



Review of Exchange Financing Options

Illinois Health Insurance Exchange

November 2012

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Introduction and Overview of Findings

While federal grants are available to finance Exchange start-up costs, state-based Exchanges are expected under the ACA to become financially self-sustaining within one year of the start of operations. The Illinois Exchange is intended to begin operations as a state-based exchange in 2015, meaning that it must become self-sustainable by January 1, 2016. States that elect to pursue a state-based Exchange have the flexibility to determine the funding mechanism best suited to supporting their Exchange. Illinois has selected three discrete funding mechanism options to consider for the financial support of the state's Exchange. In this document we will introduce, discuss and assess these options. The three options to be reviewed are: (1) a new Health Insurance Claims Assessment modeled upon a similar mechanism recently enacted in Michigan; (2) the existing assessment method used to support the ICHIP HIPAA high risk pool; and (3) an expanded ICHIP assessment that also applies to stop-loss premiums. A previous report from Health Management Associates and Wakely Consulting Group¹ presented a funding mechanism consisting of an assessment on Qualified Health Plans (QHPs) selling insurance products on the Exchange. High-level information related to the QHP assessment will be presented in this report for the purposes of comparison with the newly introduced funding options. Please see the previous report for a detailed discussion of this mechanism.

The primary differences between these methods is that the first method, a claims assessment modeled on the Michigan program, would incorporate payments made on behalf of self-insured payers in the revenue base, while the ICHIP methodology would only capture fully-insured premium amounts in the revenue base. Due to the small scale of the revenue base for stop loss insurance in relation to major medical coverage, we do not anticipate a material difference in revenue base or collections between options two and three.

Wakely estimates that the cost of a full-function, state-based Exchange in Illinois would range between \$57 and \$88 million dollars per year. Wakely estimates that the rate of assessment required to fund this estimated range of cost using the methods considered would be as follows:

Commercial Claims-based Assessment: ²	0.22% - 0.34%
ICHIP-type Assessment: ³	0.34% - 0.53%
ICHIP-type Assessment Plus Stop Loss Revenue: ³	0.34% - 0.52%
QHP Premium Assessment: ⁴	2.24% - 3.39%

The report begins with a conceptual overview of Exchange Financing that outlines various criteria to consider when choosing a financing mechanism, including Exchange enrollment, startup transition, current market distribution of coverage, and the relative scale of coverage in self-insured plans. It then provides an overview of the estimated expenses of the Illinois state Exchange. Each of the selected funding options are described in relative detail that outlines how they would be implemented, and what the current status of the assessment and any related regulations may be.

¹ Health Management Associates/Wakely Consulting Group, *Illinois Strategic and Operational Needs Assessment, Final Report*. September 2011

² Assessment is expressed as a percent of combined fully and self-insured claims expenses

³ Assessment is expressed as a percent of fully insured premium revenue

⁴ Assessment is expressed as a percent of premium revenue, based on premium estimates from Health Management Associates/Wakely Consulting Group, *Illinois Strategic and Operational Needs Assessment, Final Report*. September 2011, and enrollment estimates from Deloitte LLP, *Review of the Current Illinois Health Coverage Marketplace: Background Research Report*, September 2011

We conclude with a broad assessment of each specific option which looks at the methodology's funding base and market impact, administrative feasibility, risks and other considerations, and financial impact.

Conceptual Overview of Exchange Financing

The ACA provides states flexibility when selecting a mechanism to finance their state-based health benefit Exchange. In selecting a financing mechanism, Illinois will need to determine the methodology that can best ensure that the revenue of the Exchange comports with the expected expenditures of the organization, and that the mechanism is both fair and efficacious. In comparing different financing options, the Exchange will need to weigh several key considerations related to the soundness of any given financing source. There are several types of criteria that the Exchange should consider when making this decision, but the primary policy considerations to be weighed can be grouped into two types: (1) criteria related to the effectiveness of the funding source to meet the revenue requirements of the Exchange and (2) criteria related to the appropriate basis for the assessment based on the perceived nature and value-proposition of the Exchange. Examples of the first type of criteria include the following:

- Is the revenue basis stable, reliable, and predictable?
- Does the financing method provide sufficient flexibility to support enrollment variability during the first few years of operation or in the event of low enrollment?
- Will the financing method sufficiently mitigate the risk of a revenue shortfall?

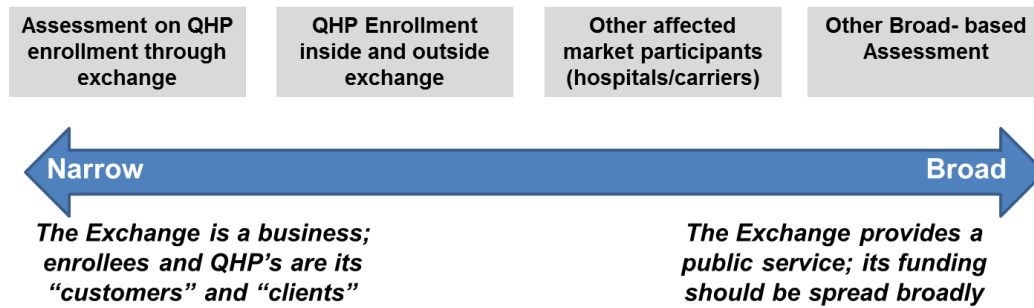
Examples of the second type of criteria include the following:

- Should the financing source be narrowly applied or broad based?
- How do health care reform implementation and the introduction of the Exchange affect different stakeholders and the state as a whole?
- Will the financing method discourage members or carriers from utilizing or participating in the Exchange?

There is some overlap in these two categories. For example, selecting a broad-based funding source may satisfy state criteria from the first list because it may be more stable and predictable, while it also may satisfy a criteria from the second list related to the Exchange's position on the appropriateness of expanding the base of assessment.

How key stakeholders view Exchange financing will be driven in large part by how they view the value proposition of the Exchange. As illustrated in Figure 2, below, the relative breadth of the funding source to support Exchange revenue can be tied to whether the perceived role of the Exchange is that of a business that should derive fees from the partners with whom it is directly involved in providing services (QHP issuers, small firms, enrollees, or individuals viewing its website), whether the Exchange provides a public service benefitting all Illinoisans and should therefore be publicly supported, or whether the Exchange is a hybrid with some business characteristics and some characteristics of a public agency.

Figure 1. Spectrum of Exchange Financing Sources



In the “Exchange as business” model, the organization provides a service to its QHP “clients” by marketing health plans and enrolling members in products. As a type of distribution channel to carriers, the Exchange may charge a fee to carriers to reflect this business relationship. In the “Exchange as public benefit” model, the Exchange provides benefits to a larger scope of stakeholders, such as administering premium and cost sharing subsidies and expanding health insurance coverage. In this view, other health care stakeholders benefit from expanded insurance coverage, and the state as a whole benefits from a safety net that will become available to individuals who are or could become uninsured.

From a quantitative perspective, a narrowly focused assessment will require a relatively higher rate of assessment because the base from which the assessment is drawn is smaller. Broadening the base of assessment will serve to increase the denominator, allowing for a lower rate of assessment against the broader base. Broadening the basis of assessment can introduce greater certainty and/or predictability to the funding source for the Exchange. A broad-based assessment will also reduce the incentive for non-participation in the Exchange on the part of issuers, relative to a narrowly focused user fee or surcharge on Exchange participants. Depending on the source of funding, however, broadening the base does not always shield the financing stream for fluctuations. In the past few years, for example, there has been a national increase in the share of employers choosing to self-insure, which has reduced the value of fully-insured premium revenue. In addition, the health care industry, like all others, can be sensitive to fluctuations in the overall economy.

