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Senate Bill 347 (as enacted)
Sponsor: Senator Roger Kahn, M.D.
Committee: Appropriations

Date Completed: 10-19-11

CONTENT

Background on Managed Care Provider Taxes

Federal law permits the use of "broad-based" provider taxes to support Medicaid services. Until 2006 these taxes were capped at 6.0%, but the cap was reduced in 2006 to 5.5%. These taxes apply to an entire provider group. The State retains some of the money, then uses the rest of the money, along with Federal Medicaid match, to increase Medicaid payment rates to the provider group.

In FY 2002-03, the State instituted a quality assurance assessment program (QAAP) provider tax for Medicaid managed care organizations (Medicaid health maintenance organizations or HMOs).

The Federal law authorizing State provider taxes had a major loophole. When listing the services that could be taxed, instead of stating "managed care organizations", the law stated "Medicaid managed care organizations". Because of this, the HMO QAAP was limited just to Medicaid HMOs, and HMOs that did not participate in Medicaid were not subject to the tax. This meant that each Medicaid HMO got back more from the rate increase than it paid in taxes.

The State instituted a QAAP for Medicaid mental health services, provided by the prepaid inpatient health plans (PIHPs), in FY 2004-05. As was the case with the HMO QAAP, the PIHP QAAP was limited to just Medicaid mental health providers due to the loophole. So, again, there were no losers at the State or local PIHP level; only the Federal government saw a net cost.

As part of the Deficit Reduction Act of 2005, the "Medicaid managed care" loophole was phased out, and the State of Michigan was forced to end its Medicaid managed care QAAPs during 2009. Removing the QAAPs without a replacement would have increased State GF/GP spending by well over $200.0 million, so the State came up with an alternative tax as a replacement.

Because Medicaid HMOs and Medicaid PIHPs are defined in statute, the State made those two entities subject to the State's 6.0% Use Tax. This was, technically, not a provider assessment, simply an expansion of the Use Tax base. The proposal received approval from the Centers for Medicare and Medicaid Services (CMS).

Since 2005 the Federal government has required states to pay "actuarially sound" capitation rates to Medicaid managed care organizations, such as the Medicaid HMOs and PIHPs Capitation rates are the rates paid to managed care organizations, based on age, eligibility group, and other demographic factors, to provide coverage to their clients. The managed care organization then takes on full financial risk for the medical services provided to that population. Michigan has had to certify that the Medicaid capitation rates paid to Medicaid HMOs and PIHPs are actuarially sound. In most years this has meant an inflationary increase in the rates paid to these entities.

One aspect of the actuarial soundness process is that one of the costs faced by the Medicaid HMOs and PIHPs is the Use Tax they pay. In other words, the State effectively reimburses the Medicaid HMOs

and PIHPs for the cost of the Use Tax they pay the State. However, this cost is a Medicaid payment, with Federal Medicaid match involved. With a Medicaid match rate that is 66.14% in FY 2011-12, the $388.4 million in taxes paid by the Medicaid HMOs and PIHPs would effectively cost roughly $131.5 million GF/GP and $256.9 million Federal Medicaid match. So while the Use Tax brings in $388.4 million in revenue, its net benefit to the State's financial situation is $256.9 million: $388.4 million from the tax less $131.5 million GF/GP needed to reimburse the Medicaid HMOs and PIHPs for the tax.

The CMS is again looking at the Use Tax and the Snyder Administration states that new rules will likely soon be issued barring the State from using this sort of approach, which has put the State in the position of considering new ways to support its Medicaid programming.

Proposed Elimination of the HMO/PIHP Use Tax

In order to head off Federal action, Governor Snyder's proposed FY 2011-12 Department of Community Health (DCH) budget assumed elimination of the HMO/PIHP Use Tax as of October 1, 2011, and its replacement on that date with a 1.0% paid health claims assessment. The enacted DCH budget reflects concurrence with the Governor's proposal.

Senate Bill 347

Senate Bill 347 will amend the Use Tax Act to terminate the HMO/PIHP Use Tax on March 31, 2012.

Senate Bill 347 is tie-barred to Senate Bill 348, which will create the 1.0% paid health claims assessment.

FISCAL IMPACT

The repeal of the Medicaid HMO/PIHP Use Tax, effective March 31, 2012, will increase State revenue by $188.5 million above the appropriated FY 2010-11 levels, which represents 6% of the total $6.29 billion appropriation for HMOs and PIHPs, divided by two to reflect half-year funding. The FY 2011-12 DCH budget assumed no Medicaid HMO/PIHP Use Tax revenue.

This would not be the only impact of retaining the Use Tax for an additional six months. As noted above, the State is responsible for paying Medicaid HMOs and PIHPs actuarially sound rates. As the tax would expire, the State would still have to make Gross payments totaling $188.5 million to cover the cost of the tax. This $188.5 million Gross payment would cost the State $63.8 million GF/GP at the FY 2011-12 Medicaid match rate of 66.14%.

The State would gain $188.5 million in revenue but would have to spend $63.8 million GF/GP to receive that revenue, for a net benefit to the State of $188.5 million less $63.8 million, or $124.7 million GF/GP compared to the enacted FY 2011-12 DCH budget.

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