Legislative Analysis

Mary Ann Cleary, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

HEALTH INSURANCE CLAIMS ASSESSMENT

Senate Bill 347
Senate Bill 348 (H-1)
Status of Bills: As Reported Out of House Appropriations Committee
Complete to 8-10-2011

A SUMMARY OF SENATE BILL 347 AND SENATE BILL 348 (H-1)

Brief Description

Senate Bill 347 would amend the Use Tax Act by ending the collection of the Use Tax of 6% on Medicaid contracted health plans and specialty prepaid health plans, also referred to as Medicaid managed care organizations, 90 days after the effective date of the Health Insurance Claims Assessment (HICA) Act. Senate Bill 348 (H-1) would create the HICA Act which would establish a 1% tax on certain paid health care claims beginning January 1, 2012, with the act being repealed January 1, 2014. Both bills are tie-barred to one another.

These bills are the result of an anticipated action by the federal Centers for Medicare and Medicaid offices to disallow the Use Tax as a means to generate State revenue to be used as a match for federal Medicaid funds. The health insurance paid claims tax is a broad-based tax which should satisfy the federal government as a replacement for the current Use Tax model.

Provider Assessment Programs - Background Information

Since 2002 Michigan has established several health care provider assessment programs as a means to implement Medicaid rate increases for hospitals, nursing homes, health maintenance organizations (HMOs), and specialty prepaid inpatient health plans (PIHPs) for Medicaid mental health services. These assessments leverage additional federal Medicaid matching funds. These initiatives are also referred to as quality assurance assessment programs (QAAPs).

Under these financing arrangements, a tax is imposed by the State on a broad class of health care providers and the revenues are appropriated in the Department of Community Health (DCH) budget to fund increases in the payment rates for Medicaid-funded services. Because the state funds allocated in this manner qualify for federal Medicaid matching funds, the result is a significant increase in the Medicaid payment rates. In addition, the State also retains a portion of the QAAP revenue to offset GF/GP that otherwise would be required to fund the Medicaid program.

Provider assessments require federal approval and must comply with the following legal requirements:

- the assessment must be broad based and uniformly imposed on an entire class of providers;

- the assessment must be the same for all providers within the same group of providers; and
- the assessment cannot include a hold harmless provision to repay the provider for the fee paid.

The net fiscal impact of the assessment fee varies for each provider based on the volume of Medicaid services it provides. Those that serve a high volume of Medicaid patients receive the most benefit while those that provide a smaller percentage of Medicaid services receive less benefit. In fact, some providers may pay a higher tax than they receive in the form of higher Medicaid payment. Within the federal restrictions that apply, Michigan has sought to minimize the potential losses for those providers that provide fewer Medicaid services.

Medicaid Managed Care Organization Assessment - History

The State began the quality assurance assessment program in FY 2002-03 for Medicaid health management organizations (HMOs) covering physical health services. In FY 2004-05, mental health services were included by assessing the prepaid inpatient health plans (PIHPs).

On April 1, 2009, the HMO and PIHP provider tax was replaced with a Use Tax as the federal government required the State to stop using the non-broad based taxing model. The FY 2011-12 DCH budget assumes the replacement of the Use Tax with a health insurance claims assessment (HICA) as there is an understanding by the Executive that the Use Tax model will be disallowed by the federal government.

Senate Bill 347

Senate Bill 347 would amend the Use Tax Act by ending the collection of the tax on Medicaid contracted health plans and specialty prepaid health plans, also referred to as Medicaid managed care organizations, 90 days after the effective date of the Health Insurance Claims Assessment Act.

Enacting Section: SB 347 is tie-barred to SB 348.

Senate Bill 348 (H-1)

Senate Bill 348 (H-1) would create the Health Insurance Claims Assessment (HICA) Act which establishes a 1% tax on certain paid health care claims beginning January 1, 2012, with the act being repealed January 1, 2014.

Claims Exemptions: SB 348 (H-1) defines what paid claims are for health and medical services providers, and provides for certain exemptions. Exempted claims include the following,

- claims-related expenses
- certain payments to qualifying providers under an incentive compensation arrangement
- claims paid for accident, accident-only coverage, credit, disability income, long-term care, health-related claims under automobile insurance, homeowners insurance, farm owners,

commercial multi-peril, and worker's compensation, or coverage issued as a supplement to liability insurance
• claims paid for non-residents of this state
• proportionate share of claims paid for services under a health benefit plan for federal employees
• claims paid for State resident for services outside of the State
• claims paid under Medicare, Medicare advantage, Medicare part D, Tricare, Veterans Administration, and Patient Protection and Affordable Care Act high risk pools
• health reimbursement to individuals as authorized under federal law
• health costs paid by individual's cost sharing requirements, including deductibles, coinsurance, or copays

Levy and Collection: The assessment begins January 1, 2012, and would be 1% on non-exempted paid claims of non-exempted carriers and third party administrators. A 0.1% assessment will be levied on a carrier with a suspension or exemption under section 3717 of the Insurance Code of 1956. The assessment collected shall not exceed $10,000 per insured individual or covered life annually. The Department of Treasury is responsible for collections.

The base collection amount is $400.0 million and will be adjusted annually according to a medical inflation rate determined by the National Health Expenditures Accounts Report issued by the federal Centers for Medicare and Medicaid Services, Office of the Actuary. If the annual collections exceed the inflation adjusted base, a proportional credit will be given in the immediately succeeding year. Notices of credits will be sent by July 1 and refunds may occur beyond the statutory repeal date.

