THE NATIONAL CENTER FOR COVERAGE INNOVATION AT FAMILIESUSA

A Golden Opportunity for States to Make Health Insurance More Affordable: Rapid Action Required

Executive Summary

If states act quickly, they can significantly lower residents' health insurance costs by claiming revenue the federal government is about to abandon. In December 2019, Congress ended the federal government's health insurance assessment (HIA), effective January 1, 2021. If states pass legislation in 2020, they can create replacement assessments on insurance companies that capture $14 billion a year without raising insurers' payments above current levels. (Table 1).

One important difference between a state HIA and the expiring federal HIA involves the use of assessment dollars. Originally applied to prevent the Affordable Care Act (ACA) from increasing the federal budget deficit, the federal HIA now funds the national government's general operations. It is not targeted to any specific use. By contrast, a state can direct its HIA revenue to lower families' health costs in ways that benefit not just consumers but also insurers and even small employers.

The ideal structure of health insurance assessments will vary from state to state, but all states face one common truth: If they do not act in 2020, they will lose out on a significant potential revenue stream that is now available without raising assessments on insurers. States that seize this current opportunity could benefit for years to come, leveraging revenue to greatly lower health care costs for struggling families.

Table 1. Revenue from a State Health Insurance Assessment that Replaces the Expiring Federal Assessment, by State and Market Subject to Assessment: 2021 (thousands of dollars)

	Individual Market	Small-Group Market	Fully Insured Large-Group Market	Medicaid MCOs	Total
AK	$6,566	$4,060	$15,087	$-	$25,713
AL	$42,908	$32,834	$64,764	$305	$140,811
AR	$54,958	$10,667	$29,827	$-	$95,452
AZ	$45,210	$25,977	$64,329	$80,662	$216,178
CA	$324,449	$301,712	$1,087,986	$436,410	$2,150,557

	Individual Market	Small-Group Market	Fully Insured Large-Group Market	Medicaid MCOs	Total
CO	$33,057	$33,052	$71,306	$5,248	$142,663
CT	$29,285	$28,795	$59,789	$-	$117,869
DC	$4,040	$13,546	$90,855	$24,474	$132,915
DE	$5,697	$5,896	$13,585	$-	$25,178
FL	$280,783	$79,996	$294,393	$386,115	$1,041,287
GA	$79,558	$40,473	$142,289	$100,418	$362,738
HI	$5,307	$17,217	$60,127	$22,208	$104,859
IA	$23,391	$22,372	$44,730	$111,528	$202,021
ID	$14,646	$8,901	$24,368	$-	$47,915
IL	$88,974	$93,180	$266,156	$195,052	$643,362
IN	$21,722	$27,787	$59,145	$102,576	$211,230
KS	$25,224	$19,343	$45,303	$79,256	$169,126
KY	$19,114	$17,637	$49,783	$142,653	$229,187
LA	$34,973	$29,826	$64,215	$180,321	$309,335
MA	$15,284	$30,776	$119,205	$41,601	$206,866
MD	$37,014	$36,016	$137,173	$134,602	$344,805
ME	$9,174	$7,061	$28,902	$-	$45,137
MI	$39,412	$52,220	$149,431	$167,123	$408,186
MN	$9,050	$33,252	$79,909	$42,831	$165,042
MO	$51,430	$33,592	$91,494	$44,565	$221,081
MS	$18,828	$11,772	$26,447	$62,404	$119,451
MT	$11,212	$7,180	$10,804	$-	$29,196
NC	$136,458	$41,379	$90,456	$-	$268,293
ND	$7,623	$8,779	$20,198	$8,102	$44,702
NE	$23,687	$10,255	$35,764	$31,588	$101,294
NH	$10,813	$8,396	$22,880	$7,476	$49,565

