaid program. Second, the combination of significant subsidies, insurance market reforms (e.g. guaranteed issue, elimination of pre-existing condition exclusions, and modified community rating), the creation of new state-based health insurance "exchanges," and a new requirement for individuals to obtain coverage is projected to significantly reduce the uninsured population. The CBO estimates that the ACA will

increase the number of Americans *with* health insurance by 32 million in 2016 and by about 34 million in 2021. Moreover, the CBO estimates that 24 million individuals will purchase health insurance coverage through the new “exchanges” by 2021 and that an additional 17 MM more individuals will be covered under Medicaid and CHIP.<sup>10</sup>

Our assumptions for the changes in enrollment on the commercial and Medicaid populations are based on the estimates prepared by the CBO and presented in the testimony of CBO Director Douglas Elmendorf before the Subcommittee on Health of the Committee on Energy and Commerce on March 30, 2011.

Recent trends in group experience indicate that the number of groups that self-insure is increasing, with a resulting decline in the insured market.<sup>11</sup> If these trends were to continue, it would affect the impact of the insurer fees since the self-insured groups are not charged for the insurer fees, while the dollar amount of fees that are to be collected from the market would remain the same. In this way, if more firms self-insure, additional costs would need to be shouldered by fully insured firms. It is also worth noting that the ACA contains several provisions, including the new annual fee on insurers that is the subject of this report that may accelerate the trend toward self-insurance. Therefore, while our lower-end estimate of the insurer fees reflects the current split between insured and self-insured plans, our higher-end estimate reflects a continuation of this move to self-insurance. Specifically, we relied upon a recently quoted study by Mark Farrah Associates that the number of self-insured groups increased by 11% and the number of insured groups decreased by 13% over the last five years. This same slope of change was projected forward to 2018 in our analysis.

Finally, the Medicare premiums in our analysis represent payments to private plans for Medicare Advantage (“MA”) and Medicare Part D. However, the ACA will significantly affect the payments to MA plans by reducing the payments to be closer to costs reflective of the Medicare fee-for-service program. The expectation is that this will impact the level of coverage offered by MA plans and the beneficiary premiums charged by these plans. In this regard, both the CBO and the Office of the Actuary expect reduced enrollment in the MA plans. The CBO’s March 2011 baseline projections discussed in the section above reflect this reduced enrollment.

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<sup>10</sup> CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010; March 30, 2011.

<sup>11</sup> “Self-Insurance Grows Among Small Businesses.” Wall Street Journal. March 23, 2011.

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## Results

Using the assumptions provided above, we projected the net premiums forward to each year from 2014 to 2023. Next, we calculated the ratio of the insurer fees to the projected applicable premiums. Finally, we grossed up the ratio to reflect the non-deductibility of the fees by assuming a 35% overall federal tax rate, reflecting the federal statutory rate for corporate income tax. This implies that for each dollar paid in fees, an additional \$1.54 in premium must be collected. While the actual federal tax rate for any particular insurer (reflecting federal taxes paid by insurers as a percentage of net income) may be less or more than 35%, we found that the 35% was a reasonable assumption.<sup>12</sup> We also note in regard to assuming a federal tax rate of 35% that for conservatism we did not factor in the impact of existing state level percentage of premium based taxes (which would have the effect of increasing our premium impact estimates further).

Similarly, for conservatism, we have not included in our premium impact estimates the additional, incremental effect of the \$5 billion in contributions being assessed through the ACA's provision on transitional reinsurance for the "non-group" or individual market that go directly to the general fund of the United States Treasury. The \$5 billion in assessments is also likely to impact premiums affected by the new fees.<sup>13</sup> We estimate that the incremental effect of including the \$5 billion would be to raise our commercial premium impact estimates by roughly another 0.1% to 0.2% between 2014 and 2016.<sup>14</sup>

As discussed above, for the base premiums and the group insured membership we applied different assumptions to reflect alternate scenarios. Therefore, our results are represented by a range. The lower-end of the range of the premium increase reflected under Method 1 is based on higher aggregate premiums over which the fees will be spread and no change in the current

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<sup>12</sup> Our analysis of 2009 financial statements for health plans generally found the modal federal tax rate to be around 35% (34 to 36%), with two-thirds paying 30% or more of net income in federal income taxes.