Before discussing specific potential financing options, it is worth touching on a few key factors that can impact Exchange financial sustainability, including the issues of enrollment scale, the transition from federal funding to self-sustainability, the decision around whether or not to pursue a Federal BHP option, the current distribution of covered individuals in Illinois by market segment, and considerations specific to a QHP surcharge or volume based funding mechanism.

Key Considerations Related to Exchange Financing

1. Enrollment Scale

The estimated scale of Exchange membership is a critical consideration in developing Illinois' plan for Exchange self-sustainability. This is true for two reasons. First, an increase in membership scale will increase the total cost of running the Exchange in absolute dollar terms. This is the case because, although a substantial portion of Exchange costs will be fixed, the marginal cost of adding additional volume of enrollees through the Exchange will add additional cost to the Exchange as enrollment grows. For example, increasing membership will require an increased number of call center representatives, a greater level of database support, and additional need for financial reconciliation of member billings and collections. Conversely, as the scale of enrollment grows larger, the unit cost, or cost per-member per-month (PMPM), will tend to decrease. This is because the Exchange will have a greater membership base across which to spread its fixed costs. At low levels of enrollment, the total cost of the Exchange will be lower, but the PMPM cost of operating the Exchange will be relatively high. Similarly, as enrollment grows, the cost of the Exchange, on a PMPM basis and as a percent of total revenue for Exchange premiums, will tend to decline. Again, this is due to the fact that at higher levels of enrollment the Exchange's fixed costs will be spread across a larger base. This is an important concept we will discuss in more detail when we consider different options for financing the Exchange.

2. Transition from Start-Up to Self-Sustainability, 2014 - 2015

The transition period during the first year of operations will be critical for the Exchange as federal funding winds down and the Exchange transitions to become financially self-sustaining. After the first full year of state-based operations, federal funding will cease and it is expected that the Exchange will be generating enough revenue in 2016 to cover its operating expenses. Prior to this date, the Exchange will need be able to address several key areas including:

- a. Is the Exchange entering into vendor agreements, long-term contracts, and infrastructure spending commitments that will be financially sustainable once federal funding ends?
- b. Will the federal government allow the Exchange to develop some level of surplus during start up and the first year of operations?
- c. What is the range of enrollment estimates and can the Exchange meet its expense obligations at the low end of the enrollment range?
- d. If enrollment is ramping up more slowly than expected, can vendor payment terms be adjusted?
- e. Can the Exchange establish a line of credit to cover initial start-up expenses and meet short-term cash flow issues in the event that revenues fall short of covering expenses while membership ramps up?
- f. Is there a timing delay between when a funding source is established and when cash is available for Exchange operations? Will cash flow beginning in 2015 be sufficient to cover the organization's expenses?

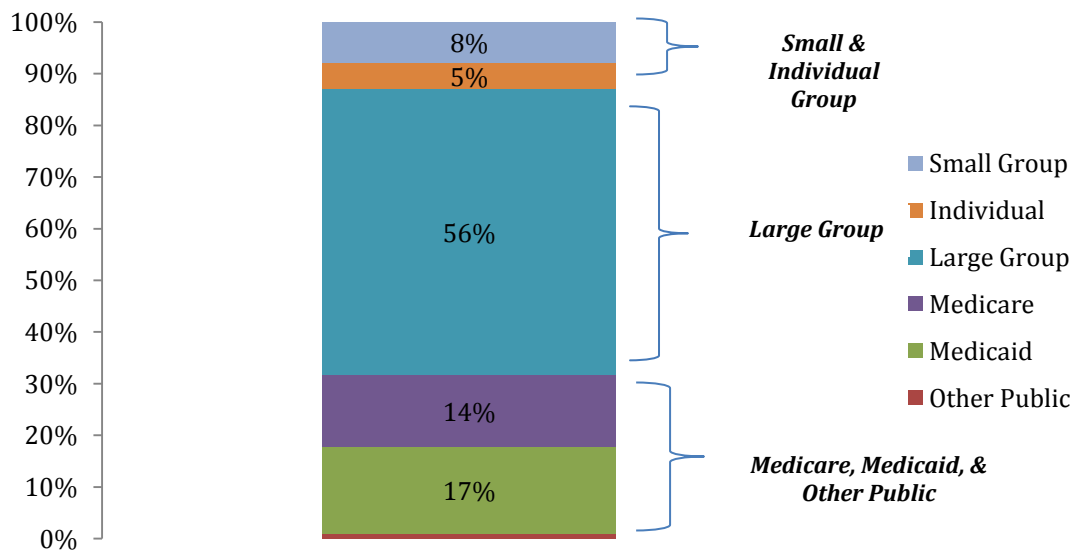
These questions will be particularly relevant during the first years of operations, because enrollment during this time, and therefore overall costs, will be uncertain. As enrollment ramps up

and becomes more stable, the Exchange will have greater certainty, and thus greater flexibility, in its financial decision-making.

3. Current Coverage Distribution

Another important type of information to consider when selecting a financing source is the level and distribution of existing insurance coverage by market segment. The Exchange will be selling to individuals and small businesses in the small and non-group insurance markets. As indicated in the figure below, these markets represent a small portion of the total insured non-elderly population in Illinois - roughly 13%. Actual enrollment through the Exchange in these markets is expected to incorporate a sub-set of these existing market participants, supplemented heavily with individuals who are currently uninsured.

Figure 2. Distribution of Insured Population by Market Segment



Source: Kaiser Family Foundation State Health Facts, based on the U.S. Census Bureau’s Current Population Survey, 2009. Additional information provided by the MEPS Survey-Illinois, 2009

An additional 32% are covered through Medicare, Medicaid or other public programs. The largest portion of insured individuals, approximately 56%, is covered in the large group market. As discussed below, a majority of those covered through this largest portion of the commercial market are covered through self-insured plans.

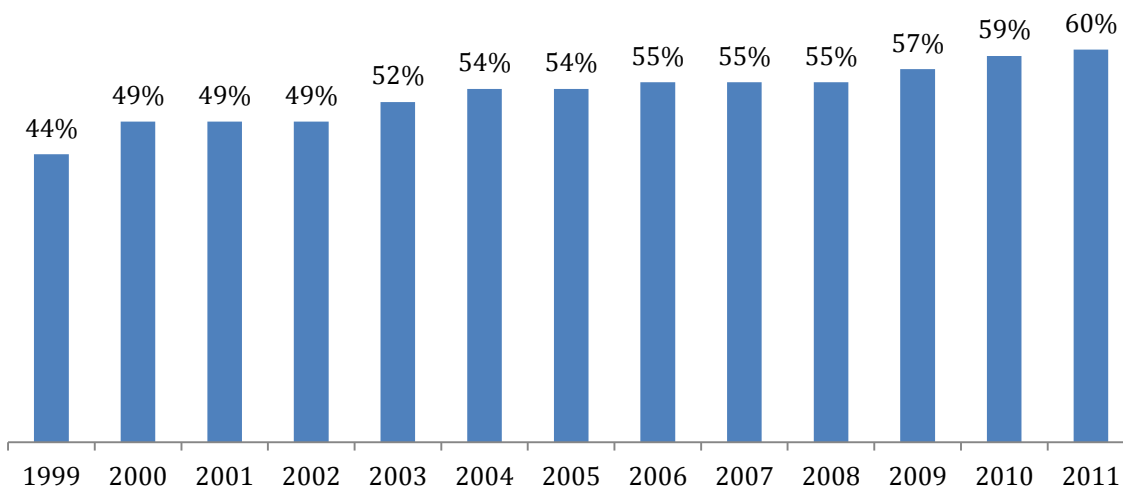
4. The Self-Insured Market

The largest share of employer-based health insurance is provided by self-insured employers, who assume the financial risk of insuring their employees rather than paying premiums to a carrier. Nationally, approximately 60% of employees that receive employer health benefits are covered under a self-funded plan, and this percentage has been increasing over time. Self-funded plans are exempt from most state insurance laws, including reserve requirements, mandated benefits,