	Individual Market	Small-Group Market	Fully Insured Large-Group Market	Medicaid MCOs	Total
NJ	$65,879	$75,749	$171,531	$254,028	$567,187
NM	$7,773	$7,351	$20,269	$111,474	$146,867
NV	$17,314	$12,918	$45,853	$44,595	$120,680
NY	$43,101	$216,859	$353,025	$149,836	$762,821
OH	$41,001	$68,976	$149,298	$199,264	$458,539
OK	$33,152	$27,775	$55,602	$-	$116,529
OR	$22,572	$17,780	$69,573	$12,776	$122,701
PA	$92,316	$97,633	$237,488	$196,983	$624,420
RI	$4,372	$9,529	$19,763	$14,521	$48,185
SC	$44,043	$17,737	$48,030	$78,102	$187,912
SD	$8,058	$8,218	$13,956	$-	$30,232
TN	$54,855	$37,784	$68,233	$156,990	$317,862
TX	$167,229	$144,489	$307,185	$396,500	$1,015,403
UT	$14,632	$11,520	$43,996	$11,244	$81,392
VA	$63,054	$50,806	$158,484	$59,860	$332,204
VT	$6,164	$7,109	$5,821	$-	$19,094
WA	$39,234	$39,458	$133,268	$119,847	$331,807
WI	$39,574	$35,835	$125,195	$34,394	$234,998
WV	$8,066	$6,676	$19,858	$35,454	$70,054
WY	$6,846	$3,307	$5,328	$-	$15,481
Total	**$2,289,082**	**$1,991,458**	**$5,412,456**	**$4,283,386**	**$13,976,382**

Source: Chris Carlson, Glenn Giese, and Thomas Sauder, Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later. Oliver Wyman. August 28, 2018, https://health.oliverwyman.com/2018/08/new-analysis--how-the-acas-hit-will-impact-2020-premiums.html.

Note: The amounts shown are for coverage sold within each state. These amounts include both federal HIA revenue and additional premium costs that cover federal corporate income tax liabilities associated with the HIA. The latter could be captured through an additional state assessment to prevent for-profit insurers from experiencing a windfall due to a shift from federal to state assessment collection. "MCO" = managed care organization.

A Golden Opportunity for States to Make Health Insurance More Affordable: Rapid Action Required

Introduction

Perhaps the greatest single challenge facing consumers who rely on the individual market for health coverage is affordability. Inability to pay for insurance is by far the most common reason the uninsured give for lacking coverage.[1] Just 43% of consumers who qualify for federal premium tax credits (PTCs) have used that financial assistance to purchase insurance.[2]

Many state lawmakers have long wanted to make insurance more affordable. Often, they have been unable to do so because it required funding that was hard to find within state budgets. These policymakers now have an extraordinary opportunity, thanks to the federal government's phasing out of an assessment on health insurance companies. If states pass legislation in 2020, they can capture the revenue stream being abandoned by the federal government and use the money to make insurance more affordable, without raising assessments on insurers and without increasing state budget costs.

To explain the remarkable opportunity now facing states, this issue brief begins by describing the current federal health insurance assessment (HIA), which is being phased out on January 1, 2021.* It then analyzes state options for continuing the HIA on insurance sold within the state's borders, using the money to lower health costs for state residents. An accompanying issue brief, How States Can Use New Revenue to Lower Consumer Costs in the Individual Health Insurance Market,[3] explores in more detail how states can use this money to substantially lower residents' costs of health coverage and care.

The Federal Government's Health Insurance Assessment (HIA) Is Now Being Phased Out

The Affordable Care Act (ACA) included several funding sources that, together, prevented the legislation's coverage expansion from increasing the federal budget deficit. One source was an assessment on health insurance premiums. After the ACA passed, the revenue was not targeted to any specific use.

The HIA first took effect in 2014. Congress issued a one-year moratorium on the assessment for 2017 and a separate one-year suspension for 2019. The assessment is currently being charged and is built into 2020 premiums.

Insurance companies sought to repeal this assessment for years. The industry finally prevailed in December 2019, when Congress passed legislation to phase out the assessment on January 1, 2021.[4, 5]

Here's how the HIA works. Each year, the federal HIA is revised to produce specific amounts of revenue. The Internal Revenue Service (IRS) updates these total revenue targets based on overall health insurance premium growth. For 2020, the HIA's national revenue target is $15.5 billion.[6] Each insurer's payment is based on its share of all premiums that are subject to the assessment.

* Formally, the federal HIA is called a "Health Insurance Provider Fee." Colloquially, it has sometimes been termed, the "Health Insurance Tax" or "HIT."