<sup>13</sup> PPACA Section 1341. This provision establishes a "transitional reinsurance" program under which health care insurers as well as third-party administrators on behalf of group health plans are required to fund a reinsurance program based on relative shares of commercial, fully insured major medical coverage and self-insured group coverage to support the non-group market with respect to the expenses of high-risk individuals. The total amount assessed through this provision is \$25 billion between 2014 and 2016. \$20 billion is to be returned to the market in some form to help stabilize the costs of coverage in the non-group or individual market. As noted, \$5 billion goes directly to the U.S. Treasury and is not returned to the market. The contribution schedule is \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016. The \$5 billion is assessed through additional contributions of \$2 billion in years 2014 and 2015, and \$1 billion in 2016.

<sup>14</sup> Earlier versions of the health reform legislation suggested that the \$5 billion was to fund the temporary early retiree insurance program applicable to participating employment-based plans.

makeup of the group market. The higher-end of the range reflected under Method 2 reflects lower aggregate premiums over which the fees can be spread and a decrease in insured group lives due to a trend among employers to self-insure. Table 2 shows the range of results by year.

**Table 2: Estimated increase in average premiums due to fees on insured plans**

Plan type	2014	2015	2016	2017	2018	2019 to 2023
Method 1	1.9%	2.6%	2.4%	2.9%	2.9%	2.8%
Method 2	2.3%	3.2%	3.1%	3.7%	3.7%	3.7%

Table 2 represents the increase in average premium rates that will be required to fund the payments that insurers will be required to make to support the new fees imposed on insurers.

## Commercial market

We use the term commercial market here to represent the individual, small group and large group fully insured markets. The split for each market is determined based on the allocation of premium found in the health plans' supplemental exhibits. For the individual market, as depicted in Table 3 which shows the average of our estimates, the additional fees would increase the premiums paid over the ten-year period for single contracts by \$1,900 under the lower-end estimate and \$2,400 under the higher-end estimate (for an average \$2,150 increase in premiums), and family contracts by \$4,500 and \$5,700 (for an average \$5,080 increase in premiums). For people in the individual market who qualify for premium subsidies and purchase coverage through a health insurance exchange, some portion of these additional costs will be funded through the subsidies (although the government's subsidy costs would increase presumably offsetting federal revenues from the new fee). Those individuals and families who are not eligible for subsidies, and anyone who has to repay subsidies due to a change in eligibility, will bear the full cost of the fees, requiring that they pay more out-of-pocket and making coverage less affordable. Typically in insurance markets, when premiums are increased for a given coverage, the insured individuals that are most likely to decline to purchase the coverage are those that are younger and/or are in better health and are needed to help create well-balanced risk pools. While the fees therefore risk increasing adverse selection in the market to a level greater than it otherwise would have been (which would have the effect of increasing premiums) we have not factored this into our analysis. Factoring in adverse selection would tend to increase the premium impact of the new annual fees.

For the large group market, the additional premiums to be paid over the ten-year period would range from \$2,300 to \$2,900 for single contracts (for an average \$2,610 increase in premiums), and range from \$6,200 to \$8,000 for family contracts (for an average \$7,130 increase in premiums). Further, for the small group market, the additional premiums to be paid over the ten-year period would be range from \$2,400 to \$3,100 for single contracts (for an average \$2,760 increase in premiums), and range from \$6,000 to \$7,700 for family contracts (for an average \$6,830 increase in premiums). For small groups, an increase in cost would further increase the challenges smaller firms typically face in sponsoring health benefits, and could increase the

likelihood that groups would exit the market and have their employees purchase coverage in the individual market. For large and potentially even mid-size to smaller groups, this increase could hasten the movement toward self-insurance, where at least the insurer fees could be avoided (although not the reinsurance contribution). Such movement would ultimately increase the burden on those groups that continue to purchase coverage in the insured market.