premium taxes, and consumer protection regulations. To mitigate their exposure to high-cost claims, most self-funded plans (approximately 60%) use stop-loss or reinsurance coverage to limit their liability.

Information on the size and scope of the self-insured market in Illinois is limited. However, national data exists that can be helpful to understand the relative importance and growth trends relating to this segment of coverage. Nationally, 60% of covered employees are covered through a self-funded plan, and 82% of covered workers in firms with 200 or more employees are covered in self-insured plans. Applying this figure to the coverage distribution in Illinois, we can estimate that approximately 46% of those currently insured in Illinois receive their health benefits from a self-insured plan. As illustrated in figure 1, below, the size of the self-insured market continues to grow. Between 2000 and 2011, the share of covered employees covered in self-funded plans increased from 44% to 60%, and this trend is likely to continue.⁵

Figure 3 Percent of Covered Workers Covered by a Self-Funded Plan, 1999 - 2011



Source: The Kaiser Family Foundation and Health Research & Education Trust, Employer Health Benefits Annual Survey, 2011.

Note: To highlight trend, the bottom of this chart has been cut off.

To the extent that Illinois seeks a broad-based funding strategy, both the relative and increasing size of the self-insured pool are important considerations when determining an appropriate funding strategy.

⁵ The Kaiser Family Foundation and Health Research & Education Trust, Employer Health Benefits Annual Survey, 2011.

5. *Special Considerations Related to QHP Surcharges*

In a prior report provided to the State of Illinois, Wakely analyzed a QHP premium revenue-based surcharge as an Exchange funding mechanism. There are a number of factors unique to this funding source that are worth exploring briefly as contextual information should the state consider this option.

In this type of funding model, the Exchange would assess a percentage or fixed fee on QHPs for the revenue and/or membership they earn on their Exchange business. Under ACA rating rules, premiums for the same product must be the same inside and outside the Exchange. Therefore, this fee will not make premiums higher inside the Exchange than they would be outside; rather, carriers would be required to spread this fee cost across their entire small or non-group book of business. While premium prices will remain the same inside and outside the Exchange, carrier yields for the same product will be somewhat lower for business sold through the Exchange due to the assessment on Exchange business. At high relative fee rates, this may create market distortions by dis-incenting carrier participation. At lower fee levels (such as those projected for Illinois) this is not expected to create this type of distortion.

Because this type of funding mechanism is dependent upon actual enrollment and premium revenue within the Exchange, to estimate the surcharge rate that would need to be applied to QHP premium revenue to support Exchange operations, the Exchange will need to estimate the overall level of enrollment, the estimated premium level at each of the precious metal actuarial value tiers (Gold, Silver, Bronze, etc.), and the estimated enrollment by each of the precious metal tiers and the catastrophic plan.

The overall level of enrollment is important because it affects the level of expenses as a percent of total premium revenue. At low levels of enrollment, a fee-based funding mechanism can be challenging to sustain, as it will require a relatively high per-member per-month fee, or, in other words, a higher portion of the total premium must be captured to sustain Exchange operations. Conversely, at higher membership levels, the Exchange can sustain operations with a relatively modest surcharge on QHPs.

The premium level of products sold through the Exchange is another critical factor in estimating the rate of assessment required to support Exchange operations. The higher this premium level, the lower the rate of assessment needs to be, and vice versa. The average premium level within the Exchange will be sensitive to several factors, including:

- The overall cost of health care within Illinois and Illinois-specific preference for more or less rich benefit designs. These factors are reflected in the overall average non-group and small group health insurance premiums in the state.
- The relative enrollment balance between small and non-group coverage in the Exchange as small group premiums tend to be higher due to the fact that employers generally seek richer coverage, while individual purchasers tend to be more price sensitive.
- The mix of products and/or benefit designs selected by Exchange enrollees. To the extent that members gravitate towards more or less costly product designs, the average premium from which the Exchange draws its revenue will also be higher or lower.

Although the actual enrollment distribution is uncertain, the Exchange can anticipate a heavy concentration of enrollment at the silver tier level, particularly in the non-group Exchange, because this is the tier level to which premium and co-pay subsidies are tied. For the small group Exchange, it is reasonable to expect a somewhat more dispersed product distribution, including greater representation in the richer benefit types, as we anticipate that small businesses will be more likely to purchase more robust benefit packages than more price-sensitive individuals.

Using previously determined enrollment estimates, Wakely estimates that Exchange operations in 2015 would equal \$57-\$88 million, with enrollment estimated to vary between 415,200 and 968,000. To generate the necessary funding through a QHP premium surcharge would require a per-member per-month (PMPM) assessment ranging between \$8.92 in a high enrollment scenario to \$13.47 in a low enrollment scenario.

Table 1. Range of Estimated 2015 Exchange Enrollment, Expenses, and Necessary QHP Surcharges in Low, Moderate, and High Enrollment Scenarios

	Low	Moderate	High
Estimated Year End Membership	415,200	692,000	968,800
Estimated PMPM QHP Surcharge	\$13.47	\$10.29	\$8.92
PMPM Cost as a Percentage of Expected Monthly Premium	3.39%	2.59%	2.24%
Estimated Total Exchange Cost	\$57,365,780	\$73,041,573	\$88,595,438

Source: Wakely Consulting Group and HMA, Illinois Exchange Strategic and Operational Needs Assessment, Final Report. September, 2011.

6. Market Context: Additional Revenue Provisions under the ACA

The introduction of an Exchange funding mechanism will take place along with several other revenue and/or cost reduction initiatives that are being introduced as part of ACA implementation and that will have an impact on the health care market. The ACA includes a number of provisions that require the health care industry to make a financial contribution towards implementation in recognition of the fact that certain market segments are likely to gain financially from increased levels of coverage. Specific industries affected include insurers, hospitals, and pharmaceutical and medical device manufacturers. Although there are differing opinions as to the net impact on these industries from the implementation of the ACA, the general consensus is that the increase in coverage and reduction in uncompensated care will be a net positive. The brief overview of these provisions and assessments included below is intended to provide some broader context to consider as the state weighs options for financing the Exchange.

1. Health Insurance Industry Assessment

This provision imposes an annual flat fee of \$6.7 billion on the health insurance sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are \$25 million or less and whose fees from administration of employer self-insured plans are \$5 million or less.