The assessment applies to the following health insurance categories:

- Individual insurance
- Small group coverage
- Fully insured large group coverage
- Medicaid managed care organizations (MCOs)
- Federal employee and retiree coverage
- Medicare Advantage plans
- Medicare prescription drug plans

Insurance companies cannot deduct the federal HIA as a business expense. The premium increases that result from the HIA are thus classified as revenue for the purposes of determining corporate tax liability. To offset the resulting corporate tax increase, for-profit insurers raise premiums by amounts that are slightly higher than what is needed to pay the HIA.

If state lawmakers create state HIAs during their 2020 legislative sessions, they can capture most of the revenue the federal government is abandoning and use it to lower residents' health insurance costs.

State Have Many Options for Capturing This Revenue Without Asking Insurers to Pay More Than They Pay Today

If state lawmakers create state HIAs during their 2020 legislative sessions, they can capture most of the revenue the federal government is abandoning and use it to lower residents' health insurance costs. A state's insurers would continue paying their assessments, but instead of the money going to Washington, D.C., it would stay inside the state and help residents buy insurance.

One important difference between the expiring federal HIA and a replacement state HIA involves states' ability to decide how the money is used. The federal HIA provides general federal revenue. Although it offset the ACA's coverage expansion costs when the ACA was enacted, the funding has never been targeted for any particular use. By contrast, a state can direct its HIA funds to lower consumers' costs in the individual market. This can benefit, not just state residents, but also insurers by providing additional customers, improving the risk pool, drawing down additional federal dollars to support the individual market, and more. It thus gives insurers a way to benefit from the funding they provide, along with their customers.

States must act quickly to take full advantage of this opportunity. Only if a state HIA becomes effective by January 1, 2021, will the state be able to claim new revenue without insurers having to pay charges above 2020 levels.

Is a State HIA a Tax Increase?

Most states already require insurers to pay taxes or fees. A state HIA would thus increase the amount most states collect from insurance companies. But from an insurer's perspective, a state HIA would simply replace a federal HIA, without any increase in assessments. The money a state's insurers now send to Washington, D.C. — costs already included in 2020 rates — would come back to the state and be used to help residents obtain more affordable coverage and care. If that money is carefully directed, insurers that operate in the individual market could benefit, along with consumers.

Prior state experience is illustrative: **Maryland** created a state HIA that operated during the 2019 suspension of the federal HIA. The state HIA collected revenue that the state's insurers would have paid the federal government, had the federal HIA been in effect for 2019. The state used the money to finance reinsurance that lowered premiums in the individual market.

Republican Governor Larry Hogan, whose political identity centered around opposing tax increases in any form,[7] enthusiastically supported the legislation as making coverage more affordable without raising taxes. Insurers supported the initiative, along with legislators from both parties. Rather than speak of a "tax increase," news reports characterized Maryland's HIA as a law "that kept in place a tax on insurance carriers that Congress had eliminated at the federal level."[8] Because the state used the money to lower residents' health care costs, premiums fell by 13.2% in 2019 and another 10.3% in 2020.[9]

States That Enact An HIA Can Obtain Significant Revenue

A state-based HIA faces limitations that do not apply to the federal assessment. Unlike the federal HIA, states cannot impose an assessment on Medicare plans or on health insurance that covers federal workers and retirees. A state can assess only premiums charged in the individual market, the small group market, the fully insured large group market, and Medicaid MCOs. Even with those limitations, states can still collect more than 70% of federal HIA revenue.[10]

Table 1 (page 1), shows what each state could collect by keeping federal HIA levels in effect for insurers that provide coverage within the state's borders. Table 2 (see p. 7) shows that, with two market segments – the individual market and Medicaid MCOs – most state revenue would come from the federal government, rather than insurers or consumers:

- When consumers buy individual coverage with PTCs, the PTCs cover premium charges that result from insurance assessments. The vast majority of people in the individual market use PTCs, so the federal government pays 70% of all assessment costs in this market. On average, each $1 in assessment revenue that comes from non-federal sources is matched by $2.33 in federal assessment dollars that a state could use to make individual market coverage more affordable. The net impact can help carriers and lower costs for consumers, as happened in Maryland.
- Medicaid MCOs are paid by a combination of state and federal Medicaid dollars. The federal share varies by state and by population. Calculated conservatively, the federal government covers 59% of those costs, on average.[11]

Altogether, these federal contributions total at least $4.2 billion per year (table 2 on p. 8).

