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The Health Insurance Providers Fee and Medicaid Managed Care Capitation Rates

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What Is the Health Insurance Providers Fee?

Section 9010 of the Affordable Care Act (ACA) created the Health Insurance Providers Fee—sometimes called the Health Insurer Fee—as one source of funding for the ACA provisions. The Health Insurance Providers Fee (fee) is an excise tax by the federal government on entities in the United States that provide health insurance. Notable exclusions are self-insured employers, government entities and certain non-profit corporations. The Internal Revenue Service issued proposed regulations for the fee on March 4, 2013 and final regulations are expected to be released soon.

The fee is a fixed amount each year ($8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, etc.) as defined in the regulation which in aggregate is to be collected across entities to which the fee applies. The amount each entity pays is developed by calculating the entity's percentage of its previous year's net premiums written as a percentage of every entity's previous year's net premiums written. For each entity, the Internal Revenue Service (IRS) will exclude 100 percent of the first $25 million of net premiums written and 50 percent of the next $25 million of net premiums written when calculating the entity's total net premiums written.

The fee is due by the date specified by the secretary of the Treasury, but no later than Sept. 30 each year. The fee paid in the year is the fee for that calendar year (fee year). Invoices will be sent to each entity no later than Aug. 31 of the fee year. The actual amount each entity will pay will not be known until the date the invoice is received.

An important characteristic of the fee is that it is not tax deductible to the entity.

Managed Medicaid Issues Related to the Fee

Medicaid managed care capitation rate setting is governed by the Code of Federal Regulations—42 CFR 438.6(c). This regulation requires that Medicaid managed care capitation rates be actuarially sound. The Centers for Medicare and Medicaid Services (CMS) provide oversight to ensure that this regulation is followed and has developed some guidance for actuarially sound rate development through a rate-setting checklist. In response to the checklist, the American Academy of Actuaries (AAA) released a Health Practice Note that provides guidance on following the checklist. The AAA is in the process of developing an actuarial standard of practice (ASOP) to provide actuaries with more binding guidance for setting Medicaid managed care rates.

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Through the regulations and guidance described above, the Medicaid rate-setting actuaries have developed a practice of including fees and taxes in actuarially sound capitation rate development. CMS allows premium taxes to be included in the Medicaid managed capitation rate and the states to receive federally matching funds, as long as the premium tax is "broad based." This practice has served to include fees and taxes in the capitation rates with little risk to the managed care organizations (MCOs), while maximizing federal matching funds in the state. Many times the tax is a flat percent of revenue, so the capitation rates can be grossed up to reflect the tax on a prospective basis with no risk at all to the MCOs or the states. The Health Insurance Providers Fee, however, is not like most state premium taxes, so requires additional considerations.

Additionally, states historically have developed fees and taxes for Medicaid premiums as a way to maximize federal revenues by drawing down federal Medicaid funds to pay for taxes that are ultimately transferred to general revenues. Certifying actuaries have included these taxes as part of the capitation rates with full state approval, since they designed the tax for just that purpose. The fee is not a state tax and will instead go to the federal government, so the state, in this case, is transferring state funds to the federal government tax coffers instead of the other way around. States may be more reluctant to fund this tax given that it provides them with no funding advantage. Actuaries must determine how to treat the tax to ensure the rates are actuarially sound.

Several characteristics of the fee create problems when trying to build the fee into Medicaid managed care rates on a prospective basis as follows:

- The fee is not a percent of premium like most taxes on Medicaid managed care revenue, and it is an unknown amount for the majority of the fee year, so it cannot be readily built into the Medicaid capitation rates.

- The fee is for a calendar year whereas most Medicaid managed care rates are for fiscal years that span more than one calendar year.

- The fee paid in a fee year is calculated off of the prior year's premiums, so there are questions about which capitation rates are associated with the payment.

- The fee is paid in September of the year even though it is for the entire fee year. If the expected amount of the fee is paid in equal distributions in the capitation rates throughout the calendar year, the aggregate fee amount must be paid by the MCOs before they have received the entire amount of payment in their rates. Additionally, if the fee is paid in the capitation rates through the year, the states are prefunding the expense before the amount is paid back to the federal government, so the state does not benefit from holding the funds until they are due.