2. Pharmaceutical and Medical Device Manufacturers Assessments

The ACA imposes a flat annual fee of \$2.3 billion on the pharmaceutical manufacturing sector beginning in 2010 allocated across the industry according to market share. Similarly, the ACA imposes an annual flat fee of \$2 billion on the medical device manufacturing sector beginning in 2010 allocated across the industry according to market share. The fees do not apply to companies with sales of branded pharmaceuticals or medical devices in the U.S. of \$5 million or less.

3. Medicare and Medicaid Disproportionate Share Hospital Payment Reductions

To partially offset anticipated hospital revenue gains from increased coverage and reductions in uncompensated care and bad debt, the ACA includes provision to reduce Disproportionate Share Hospital (DSH) payments for Medicare and Medicaid. These payments are currently made to hospitals to offset the costs they incur to care for uninsured or underinsured individuals. Beginning in 2014, the ACA reduces national Medicare and Medicaid DSH payments by approximately \$5 billion and \$0.6 billion per year, respectively.

4. Insurance Excise Tax

The Affordable Care Act levies a new excise tax of 40% on insurance companies and plan administrators for any health coverage plan with an annual premium that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage. The tax applies to self-insured plans and plans sold in the group market, and not for plans sold in the individual market. The tax applies to the amount of the premium in excess of the threshold. A transition rule increases the threshold for the 17 highest cost states for the first three years. An additional threshold amount of \$1,350 for singles and \$3,000 for families is available for retired individuals aged 55 years and older, and for plans that cover employees engaged in high risk professions.

5. Temporary Reinsurance Pool Assessment

The ACA creates a temporary reinsurance pool that will be financed through a membership-based assessment on both fully insured plans and self-funded third-party payers. This assessment will be used to support the recoveries payable to carriers enrolling high-risk individuals in the non-group market. In essence, funds collected across the entire market will be paid to offset potential market instability and/or price increases in the non-group market. Total collections, nationally, will be \$25 billion over three years. The portion of this money to be collected in each state should be proportional to the size of their population, but will depend in part on the state's risk pool, as well as decisions taken by the state around whether or not to increase the value of this reinsurance program (and hence the required assessment).

This program is somewhat different from those outlined above in that it is not intended primarily to raise free and clear revenue from the market (although program administrative costs and a small contribution to the U.S. Treasury will be included in payer contribution payments.) The amount of money collected through this will remain largely budget neutral to the health market overall. However, it does represent a transfer of money from large group, small group, and self-insured business to support payments into the non-group market.

Estimated Exchange Expenses

To help gauge the level of funding required to support the Exchange once operational, Wakely previously developed an estimate for Exchange operating expenses for 2012 through 2015.⁶ Because the focus of this report is on the revenue required to sustain the Exchange once federal grant funding is no longer available, our focus will be on estimated operating expenses starting in 2015. To develop expense estimates for the period of Exchange operations, Wakely developed estimated expenses by budget line item that scale up and down based on projected enrollment in the Exchange. Wakely first developed an expected baseline expense on a per-member per-month (PMPM) basis, using historical data from the Health Connector in Massachusetts, after it had moved beyond start-up. We relied upon information from the Massachusetts Exchange because, as one of very few existing Exchanges and the organization most closely resembling the functionality that will be required of a state-based Exchange as defined in the ACA, it provides the most similar benchmark organization for cost comparison purposes. We then adjusted that experience for a larger anticipated enrollment scale in Illinois, other circumstances specific to Illinois⁷, and functions required by the ACA. We then projected expenses for low, moderate, and high enrollment scenarios, and estimated the revenue that would be required to achieve approximate break-even in 2015.

For enrollment, Wakely used estimates derived from multiple sources related to four sub-populations to develop the universe of individuals eligible to enroll through the Exchange, which we estimate to be approximately 2.6 million. The four sub-populations modeled include current small-group insured individuals, current non-group insured individuals, individuals enrolled in public programs that will become eligible to purchase through the Exchange, and uninsured individuals. The estimates and the sources of data are described in greater detail later in the document. We then assumed a range of take-up assumptions for each of these four sub-populations to develop low, moderate, and high enrollment scenarios. The low scenario was developed to allow Illinois to evaluate the level of premium assessment necessary to break-even should enrollment in the Exchange fall well below expectations.

The 2015 estimated range on a dollar basis is between \$57 million in the low scenario and \$88 million in the high scenario. Therefore, for 2015, the estimated range of spending, on a PMPM basis, is between \$13.47 PMPM for the low scenario and \$8.29 PMPM for the high scenario. As

⁶ Health Management Associates/Wakely Consulting Group, *Illinois Strategic and Operational Needs Assessment, Final Report*. September 2011.

⁷ Factors include relative price and wage levels, total population size, and the number of issuers participating in the Illinois market.

discussed in the Illinois Exchange Strategic and Operational Needs Assessment Report provided by HMA and Wakely Consulting in September 2011, these estimates were based on currently available data, or, where data is incomplete, on proxy or benchmark data, and will need to be refined as additional data becomes available or as material policy decisions are reached.

Table 2. Range of Estimated 2015 Exchange Expenses in Low, Moderate, and High Enrollment Scenarios

	Low	Moderate	High
Estimated Year End Membership	415,200	692,000	968,800
Estimated PMPM Exchange Cost	\$13.47	\$10.29	\$8.92
Estimated Total Exchange Cost	\$57,365,780	\$73,041,573	\$88,595,438

Source: Wakely Consulting Group and HMA, Illinois Exchange Strategic and Operational Needs Assessment, Final Report. September, 2011.

Overview of Selected Funding Options

To support the estimated cost of operating a state-based health benefit Exchange, Illinois has identified three potential funding models to consider and assess. These include a mechanism modeled on the Health Insurance Claims Assessment (HICA), recently enacted in Michigan to support the state’s Medicaid program; the existing ICHIP assessment, which supports the state’s HIPAA high risk pool; and a modification of the ICHIP assessment that incorporates stop-loss carriers to a greater extent than they are currently incorporated into the existing assessment. This section will provide an overview of these three funding models, focused on the liable entities under the various models as well as the administrative functions required to support them.

HEALTH INSURANCE CLAIMS ASSESSMENT

I. Background

On January 1, 2012, the Health Insurance Claims Assessment (“HICA”) Act became effective in Michigan. Intended to support the state’s Medicaid program, this act levies a one-percent (1%) tax on all ‘paid claims’ for health related services provided to Michigan residents within the state and applies to payments made on behalf of individuals in both fully-insured and self-funded insurance plans. ‘Paid Claims’ are defined as actual payments, net of recoveries, made to “health and medical services providers” or reimbursed to an individual by a carrier, third party administrator, or stop-loss (excess loss) carrier. Within the statute, “Health and medical services” have a broad definition which includes but is not limited to:

- medical care, dental care, pharmaceutical benefits, hospitalization, ambulatory services, emergency and nonemergency transportation;
- services provided by physicians (M.D.s & D.O.s), nurses, dentists, chiropractors, acupuncturists, audiologists, optometrists, speech-language therapists, pharmacists, physical therapists, podiatrists, psychologists, occupational therapists, dietitians, nutritionists, social workers, and respiratory care therapists; as well as
- Behavioral health services, including mental health and substance abuse

All traditional group health plans, including medical, dental, vision, prescription drug plans, and mail-order pharmaceuticals that are delivered to a resident within the state are subject to the tax. Various wellness programs are also subject to the tax if those programs are administered by a TPA. Most federal health insurance plans, including Medicare Advantage plans, Medicare prescription drug plans, and FEHB plans, are exempt from the HICA tax; however, Medicare supplemental insurance is not exempt.

