Congress of the United States
Washington, DC 20515

October 8, 2014

The Honorable Sylvia M. Burwell
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Jacob J. Lew
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Dear Secretary Burwell and Secretary Lew:

As you are aware, Section 9010 of the *Patient Protection and Affordable Care Act* (P.L. 111-148), as amended, imposes an annual fee on health insurance providers, with the first fees due in 2014. Specifically, the fee is imposed on any "covered entity," which is defined as an entity "engaged in the business of providing health insurance for United States health risks." See §9010(c). The term "United States health risk" is defined as "the health risk of any individual who is (1) a United States citizen, (2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or (3) located in the United States, with respect to the period such individual is so located." See §9010(d). The term "United States" is defined as "the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States." See §9010(h).

On its face, Section 9010 appears to impose the annual fee on health insurance providers in the five U.S. territories in the same manner and to the same extent that it imposes this fee on providers in the 50 states and the District of Columbia.[1] For the reasons stated below, we believe that application of the Section 9010 fee to health insurance providers in the territories is inappropriate and unjust, especially since it is inevitable that some or all of this fee will be passed on to individual plan-holders (in the form of higher costs and reduced services) and to physicians and hospitals (in the form of lower reimbursement rates).

[1] There are insurers that provide coverage in Puerto Rico, Guam, the U.S. Virgin Islands and the Northern Mariana Islands that are subject to this fee. It is not clear whether there are insurers in American Samoa that are subject to the fee in 2014, but there may be and there certainly could be in future years. With respect to Puerto Rico, based on information released by the Internal Revenue Service, over a dozen health insurance providers wrote a total of $7.2 billion in net premiums that are subject to the Section 9010 fee, which is approximately 1.4% of the national total of $504.3 billion. As a result, a rough estimate is that companies writing coverage in Puerto Rico will pay a combined total of $112 million in Section 9010 fees in 2014, $158 million in 2015, and even more in subsequent years. With respect to Guam, insurance providers wrote a total of $228.3 million in net premiums in 2014, so a rough estimate is that they will pay a combined total of $360,000 in Section 9010 fees this year. The IRS does not provide germane information for the U.S. Virgin Islands or the Northern Mariana Islands, but we have been advised that at least one insurer that provides coverage in each territory is subject to the Section 9010 fee.

Therefore, we urge the Administration to adjust this fee for health insurance providers in the territories, either by providing a "temporary safe harbor" as the Administration did in the case of expatriate plans or by using any other available mechanism. If the Administration concludes that it lacks the authority to take action, we urge you to propose a legislative remedy for enactment by Congress, ideally as part of the President's budget request to Congress for Fiscal Year 2016.[2]

Our reasoning is straightforward. The purpose of the Section 9010 fee is to help offset the cost to the federal government of the provisions in the ACA that require increased federal outlays. But the territories are treated completely differently—that is, worse—than the 50 states and D.C. under nearly every important provision in the law, including each of its key spending provisions.

For starters, under the ACA, most legal residents of the United States must either obtain health insurance or pay a penalty, a provision known as the individual mandate. The individual mandate does not apply to residents of the territories. Likewise, certain employers that decline to offer their employees health insurance coverage that meets specified standards will be assessed a penalty, a provision known as the employer mandate. The employer mandate does not apply to employers in the territories. Relatedly, small employers that do provide health insurance coverage to their employees may be eligible to receive a federal tax credit of up to 50 percent of the cost of that insurance. The Congressional Budget Office estimates that this provision will cost the federal government $16 billion between 2014 and 2024.[3] However, small employers in the territories are not eligible for these tax credits.

More fundamentally, under the ACA's central provision, many individuals and families can purchase insurance through an exchange operated either by the federal government or by a state government, with the federal government providing subsidies to those households with annual incomes below a certain level. The CBO projects that, within a few years, 25 million Americans will receive health insurance coverage through the exchanges. Yet, not one of those Americans will reside in the territories, since the territories were unable to establish state exchanges and our constituents are not eligible to participate in a federal exchange. CBO estimates that, between 2014 and 2024, it will cost the federal government $1.049 *trillion* to provide exchange subsidies and make related expenditures. This is the largest single outlay in the ACA—which the Section 9010 fee is designed to partially offset—and yet these federal dollars will not help territory residents.

In addition, under the ACA, the states and D.C. are permitted—but not required—to expand eligibility for Medicaid, a federal-state program. If a state elects to expand eligibility for Medicaid, the federal government covers 100 percent of the cost of covering this newly-eligible

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[2] One approach to resolve this matter would be to repeal or relax the Section 9010 fee as it pertains to health insurance providers in the territories. An alternative approach would be for the Section 9010 fees paid by health insurance providers in the territories and collected by the U.S. Department of the Treasury to be transferred to the governments of the territories to be used to improve their health insurance markets.

[3] All references to Congressional Budget Office estimates in this letter are based on Congressional Budget Office, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act" (April 2014).

population from 2014 to 2016, 95 percent of the cost in 2017, 94 percent of the cost in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. CBO estimates that the added cost to the federal government for Medicaid (and CHIP) attributable to the ACA will total $812 billion for the 2014-2024 period.

By contrast, the territories are treated in an entirely different manner than the states and D.C. under federal Medicaid law. As the ACA was being drafted and debated, we had to fight vigorously to obtain $7.3 billion in additional Medicaid funding for the territories, to be drawn down between 2011 and 2019. We are proud of the battle we waged on behalf of our constituents and the historic result it produced. But we are under no illusion that parity, or anything approaching it, was achieved. The territories are not eligible for the enhanced federal contribution to cover our newly-eligible Medicaid population, the territories continue to receive far fewer federal Medicaid dollars than they should in light of their respective poverty levels, and the territories are required to pay a local "match" that is significantly higher than what a similarly-situated state would pay.

Finally, the ACA made a number of important reforms designed to protect consumers, such as prohibiting insurers from denying health coverage to individuals with pre-existing medical conditions, imposing annual and lifetime limits on coverage, or terminating coverage when a beneficiary gets sick or injured, among many others. In 2010, HHS concluded that these ACA reforms generally applied in the territories. This year, however, HHS reversed its position. As a result, in the individual market, federal law does not prohibit territory residents from being sold a plan that does not comply with the ACA reforms. In the group market, a territory insurer has no obligation under federal law to offer an ACA-compliant plan.[4] The territories are now the only U.S. jurisdictions where this is the case.

In summary, although the ACA made historic improvements to the Medicaid programs in the territories, the law discriminates against the territories in major respects. If the territories are not entitled to receive all—or even most—of the *benefits* of the ACA, it is absolutely unprincipled to subject us to the *burdens* of the law, such as the Section 9010 fee, which is designed solely to offset the cost of spending provisions that apply in the states and D.C. but do not generally apply in the territories.

We look forward to your response.

[4] Under the ACA, a group health *plan*—for example, an employer—in the territories is subject to the ACA reforms; the insurance *provider*, however, cannot be held liable for offering a non-ACA-compliant plan. This rather illogical state of affairs is unique to the territories.

Sincerely,

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Member of Congress

Donna M. Christensen
Member of Congress

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