Table 2. Federal Contributions Included Within State Revenue from Health Insurance Assessment, by Market and State: 2021

State	Individual Market		Medicaid MCOs		Total Federal $ (thousands)
	$ (thousands)	% of Market Revenue	$ (thousands)	% of Market Revenue	
AK	$5,533	84%	$-	n/a	$5,533
AL	$33,055	77%	$221	72%	$33,277
AR	$9,002	16%	$-	n/a	$9,002
AZ	$37,545	83%	$56,471	70%	$94,016
CA	$190,204	59%	$218,205	50%	$408,409
CO	$16,359	49%	$2,624	50%	$18,983
CT	$17,097	58%	$-	n/a	$17,097
DC	$231	6%	$17,132	70%	$17,363
DE	$4,127	72%	$-	n/a	$4,127
FL	$238,486	85%	$239,237	62%	$477,722
GA	$66,860	84%	$67,310	67%	$134,171
HI	$2,416	46%	$11,775	53%	$14,190
IA	$21,052	90%	$68,869	62%	$89,921
ID	$11,014	75%	$-	n/a	$11,014
IL	$58,750	66%	$99,398	51%	$158,149
IN	$14,929	69%	$67,526	66%	$82,455
KS	$18,932	75%	$47,300	60%	$66,232
KY	$14,278	75%	$102,781	72%	$117,059
LA	$24,966	71%	$121,572	67%	$146,538
MA	n/a	n/a	$20,801	50%	$20,801
MD	$21,192	57%	$67,301	50%	$88,493
ME	$7,294	80%	$-	n/a	$7,294
MI	$24,937	63%	$107,092	64%	$132,030
MN	$3,818	42%	$21,416	50%	$25,233
MO	$43,042	84%	$28,949	65%	$71,991
MS	$14,515	77%	$48,525	78%	$63,040
MT	$7,522	67%	$-	n/a	$7,522
NC	$114,105	84%	$-	n/a	$114,105

State	Individual Market		Medicaid MCOs		Total Federal $ (thousands)
	$ (thousands)	% of Market Revenue	$ (thousands)	% of Market Revenue	
ND	$3,256	43%	$4,245	52%	$7,501
NE	$21,115	89%	$17,838	56%	$38,952
NH	$3,834	35%	$3,738	50%	$7,572
NJ	$37,540	57%	$127,014	50%	$164,554
NM	$4,478	58%	$81,889	73%	$86,367
NV	$10,541	61%	$28,229	63%	$38,770
NY	$17,913	42%	$74,918	50%	$92,831
OH	$27,171	66%	$126,792	64%	$153,963
OK	$28,572	86%	$-	n/a	$28,572
OR	$11,645	52%	$7,773	61%	$19,418
PA	$60,644	66%	$102,825	52%	$163,469
RI	$2,606	60%	$7,854	54%	$10,460
SC	$35,547	81%	$55,163	71%	$90,710
SD	$5,836	72%	$-	n/a	$5,836
TN	$47,178	86%	$103,770	66%	$150,948
TX	$135,092	81%	$245,077	62%	$380,168
UT	$11,738	80%	$7,592	68%	$19,330
VA	$50,868	81%	$29,930	50%	$80,798
VT	Data not available				
WA	$3,156	8%	$59,924	50%	$63,079
WI	$31,283	79%	$20,420	59%	$51,703
WV	$29,876	370%	$26,587	75%	$56,463
WY	$6,664	97%	$-	n/a	$6,664
Total	**$1,607,814**	**70%**	**$2,546,083**	**59%**	**$4,153,895**

Sources: Carlson, et al., Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later. Center for Consumer Information and Insurance Oversight [CCIIO], 2019. "2014-2018 Risk Adjustment Data and 2014-2018 Exchange Effectuated Enrollment and Payment Data;" Federal Register, 84, no. 232 (December 3, 2019): 66204-66206.

