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## Congress of the United States

JOINT COMMITTEE ON TAXATION  
1625 LONGWORTH HOUSE OFFICE BUILDING  
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JUN 03 2011

Honorable Jon Kyl  
United States Senate  
SH-730  
Washington, D.C. 20510

Dear Senator Kyl:

You requested that we provide you with an analysis of the effects on health insurance premium prices of repealing section 9010 (an annual fee on health insurance providers) of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (collectively "PPACA").

Sec. 9010 of PPACA imposes an annual fee on any covered entity engaged in the business of providing health insurance with respect to United States health risks. Employers who self-insure their employees' health risks and governmental entities are not covered entities. In addition, entities that qualify as nonprofit under applicable State law, meet certain other charitable tests such as having no private inurement, and receive more than 80 percent of their gross revenue from government programs that target low-income, elderly, or disabled persons (including Medicare, Medicaid, Children's Health Insurance Plan, and dual-eligible plans) are not covered entities. Finally, certain qualified VEBAs are also not covered entities. The fee applies for calendar years beginning after 2013. The aggregate annual fee for all covered entities ("applicable amount") is \$8.0 billion for calendar year 2014, \$11.3 billion for calendar years 2015 and 2016, \$13.9 billion for calendar year 2017, \$14.3 billion for calendar year 2018, and indexed to the average growth of health insurance premiums for years after 2018. Under the provision, the aggregate fee is apportioned among the providers based on a ratio designed to reflect relative market share of U.S. health insurance business. A special rule provides an exclusion, for purposes of determining an otherwise covered entity's market share, of 50 percent of net premiums written that are attributable to certain tax exempt activities.

For each covered entity, the fee for a calendar year is an amount that bears the same ratio to the applicable amount as (1) the covered entity's net premiums written during the preceding calendar year with respect to health insurance for any United States health risk, bears to (2) the aggregate net written premiums of all covered entities during such preceding calendar year with respect to such health insurance.

We estimate that repealing the health insurance industry fee would reduce the premium prices of plans offered by covered entities by 2.0 to 2.5 percent.

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## Incidence of the Fee

The fee on health insurance providers is similar to an excise tax based on the sales price of health insurance contracts. The effective excise tax rate varies from year to year depending upon the fee amount and the aggregate value of health insurance sold. In theory, the economic incidence of an excise tax imposed on sale of health insurance contracts (that is, who actually bears the cost of the tax) may differ from the statutory incidence of the tax (that is, the person on whom the tax is levied). Taxes may be borne by: consumers in the form of higher prices; owners of firms in the form of lower profits; employees of firms in the form of lower wages; or other suppliers to firms in the form of lower payments. This makes generalizations about the incidence of taxes difficult.

Nonetheless, two principles have general validity. First, in the long run, economic incidence does not depend on whom the tax is levied. The fact that the statutory incidence of the health insurance fee is on the insurer does not alter the economic incidence of the tax, which is the same regardless of who writes the check to the government. Second, taxes are shifted from those who are more sensitive to price changes (those having more “elastic” supply and demand) to those who are less sensitive to price changes (those with more “inelastic” supply and demand).

In the case of competitive markets, an excise tax generally is borne by consumers in the form of higher prices in the long term. An excise tax increases the cost of producing an additional unit, or incremental cost, of the taxed good by the amount of the tax. In a competitive market, market forces cause the after-tax price of a good to equal the additional cost of producing and selling another unit of the good. Competition drives price down to equal the cost of providing an additional unit the good or service (“marginal cost”), including the return to incremental invested capital. If supply is perfectly responsive to price changes, any price greater than marginal cost would induce new firms to enter the market and would induce increased production until prices were bid back down to marginal cost. Similarly, any price below marginal cost would induce firms to exit or reduce production (because they would now be losing money selling the taxed good). The reduction in supply allows prices to increase back up to marginal cost.

These market forces may be observed even if some of the participants in the competitive market do not seek to maximize profits as their primary objective. Tax-exempt and nonprofit producers may also pass on the tax as they also face the increased marginal cost, which they will need to recover. If they cannot, for example, raise additional funds from donors (in the case of

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charitable organizations) or member fees (in the case of membership organizations), effectively passing the tax on to them, they will need to pass on the tax to consumers in the form of higher prices.

While consumers are thought to bear the burden of excise taxes in competitive markets, some may question the degree of competition in health insurance markets. Recent surveys have noted that many regions are characterized by the presence of only a few health insurance firms.<sup>1</sup> Additionally, there may be barriers to entry in the health insurance market for small firms or those without related business, such as multiple State regulatory requirements, the cost of establishing health provider networks, health provider network effects (for example, the potentially larger value of a health provider network to consumers as the size of the network increases), and efficiency advantages in risk shifting and risk distribution for large firms.

However, the absence of many competitors does not by itself imply that there is no competitive pressure on prices. The threat of potential entrants may provide price pressure on the existing firms. Furthermore, the option to self-insure may provide a source of potential competition for full insurance, at least for larger firms.<sup>2</sup> In addition, the exchanges established under PPACA may foster more competition, and the individual mandate penalty established under PPACA is expected to reduce consumers' sensitivity to insurance price changes, thus increasing the ability of insurance providers to pass forward the cost of the health insurance fee.