II. Liable Entities

A critical feature of the HICA assessment is that it captures paid claims regardless of the funding source for covered members, i.e., it collects amounts for both fully insured and self-funded payers. The assessment is levied upon certain insurance carriers, self-insured entities, employers, employee organizations and Third Party Administrators (TPAs) that pay health insurance claims for Michigan residents for health-related services performed in Michigan. In the case of TPAs, HICA is levied against all Michigan-licensed TPAs directly, and TPAs are directly responsible for paying the tax on behalf of their self-insured group health plans. TPAs have the ability to pass the tax assessment onto their plan sponsor clients, but the TPA remains liable for the tax, and will be assessed a penalty if payment is not made. The liability remains even if the TPA is unable to recover those assessments from its plan sponsor clients. In certain cases, if the TPA fails to pay the tax due to a failure of the plan sponsor client to pay the assessment, the plan sponsor may hold the ultimate liability for the tax and penalties.

If a group health plan is serviced by both a TPA and a stop loss or excess loss insurer, both entities will be responsible for the assessment. However, the TPA will only be responsible for the assessment on 'paid claims' up to the point when the stop loss or excess loss coverage begins to apply. At that point, the stop loss or excess loss insurer will be responsible for the assessment applied to each 'paid claim' above the attachment point.

Under the HICA act, if a self-insured company uses a TPA for claims, they are both potentially responsible for the assessment. However, the assessment is due only once per each 'paid claim'. The statute lays out a clear hierarchy of responsible payers when two covered entities are involved with the same 'paid claim'. In Michigan, the act provides that "group health plan sponsors shall not be responsible for an assessment... for a paid claim where the assessment on that claim has been paid by a third party administrator."

When a TPA does not act as the paying authority, but only as the processing agent of the claim, they are still required to pay the one-percent HICA act assessment on claims that they process. This remains true even if the claims are paid directly from the client's bank account and not from the assets of the TPA.

The HICA act neither permits nor prohibits an employer from passing the cost of the HICA assessment on to its employees. If a covered entity elects to pass the assessment through to their clients or insured persons, the one-percent assessment remains the responsibility of the covered entity. Therefore, if the client or insured person cannot or does not pay the assessment, the covered entity is still liable for the one-percent assessment, and will be subject to review or penalties for failure to do so. For self-insured plans, the administrator is directly responsible for the tax; the plan sponsor may see an increase in premiums in order to offset the cost.

Indemnity only insurance products, claims paid under federal employee health benefit programs, claims-related expenses, claims paid for services provided to non-residents of Michigan, claims paid for services provided outside of Michigan state, claims paid for high risk pools, and claims issued for a Health Care flexible spending or savings account are not subject to the assessment.

III. Program Administration

Actual collection of the HICA is administered by the Michigan Department of Treasury, but responsibility for different aspects of the program is shared between the Treasury and the Office of Financial and Insurance Regulation, the Michigan state insurance bureau. The role of the OFIR is two-fold: first, it is responsible for licensing and regulating most of the entities liable for this tax (i.e., insurance carriers, excess loss carriers, and TPAs), all of whom must be licensed by OFIR. As the licensing agency, OFIR also possesses the record list of potentially liable entities. Second, liable organizations are required under HICA to develop and file with OFIR a methodology for collecting the assessment across lines of business and from their individual or employer clients. The Department of Treasury is responsible for actual collection and administration. Specific responsibilities of the Department include the following:

1. Collect quarterly and annual HICA tax return filings
2. Collect quarterly HICA assessment EFT payments and perform year-end reconciliation
3. Provide an annual report to the state budget director and legislature on the revenue collected for the prior year
4. Provide an annual report on the costs incurred for administration of the assessment and related compliance activities
5. Conduct audits and record examinations as required and allowed under Michigan tax laws
6. Assess penalties and interest
7. Hear and adjudicate appeals

Before the HICA act became effective, notices were sent out to many TPAs, carriers, and self-insured entities that may be subject to HICA. These notices outlined the steps to register with the Treasury and apply for the EFT credentials necessary to establish their quarterly payment policies. Entities who self-determine that they are not subject to HICA are able to indicate in writing to Treasury why they believe they are not liable; final determination is made after review by the department.

All HICA payments are made via EFT; other forms of payment are not accepted by the Treasury. Payments in Michigan are to be made quarterly, with the first payment due on April 30, 2012. These payments reflect the amount of assessment applied to the previous calendar quarter's paid claims. An annual return is also submitted, outlining the four quarters of payment made by the covered entities. On both the quarterly and annual return for the HICA Act assessment, covered entities are

required to show both the gross paid claims and each type of exclusion from the gross as a separate line item (e.g., member cost sharing, claims for accident-only or health-related automobile policies, etc.).

The assessment cannot exceed \$10,000 per insured individual per year. This cap has been interpreted as applying to each insurer or TPA individually, meaning that if an individual has multiple insurers, that individual has a \$10,000 cap with each insurer or TPA. If a carrier or TPA fails to pay the assessment, a penalty equal to 5% of the assessment applies after the first two months of unpaid tax. An additional 5% penalty applies for each month in default, following the initial two months. There is a maximum penalty of 25% of unpaid tax. The authority and responsibility for auditing assessment payments and liabilities is held by the Treasury, as outlined in Michigan revenue statutes.

In Michigan, HICA has a revenue cap of \$400 million per year (adjusted annually for medical inflation); if this level is exceeded, the surplus is refunded to payers of the tax. If the payer is a TPA, it is the responsibility of the TPA to refund the credited amount to the entity for which it processed the claim. However, any credit/refund received by the carrier or TPA shall be immediately applied to the succeeding years' assessment. If the carrier or TPA has no liability on which to apply the credit, or the HICA has become ineffective, any unused credit will be issued as a refund to the payer.

IV. Administrative Challenges

The application of the assessment to self-insured payers presented a few administrative challenges to the state, including (1) estimating the total value of self-insured claims payments to set the assessment and estimate revenue yield; (2) identifying liable parties to assess; and (3) developing a method to enforce the assessment on those employers that do not self-identify or file. Because the state does not have regulatory oversight over self-insured payers, there was no hard and fast data source to inform these issues. Rather, the state worked with available data and market information to develop estimates in these areas. To estimate the level of self-insured claims in Michigan to establish an appropriate assessment rate and estimate the level of funding that would be generated by the assessment, the state contracted with a consulting actuary to conduct a study of the self-insured market and estimate the current level of self-insured claims payments. Because the majority of self-insured business is administered by health carriers in Michigan, issuer annual statement filings were an important starting point for this investigation. To identify liable entities and spread the word to employers and payers about their tax liability, the state worked initially with trade associations and issuers to reach member employers and administrators. Licensed TPAs were also known to the state through separate regulatory requirements. In addition, Treasury was able to identify firms likely to be liable for the assessment by using SIC code information from business tax filings. Now that the state has collected two quarterly assessment filings, the ability to definitely identify self-funded payers remains a consideration for the state as it considers options for enforcement of the assessment.