Group Health Plans: For group health plans that use the services of a third party administrator or excess loss or stop loss insurer, the paid claim assessment will be the responsibility of the third party administrator or excess loss or stop loss insurer and will not be the responsibility of the group health plan sponsor. If the group health plan is serviced by both a third party administrator and an excess loss or stop loss insurer then each will be responsible for the assessment on its proportion of paid claims.

Payor Responsibilities: Carriers required to file rates with the Insurance Commissioner will not be required to file rates in order to collect the assessment, but will be required to notify the Commissioner of the methodology used for the collection of the assessment.

The carrier or third party administrator shall develop and implement a methodology for the collection of the assessment. The methodology is subject to the following criteria: applied uniformly within a line of business, prohibits the health status or claims experience of an individual or group as an element or factor of the methodology, requires the amount collected from groups with uninsured or self-funded coverage to be determined as a percentage of actual paid claims, and requires the amount collected to reflect only the assessment levied and not include amounts such as related administrative expenses.

Payors must file a return with Treasury and make the assessment payment on April 30, July 30, October 30, and January 30 of each year for the preceding calendar year quarter.

The Department of Treasury may require the carrier or third party administrator to file an annual reconciliation return.

Guidance is provided on due dates falling on weekend days, state holidays or legal banking holidays, and allows Treasury to require electronic fund transfer assessment payments.

The carrier or third party administrator must keep accurate and complete records as required by the Treasury and those records must be retained for up to 4 years after the imposed assessment.

Treasury and Insurance Commissioner Responsibilities: The Department of Treasury is required to administer the assessment under the taxation statutes, PA 122 of 1941, MCL 205.1 to 205.31. The assessment is to be considered a tax, but not to be considered a burden or credit in regards to Insurance Code requirements, MCL 500.476(a). Treasury is to promulgate rules for the implementation of the assessment.

The Insurance Commissioner shall be notified by the Treasury of any carrier or third party administrator that has failed to pay the assessment, or any interest or penalty when due. The Commissioner may change the licensing (operating) status, with due process, if there is a failure to pay.

Treasury is required to submit within 120 days after the January 30th quarterly filing an annual report to the House of Representatives and Senate standing committees on appropriations, and the State Budget Director. This report will indicate the amount of revenue received in the immediately preceding calendar year.

Treasury is appropriated $1.0 million General Fund/General Purpose in FY 2010-11 to begin implementing the requirements of the bill. Any funds not spent in FY 2010-11 will not lapse and will be carried forward in a work project account.

By March 1 of each year, the Treasury shall report to the House of Representatives and Senate Appropriations Committees and the House and Senate Fiscal Agencies costs incurred for administration and compliance requirements for the preceding fiscal year. Treasury shall also develop a dashboard to provide information to the public on the amount of revenue collected from carriers and third party administrators subject to the assessment.

Health Insurance Claims Assessment Fund: The Health Insurance Claims Assessment Fund is created within Treasury and all money received and collected from the assessment shall be deposited into the Fund. Other money or assets may be deposited into the Fund by the State Treasurer. Money in the Fund at the close of the fiscal year will not lapse to the General Fund and shall remain available beyond the statutory repeal date to satisfy unresolved claims and pending appeals. Transfers from the Fund upon appropriation shall be only be used to finance the expenditures of Medicaid contracted health plans and specialty prepaid health plans or pay any credits or refunds, except as otherwise provided in this act.

In FY 2011-12 and thereafter, the Treasury shall receive from the Fund an amount not to exceed 1% of the annual assessment remittances for administration and compliance requirements.

Enacting Sections: SB 348 (H-1) is tie-barred to SB 347 and is repealed on January 1, 2014.

FISCAL IMPACT:

The FY 2011-12 Department of Community Health appropriation act includes an anticipated $396.9 million of state restricted revenue generated from a full year implementation of a health insurance claims assessment of 1%. These State revenues are used to match federal Medicaid funds to generate approximately $1.2 billion of funding to support provider rates for Medicaid contracted health plans and specialty prepaid health plans. The FY 2011-12 Executive proposal included the replacement of the current 6% Use Tax on Medicaid managed care organizations with a 1% assessment on a broader base of health insurers.

Senate Bill 347 would allow the Use Tax to be in effect until April 1, 2012, half of FY 2011-12. The approximate amount generated by the Use Tax for six months, taking into consideration the typical hold harmless or actuarial soundness amounts previously provided by DCH, is $124.5 million GF/GP.

Senate Bill 348 (H-1) would allow for a 1% assessment on certain claims and certain carriers and third party administrators beginning January 1, 2012. The State Budget Office suggests first year annual revenue from the assessment of $396.9 million whereas the Senate Fiscal Agency estimate is $375.0 million. The House Fiscal Agency concurs with the Senate Fiscal Agency estimate, assumptions and methodology. There is insufficient Michigan-specific claims data information available or exempted federal claims information to project an exact revenue amount realized from the 1% assessment. There may be a lag in paid claims assessment reporting during implementation so that the full effect of the $375.0 million may be lower in the first quarter and second quarter of calendar year 2012, perhaps reducing the amount collected for FY 2011-12.

Considering the above half-year estimate of $124.5 million GF/GP from Use Tax collections and three-quarter year estimate of $281.3 million claims assessment revenue, a total of $405.8 million may be available to the State to meet the budgeted amount in the FY 2011-12 Department of Community Health Medicaid program.

Fiscal Analyst: Steve Stauff
Margaret Alston
Susan Frey