Note: For the individual market, estimates reflect the percentage of total individual market participants who buy coverage with PTCs, as reported by CCIIO. For Medicaid MCOs, estimates reflect the general program-wide Federal Medical Assistance Percentage, announced in the Federal Register for federal fiscal year 2021. The latter estimates are conservative, since no effort was made to estimate the impact of a higher FMAP for Medicaid expansion populations, the Children's Health Insurance Program, and certain other Medicaid categories. Limited data are available for Massachusetts and Vermont, which is why we present partial results for the former and no results for the latter state. Other states for which no Medicaid MCO revenue is included do not currently pay a federal HIA for this market segment, either because their Medicaid program does not use MCOs or for other reasons.

State HIAs Can Strengthen State Reinsurance Programs

Several states use waivers under ACA Section 1332 to provide insurance companies with reinsurance that covers certain high claims in the individual market that premiums would otherwise need to pay. This reduces premiums, including those charged for silver marketplace plans. The latter premiums determine PTC amounts, so premium reductions from reinsurance benefit the federal government. The federal government conveys its savings to the state via "pass-through payments" under the 1332 waiver.

An HIA can strengthen state reinsurance programs in two ways. First, the revenue can help pay for reinsurance. Second, even if not one cent of HIA revenue pays for reinsurance, a state HIA increases the state's receipt of federal pass-through dollars. That federal funding is based on the difference between PTC levels with and without reinsurance. If the federal HIA disappears without being replaced by a state HIA, silver premiums would be projected to decline by a small amount. That would lower the federal government's PTC costs without reinsurance, which in turn would reduce the state's pass-through payment. A state HIA prevents that cut to the state's federal pass-through dollars.

As noted earlier, the federal assessment is based on each insurer's national premium revenue, which makes it hard to know how much is being paid by a company's insurance sales within a particular state. Moreover, most current state insurance assessments impose a fixed charge on premiums, stated in percentage or dollar terms. That state-revenue infrastructure does not incorporate features of the federal HIA that distinguish between different kinds of carriers and different tranches of insurance company revenue.[12] A state HIA equaling roughly 2.75% to 3% of premiums is likely to fit most state circumstances in terms of total assessment amounts, but each state may need to do its own analysis.

While Using an HIA to Lower Consumers' Health Care Costs, a State Can Structure Its Assessment to Help Insurers and Small Employers as Well

As noted earlier, the insurance industry sought to repeal the federal HIA, which was not targeted to any particular use. By contrast, a state can define the uses of an HIA. The result can be a policy package that benefits not just consumers but also the insurers and employers that pay the assessment. However, lawmakers must carefully evaluate the landscape in their state before deciding how to proceed. Structuring the HIA to win support from industry can reduce the revenue available to help residents struggling with unaffordable health care costs.

Lower assessment levels. A state could garner significant revenue while cutting the assessment level to slightly below the amount that is now being charged. Doing so would let proponents argue that financial burdens on insurance companies would decline, even as the state still benefits from significant remaining revenue being abandoned by the federal government.

Individual market insurers. Insurers that sell health plans in the individual market could gain. If HIA funds are reinvested in the individual market, more customers could buy insurance, potentially improving the overall risk pool and lowering premiums. Our accompanying issue brief, How States Can Use New Revenue to Lower Consumer Costs in the Individual Health Insurance Market,[13] provides numerous examples of how helping consumers afford insurance significantly grew insurance markets in multiple states.

Group insurance and employers. Some states have major insurers that serve the group market but not the individual market. If a state spends its HIA revenue entirely on making the individual market more affordable, insurers in the group market could be paying but not gaining, unlike their cousins in the individual market. This could lead to opposition from insurers in the group market, as well as employers.

To address this potential opposition, states could devote a portion of their HIA revenue to provide employers with financial support for covering their workers. For example, fully refundable state tax credits could go to small businesses that insure their employees, to companies that offer coverage even though they have numerous low-wage workers, or to a more broadly defined set of employers.[14] For a state to take these steps without losing the ability to obtain revenue from Medicaid MCOs, it must act with care,[15] but the money garnered from employers can be recycled to benefit those employers, if needed to secure HIA enactment.

Medicaid MCOs. Opponents of a state HIA may argue that the Medicaid program would save money if the federal HIA expired without replacement by a state HIA. That could slightly lower MCO capitated rates. More than half of the savings would go to the federal government, but the remainder would go to the state.