- The amount each MCO is required to pay is a set dollar amount for all of its net premiums written and is not broken out by state; therefore, for national plans, there is not a clean way to determine how much of the MCO's total payment should be allocated to each of its Medicaid programs.

- The fee amount will vary by dollar amount and as a percent of revenue for each MCO in the state.

- The fee is not tax deductible to the MCO, so just paying the MCO the amount to cover the fee does not cover the MCO's cost of the fee. Also, each MCO may pay a different corporate tax rate, so the amount needed to cover the MCO's cost will vary by each MCO.

A recent twist to accounting for the fee is that the NAIC is proposing that MCOs expense the fee in the year before the payment is due. This could create additional accounting issues for MCOs, since states may not agree to pre-paying the fee in the capitation rates that far in advance. This requirement could also cause states to suffer a double hit to their already stretched budgets in the first year of expensing the

fee, since they may pay two years of fees in one year.

Options for Including the Fee in Capitation Rates

Usually in managed Medicaid capitation rate development, fees and taxes are included in the rate payments prospectively in such a way that there is no risk to the state or the MCO related to these items. Given that the fee varies by MCO and the actual amount of the fee will not be known until August of the fee year, normal methods for including taxes and fees in the capitation rates prospectively and without risk do not work for this fee.

Some potential options for including the fee in the capitation rates are:

- Pay the fee as a pass-through to the MCOs.

- Include an estimate of the fee in the capitation rates then true-up once the actual amount is known. The estimate could be paid with the capitation rates or it could be a withhold amount that is paid when the true-up occurs.

- Include an estimate of the fee in the capitation rates with no true-up.

The first two options dramatically reduce or eliminate the payment risk to the state and the MCOs; however, they will need to be designed in a way acceptable to CMS. The third option does not remove payment risk for either the state or the MCO. All three options will require CMS approval for including the fee in the Medicaid managed care capitation rates, but there is no guidance at this time.

The first two options may also provide the states with more flexibility in choosing the fiscal year in which to fund the fee payments. Each state should consult with their accounting department to clarify how the payments will be expensed.

For accounting purposes, the MCOs must book a payable for the fee beginning Jan. 1 of the fee year. The MCOs will want the expected payment from the state established in a way that will allow them to also book a receivable to offset the payable so this will not impact the MCOs' earnings. The methods above may make this a little more challenging, so the state should work with the MCOs to determine if there is language that can be included in the contracts to reduce the impact of an accounting mismatch.

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Tax Deductibility Issue

An important characteristic of this fee for rate setting is that it is not tax deductible. Therefore, if the full amount of the tax is reflected in the rate, the fee amount should be grossed up to reflect the tax amount that the MCO will pay on the fee. The tax amount can vary by MCO, which is another consideration in the development of the capitation rates and the pass-through payments.

Summary

The Code of Federal Regulations—42 CFR 438.6(c)—requires that Medicaid managed care capitation rates be actuarially sound. The AAA Health Practice Council Practice Note on the Actuarial Certification of Rates for Medicaid Managed Care Programs defines actuarially sound rates as including "any state mandated assessments and taxes"; therefore, industry practice has determined that rates are only actuarially sound if fees and taxes are included in the rate development. Actuaries along with CMS guidance will determine the industry practice for this new federal tax.

The fee is unlike most taxes included in Medicaid capitation rates, since the amount of the tax will not be known at the time capitation rates are developed and the amount can vary dramatically by MCO. Including an estimated amount for the fee in the capitation rates without future adjustments to true-up the actual amounts places risk on the MCOs and the state, so implementing a methodology for paying the fee that includes a true-up approach to make the fee more of a pass-through payment reduces the risk of mispricing this component of the capitation rates.

The options described above may meet CMS approval for including the fee in the Medicaid managed care capitation rates, but CMS ultimately will need to approve any method used. They had not issued guidance for including the fee in Medicaid managed care capitation rates at the time this article was written.