Timing of cash flows has been another challenge for Michigan. Because the assessment applies to new and renewal business only, there was a time-delay between when the assessment became effective and when revenue was yielded. This was particularly true for fully-insured business, as assessments are not paid until policies are purchased or renewed and claims begin to be incurred under the new or renewed policies. For planning purposes, understanding this time delay and the factors that will effect it (e.g., the most common renewal dates for existing policies) will be important for Illinois to consider. The magnitude of time delay in cash collections will be driven in

part based upon the time relationship of when an assessment became effective compared with the preponderance of renewals and the carrier pricing schedule. (For example, if the assessment became effective in April, and most policies renew in January, there would be almost a 12-month delay from the effective date of the assessment and the first quarterly assessment payment (assuming it took place in March or April of the following year)).

Additional administrative considerations related to the implementation of HICA involved tax payer services and public information. Both the Treasury Department and the OFIR received a high volume of phone calls and inquiries from employers and payers related to their obligations under the assessment. Both departments managed this proactively by conducting public outreach meetings to inform the public, providing robust online information, and maintaining detailed FAQ pages on the internet.

V. Legal Challenges

The Michigan HICA law was challenged on ERISA preemption grounds by the Self-Insurance Institute of America (SIIA) on behalf of self-funded payers. The SIIA complaint was filed on December 22, 2011, and it sought an injunction against the implementation and enforcement of HICA. During the litigation process, Michigan moved forward with the collection of the first two quarterly assessment payments. On August 31, 2012, the United States District Court for Southern Michigan dismissed the case by ruling that the ERISA preemption clause was not applicable to the HICA tax.⁸ The court's ruling, based upon Supreme Court and Appeals Court case law, found that the imposition of a tax on all third party payments for medical services did not touch on aspects of state laws or regulations that are preempted by ERISA (e.g., benefit structures, enforcement mechanisms, or administrative functions) and was not specifically targeted at or uniquely applicable to ERISA plans. Quoting prior Supreme Court case law, the decision stated that "Congress did not intend . . . for ERISA to preempt traditional state-based laws of general applicability that do not implicate the relations among the traditional ERISA plan entities, including the principals, the employer, the plan, the plan fiduciaries, and the beneficiaries," and noted that the HICA law did not meet this standard.

The ruling of the federal court in Michigan discussed above has been shared here for informational purposes and may not reflect or predict the likely outcome of a similar challenge to any potential Illinois-specific revenue mechanism structured similarly to the model adopted in Michigan.

ICHIP ASSESSMENT

I. Background

The Illinois Comprehensive Health Insurance Plan (ICHIP) was created by the Illinois General Assembly in 1987 and is overseen and administered by an independent board of directors. ICHIP is divided into two separate pools that are governed and financed differently. The first pool, known as the traditional pool and determined under Section 7 of the CHIP Act, provides access to health insurance coverage for certain Illinois residents who have been denied major medical coverage by a

⁸ The ruling was accessed at the following URL:
<http://www.legale.com/xmlresult.aspx?page=2&xmldoc=In%20FDCO%2020120904623.xml&docbase=CsLwAr3-2007-Curr&SizeDisp=7>

private insurer because of their health. The traditional plan is also available for people who are enrolled in both Parts A and B of Medicare due to disability or end-stage renal disease, and to other federally eligible individuals who are not eligible for any other type of coverage. The second pool, known as the HIPPA pool and determined under Section 15 of the CHIP act, provides access to health insurance coverage pursuant to the portability requirements of HIPPA, and as a qualified health plan for individuals who qualify for the federal Health Coverage Tax Credit (HCTC).

By law, ICHIP premiums must be at a percentage, known as the 'multiplier,' between 125% and 150% of the rate charged in the private sector. When determining rates, the state is divided into four geographic rate areas that reflect the relative differences in the cost of medical care in those areas. The basis for area rating is the participant's county of residence, except for the City of Chicago. For 2010, the average annual premium across all ICHIP pools was \$7,048

ICHIP was established as a state program that intended to provide an alternate market for health insurance for certain uninsurable Illinois residents, and further is intended to provide an acceptable alternative mechanism for HIPPA. The act guarantees coverage for those in the HIPPA pool, but makes no such guarantee for those enrolled in the traditional pool.

ICHIP's two pools are funded differently. Section 7, the traditional plan, is funded through a combination of member premiums and appropriations from the General Funds. Section 15, the HIPAA pool, is funded in part by the premiums paid by its members, with the remainder of cost being covered by an assessment levied on health insurers doing business in Illinois. It is important to note that the assessment is only used to fund the Section 15 (HIPAA) pool, and no funds levied are used to pay for Section 7 (traditional pool) costs. The level and rate of assessment is determined based upon the level of deficit incurred or expected to be incurred on behalf of individuals enrolled in the HIPPA pool. The ICHIP board goes through an annual process to establish both the level of member premiums and anticipated deficit projection to establish the required rate of assessment necessary to balance the pool.

II. Liable Entities

The assessment is levied on all Direct Illinois Premium Revenue for accident and health coverage, including premium revenue of life, health, property & casualty, HMOs, and voluntary health service plans. It also includes premium revenue received by stop-loss carriers for the coverage they underwrite for self-insured employers and other carriers. According to the Illinois DOI, there are three types of stop-loss coverage sold in Illinois – coverage sold by authorized issuers, certain types of coverage sold to Industrial Insured firms (i.e., coverage procured by large self-insured firms), and reinsurance sold through surplus line producers. It appears that the ICHIP assessment incorporates premium revenue from the first and largest of these groups (authorized insurers).

Any deficit incurred or expected to be incurred on behalf of federally eligible individuals who qualify for plan coverage under Section 15 of the CHIP Act is the responsibility of all insurers and is paid through an annual assessment. Within the first quarter of each fiscal year, the ICHIP board assesses all insurers for the anticipated deficit. The board may also make additional assessments no more than four times a year to fund unanticipated costs.

III. Program Administration

In order to calculate the needed assessment levels, the ICHIP board must first determine the deficit amount of the HIPAA pool. Total plan expenses including incurred losses, agent referral fees, administrator fees, and CHIP Board office expenses are subtracted from total plan income including total premiums, net of refunds, and investment income. The remaining balance becomes the deficit amount that becomes the responsibility of all insurers operating within the state.

The liability of an individual carrier assessment is determined by multiplying the total assessment, as determined above, by the percentage of total direct premiums paid by the individual insurer. The basis for distributing the assessment is Annual NAIC Financial filings supplied by the Department of Insurance. The assessment allocation basis is the share of Illinois direct premium revenue, less Medicare and FEHBP. Carriers for whom the assessment amount is so minimal that it would not exceed the estimated cost of levying the assessment may be exempted. Assessment amounts are communicated to carriers and collected by the board, which may also apply penalties for past due amounts. Carriers have appeal rights and may also petition for abatement. The amount of any abatements granted are reassessed against the other insurers in the market in the same manner described above.

The assessment amount is established annually and is typically finalized by ICHIP in July or August. Typically, the board reviews the assessment calculation during their August meeting, and invoices are sent immediately thereafter. Carriers can elect to make one lump-sum payment within 30 days of assessment or pay in quarterly installments. Based on pool performance and updated deficit projections, ICHIP may invoice carriers for supplemental assessments if they project a deficit in the pool that will require additional funding. Funding and pool balances are determined based on an accrual basis for claims incurred during the year. The assessment level is set to balance payment liabilities and collected assessment for the fiscal year, inclusive of all services that were incurred during the fiscal year (even if claims payments are made later). ICHIP is required to balance the assessment pool for actual experience, and may only assess for the projected deficit. The board engages in a two-year look-back period for reconciling payments and collections. If it is determined that over-assessments were made, a pro rata credit is provided to carriers.

