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Medicaid and CHIP FAQs:
Health Insurance Providers Fee for Medicaid Managed Care Plans
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The Centers for Medicare & Medicaid Services (CMS) has received a number of questions from states, their actuaries, and health plans about the Health Insurance Providers Fee added by Section 9010 of the Affordable Care Act, and its interaction with Medicaid managed care rate setting. CMS believes that this fee, like other similar fees, should be considered a business cost to health plans. CMS has prepared the following Frequently Asked Questions (FAQs) to provide guidance to the states as they consider the impact to their managed care plans.

Q1: How should states account for the cost of the Health Insurance Providers Fee in their actuarially sound capitation rates?

A1: States and their actuaries have flexibility in incorporating the Health Insurance Providers Fee into the state's managed care capitation rates. This fee is not unlike other taxes and fees that actuaries regularly reflect in developing capitation rates as part of the non-benefit portion of the rate. CMS believes that the Health Insurance Providers Fee is therefore a reasonable business cost to health plans that is appropriate for consideration as part of the non-benefit component of the rate, just as are other taxes and fees.

Q2: What methodologies are acceptable to account for the Health Insurance Providers Fee in capitation rates? Can states make retroactive adjustments to the capitation rates once the actual assessments on the health plans are known?

A2: States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retroactive basis. In the event that a prospective calculation results in a capitation rate that is too high or too low, the capitation rate may be adjusted after the actual tax assessment is known. States may also account for the fee prospectively by withholding such amounts until the health plan's actual fee is known. The capitation payment, net the amount of the withhold, must remain actuarially sound and the state can only claim Federal Financial Participation (FFP) on the actual expenditures paid from the withhold to reimburse the health plans for the fee.

States may account for the Health Insurance Providers Fee as an aggregated retroactive adjustment to the rates for the contract year once a health plan's liability is known. CMS anticipates that states would move to a prospective calculation as states and health plans obtain more experience with the fee.

Q3: Can the Health Insurance Providers Fee be paid to health plans as a separate payment after the plans' fee liability is known?

A3: No. There is no Federal Financial Participation (FFP) available for Health Insurance Providers Fee payments made outside of actuarially sound capitation rates, per the requirements of section 1903(m)(2)(A(iii) of the Social Security Act and implementing regulations at 42 CFR 438.6(c)(2). Therefore, any payment for the fee—whether on a prospective or retrospective basis—must be incorporated in the health plan capitation rates and reflected in the payment term under the contract.

Q4: Are there any limitations around the use of the data year (e.g., 2013) or the fee year (e.g., 2014) as the base for any adjustment to the capitation rates to account for the Health Insurance Providers Fee?

A4: There are reasonable ways to account for the Health Insurance Providers Fee as an adjustment to the states' capitation rates under either approach. In either approach, the amount of the fee should be incorporated as an adjustment to the capitation rates and the resulting payments should be consistent with the actual or estimated amount of the fee.

Q5: If the 2014 capitation rates are being adjusted to reimburse health plans for the Health Insurance Providers Fee due in 2014, should the adjustment be applied to every population?

A5: No. Since the fee due in 2014 is based on the health plan's 2013 book of business, the adjustment should only apply to the capitation rates for populations that the state covered under the managed care contract in 2013. For example, states that chose to expand Medicaid eligibility starting January 1, 2014, should not adjust the capitation rates for the new adult eligibility group to account for the fee due in 2014, because they were not covered by the managed care plans in 2013. In future years, the Health Insurance Providers Fee will continue to be based on the book of business for the immediately preceding year, so this concept will apply in calculating the fee if any new populations are added to a state's managed care program.

Q6: Should the potential effect of the Health Insurance Providers Fee on other taxes, fees, and assessments and the non-deductibility of the fee be considered in the development of capitation rates?

A6: The potential effect of the fee may be considered in the development of the capitation rates. If the state's actuary takes these potential effects into account in developing the non-benefit component of the capitation rate attributable to the Health Insurance Providers Fee, the assumptions underlying that analysis will be documented in the rate certification.

Q7: How should the Health Insurance Providers Fee be considered in risk-sharing arrangements and minimum medical loss ratio calculations?

A7: It is reasonable to consider the Health Insurance Providers Fee in these arrangements as they may exist in the contract between the state and the health plan. While CMS does not have specific requirements as to how the Health Insurance Providers Fee should be considered under these arrangements, CMS does recommend that the Health Insurance Providers Fee is generally treated in the same way as other taxes and fees for these purposes.

Q8: How should states address the exclusion of long-term care premiums from the plan's Health Insurance Providers Fee calculation?

A8: Section 9010(h)(3) of the Affordable Care Act and the IRS Health Insurance Providers Fee regulations (78 FR 71476, 71483, November 29, 2013; available at www.irs.gov/irb/2013-51_IRB/ar12.html) exclude long-term care from the definition of health insurance for purposes of calculating a health plan's fee liability. Where long- term care services are paid a capitation rate separate from other services, these payments can be easily identified and should be excluded by the health plan when reporting premiums subject to the fee to the IRS. However, where long-term care services are not easily identified within the health plan's capitation rates, the health plans may need to consult with the state and their actuaries to determine the appropriate premium receipts to report to the IRS.

Q9: How should a state account for a health plan's liability for the Health Insurance Providers Fee if a health plan contracted with a state in 2013 but does not continue that relationship in 2014?

A9: CMS believes that the process for reimbursing a health plan for the Health Insurance Providers Fee that was contracted with the state in 2013, but not in 2014, is primarily a matter to be negotiated between the state and the health plan. It is reasonable for a state to make a retroactive adjustment to the 2013 contract year rates for that health plan as it is possible that the state's actuary did not take the Health Insurance Providers Fee into consideration when developing the 2013 rates. In that case, the state may treat the fee in the same manner as it would an error in the development of the rates, and submit any necessary adjustment to CMS for approval.

However, there may be barriers to such adjustments under the contract or applicable state laws. Retroactive rate adjustments for a health plan that has left the market must be made under the contract and within the federal two-year period for timely claims. See Question 3 for more information. Going forward, states that account for the fee on a retroactive basis may want to address rate adjustments due to market exit in the contract. States that account for the fee on a prospective basis will not encounter this issue.

Q10: Is there information on when states will make payments to contracted health plans to account for the Health Insurance Providers Fee?

A10: Information on when states intend to reimburse contracted health plans for the Health Insurance Providers Fee is established in the contract. States that elect to reimburse health plans for the fee once the amount is known should establish a timeframe for payment, typically between 30 to 90 days, after receipt and review of the health plan's assessment from the Internal Revenue Service.