Table 3 below shows the impact of the insurer fees by market.

**Table 3: Average increase in premiums due to fees on insured plans<sup>15</sup>**

Year	Individual		Small group		Large group	
	Single	Family	Single	Family	Single	Family
2014	\$110	\$270	\$150	\$360	\$140	\$380
2015	\$170	\$390	\$210	\$530	\$200	\$550
2016	\$170	\$390	\$210	\$530	\$200	\$550
2017	\$210	\$490	\$270	\$660	\$250	\$690
2018	\$220	\$520	\$280	\$700	\$270	\$730
2019	\$230	\$550	\$300	\$730	\$280	\$760
2020	\$240	\$570	\$310	\$770	\$290	\$800
2021	\$250	\$600	\$330	\$810	\$310	\$840
2022	\$270	\$630	\$340	\$850	\$330	\$890
2023	\$280	\$670	\$360	\$890	\$340	\$940
<b>Total</b>	<b>\$2,150</b>	<b>\$5,080</b>	<b>\$2,760</b>	<b>\$6,830</b>	<b>\$2,610</b>	<b>\$7,130</b>

## Medicare market

In general, MA plans are paid based on the benchmarks that are set for the counties where they provide coverage and their bids in relation to these benchmarks. These benchmarks are expected to be reduced over the next few years. According to the Medicare Trustees' report, the annual increases in per capita payments for Medicare plans are limited to around 1% for the next five years, and between 2% and 3% thereafter. Because the payments that MA plans receive from CMS are set based on these benchmarks, the effect of the annual fees on the Medicare Advantage program (unless benchmark payments are adjusted to incorporate payment of the fees) is ultimately likely to be felt in the form of a reduction in benefits offered by the MA plans, or an increase in the premiums paid by MA beneficiaries. Our analysis in this regard, reflects basic economic and actuarial principles concerning the economic incidence of taxes (noting again that the annual fees are analogized by JCT to take the form of an "excise tax.")

<sup>15</sup> The increase in premiums due to insurer fees included in this table represent the average of the both the lower- and higher-end estimates included in this paper.

To determine the impact on MA plans we relied on estimates for per capita payments for Part C (i.e. the portion of the total premium paid by the government) using the Medicare Trustees Report for 2010.<sup>16</sup> We then applied the values from Table 2 to calculate the per member cost of the insurer assessments. Based on this methodology, we estimate that the fees charged to the MA plans will be \$16 to \$20 per member per month in 2014 (\$10,245 per capita payment times 1.9% to 2.3%) and will increase to between \$32 and \$42 by 2023 (\$13,901 per capita payment times 2.8% to 3.7%), with an average expected increase in the cost of MA coverage of \$3,590 over 10 years. Unless the fee is paid by the government, ultimately, it will affect MA beneficiaries through an increase in the monthly premiums that they pay (which would reflect a significant percentage increase in premiums recognizing that the average MA premium is roughly \$39 for beneficiaries)<sup>17</sup>, or in a reduction of benefits of an equivalent amount.

Part D plans will also be subject to the insurer fees. We estimate that the annual impact of the insurer fees on Part D plans will be to increase average premiums by \$9 in 2014 and by \$20 in 2023 for a total increase of \$161 over 10 years.

## Medicaid market

Fees paid by health plans participating in the Medicaid managed care market will need to be added to the base rates that states pay to private plans.<sup>18</sup> This is necessary to maintain actuarial soundness of these rates. The American Academy of Actuaries Health Practice Council developed a practice note to assist actuaries in the development of actuarial certifications for Medicaid managed care plans. In this note, the definition of actuarial soundness is “projected premiums...provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.”<sup>19</sup> We would surmise that the federal tax under consideration here was not contemplated at the time this note was written, but would fall under the definition of “all reasonable, appropriate and attainable costs.” Moreover, since the federal government shares in the financing of the Medicaid plans, an increase in the Medicaid costs due to additional federally mandated fees will partially be paid through the federal share of Medicaid.