ICHIP METHODOLOGY PLUS STOP-LOSS CARRIERS

I. Background

In order to broaden the basis of assessment beyond fully insured carriers, Illinois has requested that we explore a funding option that would include premium collections by stop-loss carriers for self-insured clients. As context, stop loss coverage is typically sought by self-insured employers or by insurance carriers to offset potential losses from extremely high-cost individuals. Because these cases are relatively rare and difficult to predict, stop loss coverage provides a form of catastrophic risk protection to these entities.

Because stop loss coverage applies to a narrow sub-set of the insured population and to a narrowly defined portion of the total claims cost incurred by these members, the total premium revenue devoted to stop loss coverage is a small fraction of total health insurance premium value. For carriers that use stop loss insurance, stop loss premium payments would generally be expected to

constitute roughly 1-2% of total premium revenue. Market wide, the percentage is likely even smaller because large national carriers commonly self-reinsure. Because the premium base for stop loss insurance is so much lower than the major medical premium base, expanding an ICHIP-like assessment to this market would not significantly expand the revenue base from which to fund the Exchange. This is particularly true because a portion of the stop loss market (as discussed below) is already assessed under the ICHIP methodology.

II. Types of Stop Loss Insurance Sold in Illinois

In Illinois, there are three different types of stop loss policies sold; each is regulated somewhat differently. The three types are: (1) policies sold through “authorized companies”; (2) those sold to “industrial insured” companies; and (3) those sold by non-authorized companies through surplus line producers. Of the three types, premium revenue earned by “authorized carriers” is already subject to the ICHIP assessment. Premium revenue from the other types (industrial insured and surplus line) is not currently assessable. The relative share of membership and premium revenue across these three types of stop loss coverage is not known, as detailed reporting is not currently required by the Department of Insurance. While there may be additional revenues that are not subject to the ICHIP assessment, as indicated earlier, the overall scale of premium revenue in comparison with major medical is small.

Authorized companies

An authorized company is one that is a licensed carrier that is registered and authorized to issue insurance policies within the state of Illinois. Because they are registered with the state, there is data available that outlines the number of issuers and the number of policies that are sold. Because the Department has a relationship with these companies, modifying reporting requirements to include either premium revenue or greater granularity related to covered lives makes it feasible to calculate an assessment that could be levied on these policies.

Industrial insured

The industrial insured are large employers that have internal staff or retained consultants to manage their health benefits. Companies with aggregate annual premium values of at least \$100,000, at least 25 full time employees, and gross assets greater than \$3,000,000, or gross revenues greater than \$5,000,000, qualify as industrial insured and are not subject to the same regulation and reporting requirements governing smaller firms. Industrial insured are allowed to purchase their insurance from unauthorized companies, or out-of-state suppliers. When a stop loss policy is issued from an unauthorized or out-of-state company, the Department of Insurance has no mandate to obtain or retain any of their enrollment or premium information.

Surplus Line

Surplus line producers are insurance producers or brokers that are licensed to procure a policy on behalf of their client in certain situations (e.g., the non-availability of a given benefit or coverage type) from an insurer that is not licensed or registered in the state. Due to the lack of Illinois regulations over these insurers, they are exempt from certain regulations which allows for increased flexibility for accepting risk and designing plans.

The state currently receives reporting from surplus line producers and also levies a tax on gross premiums for these products. Surplus line producers must file a report with the Director of Insurance detailing gross premiums, less returned premiums, on surplus line business procured. The surplus line tax is assessed at a rate of 3.5% on gross premiums, less returned premiums, with a stamping rate fee of 0.1% of premium. This tax is collected semiannually on August 1st and February 1st.

III. Program Administration

The primary considerations related to program administration are, first, that there is limited current data available related to the size of the stop loss market that is not already captured as part of the ICHIP methodology. This is relevant, on the one hand, because there may not be a significant funding opportunity based on the possibility that the market share not currently captured is quite small. On the other hand, this lack of current information is relevant because were such an approach to be selected, new reporting requirements would be necessary to provide the appropriate information base upon which to base and enforce assessment collections. Because the types of policies sold in the industrial insured and surplus line stop loss markets are separately regulated, creating such reporting requirements may require regulatory changes.

The second set of considerations is that the total revenue for stop loss insurance is much lower than the total revenue base for major medical policies. While the total stop loss market in terms of covered lives may be large, the value of these policies relative to major medical coverage is relatively small. Therefore, basing a revenue mechanism on stop loss premium revenue is not likely to effectively “expand” the assessment base beyond the fully insured market.

Assessment of Selected Funding Options

As indicated at the beginning of this report, there are several types of criteria that the Exchange should consider when considering alternative financing options. To help facilitate the state’s review of Exchange financing options, Wakely assessed the three options under consideration along four dimensions: Assessment Base and Market Impact, Administrative Feasibility, Risks and Other Considerations, and Financial Impact. The estimates for financial impact are intended to provide a high-level approximation for the potential impact from these assessments. For purposes of this exercise, and to maintain consistency with existing ICHIP funding models, Wakely relied upon the most recently available funding base information employed as part of the ICHIP assessment development to determine the total amount of fully-insured premium revenue in Illinois, and estimated the relative share of self-insured coverage and claims payments based on national estimates of the share of large group members covered in self-funded plans. As mentioned earlier, roughly 60% of covered employees nationally obtain coverage through a self-funded plan. To the extent that Illinois seeks a broad-based funding strategy, both the relative and increasing size of the self-insured pool are important considerations when determining an appropriate funding strategy.

Health Insurance Claims Assessment

A health insurance claims assessment, similar to the program adopted in Michigan, would represent a broad-based assessment of all commercially insured individuals across both fully insured and

self-funded plans. Spreading the costs broadly in this way will allow for a low overall rate of assessment and allow for a relatively high degree of stability in the funding source. Establishing such a mechanism would require the development or remediation of funds collection and assessment calculation infrastructure. However, the bulk of likely assessable entities (carriers and TPAs) are licensed by and known to the Department of Insurance, and could readily be contacted for purposes of assessment.

Assessment Base and Market Impact

Pursuing an assessment on paid claims will result in a broad based assessment that applies to both fully and self-insured payers. Using this broad base for assessment will result in a very low rate of assessment to cover Exchange expenses and will result in an increased level of stability and predictability in the funding stream relative to more narrowly defined funding mechanisms. However, like any other market-based revenue streams, such a funding source would be subject to macro-economic shifts and trends, such as a reduction in health coverage stemming from an economic downturn (potentially paired with increased demand for Exchange products). Other considerations include:

- Treating fully- and self-insured uniformly will reduce employer incentives to become self-insured to avoid assessment
- Because this mechanism would apply to coverage both within and outside of the Exchange, it diminishes any incentive to forgo purchasing through or participating in the Exchange.
- Because this mechanism will apply to all payers, it will not create a disincentive for carrier to participate in the Exchange
- Limiting the assessment to paid claims will not capture insurance administrative and overhead costs (which are captured in premium based assessment)
- The adoption of a broad funding base will provide a high level of sustainability to the funding source and shield the funding stream from ongoing changes in insurance funding basis (self- vs. fully-insured)