If necessary to forestall opposition, proponents of state HIAs can respond by allotting a designated portion of state HIA revenue to the state general fund. In effect, that would let the state realize the fiscal benefits of an expiring federal HIA, while the state retains the federal contribution and uses it to lower insurance costs for residents. In taking this step, lawmakers could consider placing clear limits on general fund access to HIA dollars, lest future legislators seek to use that revenue for purposes unrelated to health care.

Insurers that sell health plans in the individual market could gain. If HIA funds are reinvested in the individual market, more customers could buy insurance, potentially improving the overall risk pool and lowering premiums.

Will consumers save money if the federal HIA expires without being replaced by a state HIA?

Probably not, for several reasons.

- If the federal HIA goes away without a state HIA taking its place, insurers could simply pocket any savings as profits.[16]
- Federal PTCs, not consumers, absorb most premium changes in the individual market. Only the minority of consumers who buy insurance without PTCs would benefit from premium reduction, if it occurs.
- Most importantly, states' use of HIA revenue to make individual market coverage more affordable could have a bigger impact on consumer costs than any small premium reduction that would result from an expiring HIA. As noted earlier, when Maryland imposed a short-term HIA during the federal government's 2019 HIA suspension, the state used that money to cut premiums by more than 22% over two years, swamping any impact of a continued HIA.

Conclusion

States have an extraordinary opportunity to substantially lower their residents' health costs by claiming significant revenue that the federal government will be leaving on the table starting in 2021. To claim this revenue without raising assessments on insurers, states must pass legislation in 2020. States can use several different approaches for structuring those assessments and allocating the resulting revenue. But in almost every state, people who buy their own insurance without an employer's help desperately need the kind of assistance that a state health insurance assessment could finance for many years to come.

Endnotes

[1] 45% of the uninsured say that the reason they are uninsured is that insurance costs too much. The second-most frequently cited reason, loss of employer coverage, is mentioned by just 21% of the uninsured. Jennifer Tolbert, Kendal Orgera, Natalie Singer, and Anthony Damico, Key Facts About the Uninsured Population (Kaiser Family Foundation, December 2019), http://files.kff.org/attachment/Issue-Brief-Key-Facts-about-the-Uninsured-Population.

[2] Kaiser Family Foundation, "Marketplace Enrollees Receiving Financial Assistance as a Share of the Subsidy-Eligible Population: 2019," State Health Facts, downloaded on February 17, 2020, https://www.kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] How States Can Use New Revenue to Lower Consumer Costs in the Individual Health Insurance Market." National Center for Coverage Innovation at Families USA. March 2020.

[4] Further Consolidated Appropriations Act, 2020, § 502, Public Law No: 116-94.

[5] For information about the HIA's timing, see IRS, "Health Insurance Provider Fee: 2017 Moratorium, 2019 Suspension and Repeal After the 2020 Fee Year – Questions and Answers," Page Last Reviewed or Updated 08-Jan-2020, https://www.irs.gov/businesses/corporations/health-insurance-provider-fee-2017-moratorium-2019-suspension-and-repeal-after-the-2020-fee-year-questions-and-answers.

[6] The exact amount is $15,522,820,037. IRS, Part III – Administrative, Procedural, and Miscellaneous Health Insurance Providers Fee; Procedural and Administrative Guidance, Notice 2019-50, https://www.irs.gov/pub/irs-drop/n-19-50.pdf.

[7] Luke Broadwater, "Larry Hogan Is Using an Old Playbook to Attack a Plan to Transform Maryland Schools. What Does He Hope to Gain?" Baltimore Sun, November 8, 2019, https://www.baltimoresun.com/politics/bs-md-pol-hogan-kirwan-20191108-7hme635hgfbd7akehuwmoodhqa-story.html.

[8] Pamela Wood and Meredith Cohn, "Maryland Locks In Lower Premiums for Individual Health Insurance Market," Baltimore Sun, September 21, 2018, https://www.baltimoresun.com/health/bs-md-hogan-redmer-insurance-20180921-story.html.