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<sup>1</sup> See e.g., Government Accountability Office, *Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market*, GAO-09-363R, February 27, 2009, and Government Accountability Office, *Private Health Insurance: Research on Competition in the Insurance Industry*, GAO-09-864R, July 31, 2009, available at <http://www.gao.gov>.

<sup>2</sup> While there has been consolidation within the health insurance industry among those offering full insurance, the fraction of employees covered by self-insurance has increased, especially among large employers. See Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits, 2008 Annual Survey*, 2008, available at <http://ehbs.kff.org/pdf/7790.pdf> and Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," Working Paper, Kellogg School of Management, Northwestern University, October 2009.

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If the insurance industry is not perfectly competitive in a particular market, the question remains to what extent an insurance industry fee would be borne by consumers or producers in that market. Various studies have examined the effect of excise taxes on prices in less than perfectly competitive markets. Theoretically, the price could increase by: (1) more than the amount of the tax; (2) exactly the amount of the tax; or (3) less than the amount of the tax. Studies of the tobacco industry suggest that manufacturers pass on more than the full amount of the tax,<sup>3</sup> while studies of less than perfectly competitive rural retail gasoline markets suggest that producers pass on less than the full amount of the tax.<sup>4</sup> However, even in the rural retail gasoline markets in which gas stations may be the sole provider of gasoline for many miles and firms exhibit some pricing power, nearly 95 percent of the excise tax is still passed on to consumers.

While uncertainty exists, we assume that a very large portion of the fee on purchased health insurance premiums will be borne by consumers in most markets, including in some markets with a high level of concentration among market participants covered by the fee. While consumers (or employers) may respond by changing their health insurance coverage from more expensive plans to less expensive plans to offset any potential price increase, this behavior is properly characterized as the consumers bearing the burden of the excise tax by accepting lower quality (for example, a more restricted physician network) for the same price rather than paying a higher price for the same quality of insurance that they would prefer if there were no tax. To the extent that firms can avoid the fee by switching from full insurance to self-insurance, this may suggest that insurers are unable to pass on the full cost of the insurance industry fee on purchased health insurance. To the extent that health insurers maintain some pricing power in the administrative services that they provide self-insurers, the self-insurance market may bear some of the burden of the fee as well.

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<sup>3</sup> Sophia Delipalla and Owen O'Donnell, "Estimating Tax Incidence, Market Power and Market Conduct: The European Cigarette Industry," *International Journal of Industrial Organization*, vol. 19 no. 6, May 2001, pp. 885-908.

<sup>4</sup> James Alm, Edward Sennoga, and Mark Skidmore, "Perfect Competition, Urbanization, and Tax Incidence in the Retail Gasoline Market," *Economic Inquiry*, vol. 47 no. 1, January 2009, pp. 118-134.

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## Effect of the Fee on the Cost of Purchased Health Insurance

Given the incidence analysis discussed above, while there is uncertainty, we expect a very large portion of the insurance industry fee to be passed forward to purchasers of insurance in the form of higher premiums. Because less than half of the total value of health insurance is provided in a form that would be subject to the industry fee, the effect of the fee on prices of insurance is expected to vary between taxable insurance and non-taxable insurance, and over time. For those insurance premiums that are subject to the fee, we estimate that the premiums, including the tax liability, would be between 2.0 and 2.5 percent greater than they otherwise would be. You asked for an estimate of the dollar amount of price change associated with the fee on the premium for a family of four. While we have not separately estimated premiums by family size, we estimate that eliminating this fee could decrease the average family premium in 2016 by \$350 to \$400.

## Distributional Analysis of the Health Insurance Industry Fee

Regardless of any determination of the economic incidence of the insurance industry fee, at the present time the staff of the Joint Committee on Taxation is not able to distribute the effects by income of individuals. Generally, we use our individual tax model for distribution analyses. However, for some provisions, including the health insurance industry fee, we do not have sufficiently detailed data to do such an analysis. The fee applies only to the revenues from underwritten policies sold to third parties. It does not apply to the value of health benefits received by individuals through their employers who self insure the health risks of their employees, and it does not apply to certain other providers of health insurance. Our individual tax model is based upon a sample of approximately 180,000 actual tax returns. To analyze proposed tax changes related to economic activity that is not already reported on the individual tax return we impute values, or statistically match supplemental information such as data gathered by the Census Bureau, to the individual tax returns of our model. For our quantitative analysis of employer provided health benefits we have made such imputations of data relating to employees' employer-provided health care benefits to the individual model. These imputations are based on the data collected as part the Medical Expenditure Panel Survey ("MEPS"), a survey undertaken by the Agency for Healthcare Research and Quality of the Department of Health and Human Services. However, the imputations we have made to the individual tax model only relate to the value of employer expenditures for the health care of their employees. These imputations do not generally distinguish between the employers' purchased insurance coverage and benefits for which the employer self-insures. They also do not distinguish between

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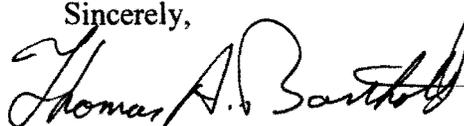
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tax-exempt insurers and other insurers. Consequently, we are unable to make any distribution of either the economic incidence or the revenues generated from the insurance industry fee.

I hope this information is helpful to you. Please contact me if we can be of further assistance.

Sincerely,

A handwritten signature in cursive script that reads "Thomas A. Barthold". The signature is written in black ink and is positioned above the printed name.

Thomas A. Barthold