Administrative Feasibility

Pursuing this strategy would require the establishment of a new funds collection mechanism and process, along with related processes such as audit, verification, and appeals. However, the state could likely leverage or repurpose existing business tax or assessment processes to implement this type of program. This would have staffing and overhead implications for the administering agency and require additional reporting on the part of assessable entities. For example, in Michigan, an initial appropriation of \$1 million was made for the implementation of the program. Aside from the need to establish a filing process, potential system upgrades to accept reports and accept funds, there are a few other considerations worth noting:

- The DOI licenses all carriers, stop loss carriers and TPAs, so identifying assessable parties will be facilitated by these existing

	<p>regulatory relationships</p> <ul style="list-style-type: none"> • There is no current reporting or existing administrative data related to necessary metrics from these entities; the state would need to collect this information in the short term to set the assessment level initially, and would then have to create ongoing enhanced reporting and/or filing forms and processes • Because self-funded payers will also be subject to ACA temporary reinsurance assessments, the state (or, upon state election and as allowed under final reinsurance regulations issued in March 2012, the federal government) will need to develop a process to assess these parties in any event.
<i>Risks and Other Considerations</i>	<p>The most significant risk related to such a funding mechanism is related to the potential for an ERISA challenge related to the state's authority to assess self-insured employers. The HICA law in Michigan has been challenged on an ERISA basis by an organization of self-insured employers; on August 31, 2012, the United States District Court for Southern Michigan dismissed the case by ruling that the ERISA preemption clause was not applicable to the HICA tax.⁹</p> <ul style="list-style-type: none"> • Because the Michigan program was initiated in January 2012, there is not yet much experience to draw on related to the impact on the market or administrative processes resulting from this program. • If this assessment is implemented and run as tax program with funds entering the general fund, the potential exists for the Exchange to compete for general fund appropriations.
<i>Financial Impact</i>	<ul style="list-style-type: none"> • The estimated cost of the operating the Exchange in 2015 would be approximately 0.22% - 0.34% of combined fully/self-insured claims costs.¹⁰

Existing ICHIP Assessment

The current ICHIP method is based on spreading a fixed amount of required funding (the amount required annually to fund the expected HIPAA high risk pool deficit) that is determined each year and allocated to individual carriers based upon their share of direct Illinois premium revenue. To leverage this process or methodology to finance the Exchange, Illinois could either employ a similar methodology (for example, by calculating an amount needed to finance the Exchange and allocating the portion due from individual insurers on the basis of their market share of premium revenue) or

⁹ The ruling was accessed at the following URL:
<http://www.leagle.com/xmlresult.aspx?page=2&xmlDoc=In%20FDCO%2020120904623.xml&docbase=CslwAr3-2007-Curr&SizeDisp=7>

¹⁰ This estimate is based on estimated Exchange operating costs of \$57 - \$88 million and estimated claims payments of \$25.1 billion.

adopt a different, metric-based mechanism applied to the same funding base (for example, setting an Exchange funding assessment as a fixed percent of net premium revenue). Adopting the first approach would place a ceiling on the overall operating expenses of the Exchange, although would allow the Exchange to potentially update the assessed amount annually or periodically to align revenue with expenses. The second would provide a fixed amount of revenue based on market premium volume, but could potentially increase (or decrease, in the event of economic downturn) naturally over time in line with changes in overall premium revenue.

Assessment Base and Market Impact

While not quite as broad as a health claims assessment, basing the Exchange revenue model on the insured revenue base currently used to fund ICHIP will result in a fairly broad assessment, a similarly low overall rate of assessment, and an increased level of stability and predictability in the funding stream relative to more narrowly defined funding mechanisms.

- The funding basis in this option would be primarily limited to fully insured plans only and would not include the self-insured. Relative to a model that applies to self-insured employers, this would reduce the base for assessment but preclude risk of ERISA challenge.¹¹
- The result would be a slightly higher rate of assessment on fully insured business and therefore a very modest risk of incenting employers already considering becoming self-insured to do so.
- This method is also not a disincentive for HIX participation because it captures all of fully-insured market rather than Exchange-only premiums

Administrative Feasibility

Because this method would be based on an existing administrative process, there would be administrative advantages to this approach:

- An existing process is already in place, so the method is familiar to the market and would be relatively easy to set up administratively by leveraging existing staff, processes, and infrastructure;
 - Information required to establish and track the amount of assessment is already captured through existing processes, so no additional reporting requirements or filing processes would be required.
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¹¹ On August 31, 2012, the United States District Court for Southern Michigan dismissed the case by ruling that the ERISA preemption clause was not applicable to the HICA tax. The ruling was accessed at the following URL: <http://www.leagle.com/xmlresult.aspx?page=2&xmlDoc=In%20FDCO%2020120904623.xml&docbase=CslwAr3-2007-Curr&SizeDisp=7>

<i>Risks and Other Considerations</i>	<p>Relative to a methodology that expands the base of assessment, the result would be a slightly higher rate of assessment on fully insured business and therefore a very modest risk of incenting employers already considering becoming self-insured to do so.</p> <ul style="list-style-type: none"> • To the extent that the trend towards self-insured coverage continues, the basis for assessment will gradually shrink over time. This trend will likely be offset in the near term by an expansion of coverage under the ACA.
<i>Financial Impact</i>	The estimated cost of operating the Exchange in 2015 would be approximately 0.34% - 0.53% of fully insured premium revenue. ¹²

ICHIP Assessment Including Stop-Loss Carriers

The current ICHIP assessment includes premium revenue for certain stop loss carriers, so a funding mechanism based upon the existing ICHIP process would only be an expansion on the ICHIP method if it captured revenue from currently non-regulated stop loss business or shifted the basis for assessment from premium revenue to membership or covered lives.

<i>Assessment Base and Market Impact</i>	This approach expands the current ICHIP assessment base mentioned above by including premium revenue from a sub-set of stop-loss carriers not currently assessed using the ICHIP methodology. Currently, certain stop-loss policies fall outside the state regulations and are therefore not captured in the existing assessment. However, the total value of revenue in this market is very small in comparison with major medical coverage. Pursuing this assessment would require additional or expanded regulatory authority for the state in order to capture the entire market, but would not significantly expand the revenue base.
<i>Administrative Feasibility</i>	There are certain administrative advantages to building off of an existing process. However, certain administrative burdens will be introduced if this option is adopted. Most notably, a portion of the stop loss market (industrial insured and surplus line), the magnitude of which is difficult to quantify, is subject to different regulations than licensed or authorized plans. As a result, there is little current information related to the assessable parties, membership, and premium amounts.

¹² This calculation is based on estimated Exchange operating costs of between \$57 and \$88 million and assessable premium revenue \$16.7 billion (ICHIP CY 2010).

<i>Risks and Other Considerations</i>	<ul style="list-style-type: none">• Because of its indirect impact on self-insured plans, such an option may also be subject to challenge on the basis of ERISA
<i>Financial Impact</i>	<ul style="list-style-type: none">• Due to the small scale of value in the stop loss insurance market relative to major medical, and the fact that this method captures only a share of additional stop loss coverage, this method is not anticipated to yield results substantially different from those captured under the ICHIP methodology as it currently stands. We estimate the rate of assessment would be between 0.34% and 0.52%¹³.

¹³ Assumes that residual stop loss premium not currently assessable under ICHIP is 1% of total fully insured premium revenue.