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<sup>16</sup> The Trustees Report provides estimates up until 2020. To provide a 10-year estimate we projected the payments for an additional three years, assuming a flat-growth rate of 4.6%, consistent with the Trustee’s Report projection from 2019 to 2020.

<sup>17</sup> Kaiser Family Foundation. Medicare Advantage Enrollment Market Update. September 2011. <http://www.kff.org/medicare/upload/8228.pdf>

<sup>18</sup> In general, the fees apply to Medicaid managed care plans, although certain non-profit plans that predominantly serve Medicaid populations would be exempt from the fee.

<sup>19</sup> Health Practice Council Practice Note. August 2005. Actuarial Certification of Rates for Medicaid Managed Care Programs.

We estimate that the insurer fees will increase the average cost of Medicaid coverage by about \$1,530 per enrollee between 2014 and 2023.<sup>20</sup> Total increases in the costs to Medicaid plans over this period are expected to exceed \$20 billion (reflecting the share of the annual fee applicable to beneficiaries receiving coverage under these plans). These fees will put pressure on already-strained Medicaid budgets and may result in decreased benefits to beneficiaries, limit the ability of states to contract with health plans by squeezing the premiums they pay, or create disruption if the rates states are willing to pay are not actuarially sound.

Table 4 below shows the annual impact of the fee on the costs for Medicare and Medicaid.<sup>21</sup>

**Table 4: Average increase in cost for government-sponsored plans due to fees on insured plans**

Year	Annual per capita increase			Total cost (\$ billion)	
	Medicare			Medicare	Medicaid
	Part C	Part D	Medicaid		
2014	\$220	\$9	\$80	\$1.4	\$0.9
2015	\$300	\$13	\$120	\$1.7	\$1.4
2016	\$290	\$13	\$120	\$1.6	\$1.5
2017	\$350	\$16	\$150	\$1.7	\$2.0
2018	\$370	\$17	\$160	\$1.6	\$2.1
2019	\$380	\$17	\$160	\$1.8	\$2.2
2020	\$390	\$18	\$170	\$1.9	\$2.4
2021	\$410	\$19	\$180	\$2.1	\$2.5
2022	\$430	\$19	\$190	\$2.2	\$2.7
2023	\$450	\$20	\$200	\$2.3	\$2.9
<b>Total</b>	<b>\$3,590</b>	<b>\$161</b>	<b>\$1,530</b>	<b>\$18.3</b>	<b>\$20.6</b>

<sup>20</sup> This reflects an estimated average per member, per month payment of \$317 in 2014, increasing to \$513 in 2023. The \$317 PMPM amount is based on data from the Medicaid and CHIP Payment and Access Commission ("MACPAC").

<sup>21</sup> The increase in cost is based on the percentage impact of the fee (averaged across the two methods) for the year times the per capita costs from the Medicare Trustees report. For example, the average fee of the two methods from Table 2 in 2014 is 2.1% times the per capita spending of \$10,245, equaling an annual fee amount of \$220 (rounded to the nearest \$10). The Medicaid estimate follows the same methodology and is based on the same percentage impact from Table 2 (averaged across the two methods) multiplied by the estimated Medicaid per member, per month payment of \$317 based on MACPAC data.

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## Conclusions

Our analysis quantifies the impact of the fees imposed on health insurers under the ACA on the cost of health insurance coverage in both the commercial and public sectors. Our analysis estimates that the insurer fees will increase the costs of fully insured coverage by an average of 1.9% to 2.3% in 2014, further increasing over time such that by 2023, the fees will ultimately increase costs on average by 2.8% to 3.7%. As illustrated above, this implies a material increase the average dollar cost of fully insured coverage, raising the average cost of such coverage by several thousand dollars over a 10-year period beginning in 2014.





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