[9] Morgan Eichensehr. "Maryland's ACA individual health plan premiums to fall by 10.3% average." Baltimore Business Journal. September 20, 2019. https://www.bizjournals.com/baltimore/news/2019/09/19/marylands-acaindividual-health-plan-premiums-to.html Delaware also enacted a state HIA that replaced the (suspended) federal HIA in 2019. For information about both assessments, as well as other useful information about this general issue, see Jason Levitis, John-Pierre Cardenas, and Steven Costantino, Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee (State Health and Value Strategies, January 30, 2020), https://www.shvs.org/wp-content/uploads/2020/01/FINAL-Updated-Insurer-Fee-Slide-Deck.pdf.

[10] As another difference, for-profit carriers can deduct state HIAs from their federal corporate income tax liabilities. As noted earlier, no such deduction applies to the federal HIA. To avoid losing some of the revenue being collected by the federal government, a state could slightly raise the assessment level on for-profit insurers to prevent them from experiencing a federal tax windfall that would otherwise result from changing the assessment's deductibility status. Chris Carlson, Glenn Giese, and Thomas Sauder, Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later (Oliver Wyman, August 28, 2018), https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf. Unlike the federal government, which was bound by the ACA's statutory text, a state could also extend the HIA to include plans outside the ambit of ACA safeguards, such as short-term, limited-duration insurance, or even third-party administrators that help employers self-insure.

[11] The HIA, like other fees and assessments, does not affect medical loss ratio calculations for Medicaid MCOs. 42 CFR § 438.8 (e)(2)(v)(A), (f)(1); Centers for Medicare & Medicaid Services, Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans, (CMS, October 2014), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/FAQ-10-06-2014.pdf.

[12] For each affected insurer's national book of business, the first $25 million in premium revenue is not assessed, and the next $25 million is assessed at half of standard HIA levels. In addition, non-profit insurers that receive at least 80% of their revenue from Medicare, Medicaid, and the Children's Health Insurance Program are exempt from the federal HIA; and other non-profit insurers pay only half of standard HIA levels. see Levitis, et al. Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee

[13] Dorn. How States Can Use New Revenue to Lower Consumer Costs in the Individual Health Insurance Market.

[14] A state could lower the assessment level for group plans either in place of or in addition to such a reinvestment strategy,

compensating for that reduction by increasing assessments on individual market plans.

[15] Federal statutes and regulations create guardrails limiting state assessments that include Medicaid MCOs. Such an assessment must meet three fundamental requirements:

(1) It must be "broad-based," which means that it must be imposed on all HMOs and PPOs, not just Medicaid MCOs. Social Security Act (SSA) Section 1903(w)(3)(B) and (7)(A)(vii); 42 CFR §433.68 (b)(1) and (c), 42 CFR §433.56 (a)(8).

(2) It must be "uniform," which means that it must be imposed at the same rate for all entities subject to the assessment. SSA Section 1903(w)(3)(C)(i)(III); 42 CFR §433.68(d)(1)(iii).

(3) It may not have a "hold harmless provision," which means, among other things, that the state may not provide for a payment to entities subject to the assessment where the payment amount is positively correlated with the amount of the assessment paid by those entities. SSA Section 1903(w)(4)(A); 42 CFR §433.68 (f). However, if an assessment charges less than 6% of premiums, it is automatically exempt from this hold-harmless requirement. As a result, so long as the state assessment falls below the 6% threshold, the state can hold group insurers harmless without running afoul of federal law. The text thus flags the possibility of using HIA revenue to provide refundable tax credits to small employers that provide health coverage to their workers.

The federal government is required to waive these requirements if a state shows that, despite the waiver, the net impact of the assessment and its associated expenditures will remain "generally redistributive in nature." This essentially means that the waiver must not increase the proportion of the tax paid by Medicaid MCOs. SSA Section 1903(w)(3)(E)(ii)(I); 42 CFR §433.68 (e). Accordingly, a state should be able to vary the assessment between group and individual market insurance without running afoul of the federal uniformity requirement, so long as Medicaid MCOs' proportionate contribution of HIA revenue does not increase.

[16] The only exception would involve insurers at risk of violating medical loss ratio requirements, who must give any profits that exceed the margins allowed by the Affordable Care Act to consumers in the form of rebates.

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