MARSH & McLENNAN AGENCY

SPECIAL ALERT

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POTENTIAL REPEAL OF THE HICA

The Michigan Health Insurance Claim Assessment (HICA) was instituted as of January 1, 2012. It is a tax applied to claims paid by group health plans (insured and self-funded plans). The funds collected were used to fund Michigan's Medicaid program. Insurance carriers and third party administrators (TPAs) paid this assessment to the state. Ultimately, however, employers funded this assessment.

In June 2018, Governor Snyder signed into law three separate bills designed to replace the HICA. The three bills are as follows:

- **SB992** – Repeals HICA
- **SB993** – Amends the Use Tax Act to delete a provision that reinstates the state's Medicaid managed care use tax on July 1, 2020, or if HICA is repealed or the rate is reduced to 0%, whichever is sooner.
- ***SB99***4 – Creates the **Insurance Provider Assessment Act ("IPA")** to account for the HICA repeal and the elimination of the triggering event to reinstate the Medicaid managed care use tax.

These bills have a proposed effective date of October 1, 2018. However, they need the approval of the Centers for Medicare and Medicaid Services (CMS). These bills are linked. All the bills must be approved for any bill to go into effect. If CMS has not approved these changes by October 1, 2018, the effective date will be the first day of the first calendar quarter following CMS approval.

HICA did generate revenue to fund Medicaid but it generated far less revenue than was initially expected. In addition, HICA was scheduled to sunset in 2020. The Insurance Provider Assessment Act (IPA) will be a different way for Michigan to collect funds for Medicaid.

IPA may be more favorable for many employers. Insurance providers will pay this fee monthly for member months.

Member months are defined as the total number of people for whom the ***insurance provider*** has recognized revenue for one month. The Department of Insurance and Financial Services would determine member months.

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We welcome your comments and suggestions regarding this issue of our Special Alert. For more information, please contact your Account Manager or visit our website at www.mma-mi.com.

The count will not include anyone enrolled in any of the following:

- Short-term medical plans (1-time limited duration)
- Non-comprehensive medical coverage including specified disease, limited benefit, and accident only coverage
- Accidental death and dismemberment coverage
- Disability income coverage
- Long-term care coverage
- Medicare supplement, Medicare, Medicare Advantage and Medicare Part D plans
- Stand-alone dental, vision and, prescription coverage
- Federal employee health benefit plans and Tricare
- Stop-loss, excess-loss coverage, administrative services only, or administrative services contracts

An ***insurance provider*** is defined as a Medicaid managed care organization or a health insurer. A health insurer is an insurer authorized under the Insurance Code to deliver, issue for delivery, or renew a health insurance policy in Michigan. It includes health maintenance organizations, but does not include a state department or agency administering a plan under the Social Welfare Act or a person administering a self-funded plan.

The assessment depends on the provider and circumstances:

- **Tier 1** - Medicaid managed care organizations will pay fixed and variable rates as follows:
  - For the number of member months and the dollar amount necessary per member month, as determined each year by DHHS, to achieve a result of between 1.00 and 1.02 on the statistical test imposed by CMS (described above).
  - For each remaining member month not assessed as above, $1.20 per member month.
- **Tier 2** – Health insurers (includes HMOs) will be subject to a tax of $2.40 per member month (not supported with federal Medicaid funds)
- **Tier 3** - Prepaid Inpatient Health Plans will be charged a fixed fee of $1.20 per member month (for all member months not supported with federal Medicaid funds)

WHAT DOES THIS MEAN TO EMPLOYERS?

These proposed changes would benefit self-funded employer group health plans. These plans were subject to the HICA but will not be subject to the IPA. Once the change to the IPA goes into effect, self-funded plans will no longer need to budget for the 1 percent health insurance claim assessment. Insured plans will need to start budgeting for the IPA. However, the calculation will be complicated and likely the IPA will simply be built into insured rates.

Remember, these changes will go into effect only after CMS approves them. Please contact your Marsh & McLennan Agency | Michigan Vice President with any questions.MMA

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