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BILL ANALYSIS

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Senate Bill 893 (Substitute S-3 as reported)
Senate Bill 913 (Substitute S-2 as reported)
Sponsor: Senator Roger Kahn, M.D.
Committee: Appropriations

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CONTENT

Background on the Use Tax and the Health Insurance Claims Assessment

Federal law permits the use of "broad-based" provider taxes, capped at 6.0%, to support Medicaid services. 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 of Michigan 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 Michigan's 6.0% Use Tax. This was, technically, not a provider assessment, but 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. For instance, in the final year of the Use Tax, FY 2011-12, with a Medicaid match rate that was 66.14%, the $388.4 million in taxes paid by the Medicaid HMOs and PIHPs effectively cost $131.5 million GF/GP and $256.9 million Federal Medicaid match. So while the Use Tax generated $388.4 million in revenue, its net benefit to the State's financial situation was $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.

Because the CMS began looking at the Use Tax and due to fears of new rules that could be issued barring the State from using this sort of approach (and concerns about retroactive disallowances due to the use of Federal funds, which could have cost the State hundreds of millions of dollars), the Legislature passed in 2011 and the Governor signed Senate Bills 347 and 348, which ended the Use Tax and implemented the Health Insurance Claims Assessment (HICA).

The HICA took effect on January 1, 2012. The HICA replaced the Use Tax that had been applied to Medicaid managed care organizations. Revenue from the HICA is used to support the State's Medicaid program.

The HICA rate was set at 1.0% of all paid health claims. There are exceptions: Federal government programs such as Medicare, Veterans Administration health care services, and fee-for-service Medicaid are not subject to the HICA, as the State cannot tax the Federal government. Similarly, out-of-pocket costs are not subject to the HICA. There is also a lower rate of 0.1% for a very limited number of small health insurers.

Due to concerns that the HICA could raise more than the $400.0 million in revenue that was projected, a system of credits was created. If revenue in any year exceeds $400.0 million as adjusted by medical inflation as measured by the annual National Health Expenditures Accounts report, each carrier, and third party administrator (for self-funded plans), will receive a proportional credit against the subsequent year's HICA assessment.

Revenue

The FY 2013-14 Department of Community Health (DCH) budget was built on the assumption of $400.0 million in HICA revenue, as was the Governor's proposed DCH budget for FY 2014-15. The Snyder Administration had estimated, based on modeling of health care expenditures in Michigan, including those such as Medicare that would not be subject to the HICA, that the tax base would be about $40.0 billion. The Senate Fiscal Agency (SFA) estimated a slightly smaller tax base of $37.5 billion, leading to an SFA estimate of $375.0 million in full-year revenue.

In reality, the revenue came up far short of that amount. There were two principal factors in these faulty estimates: First, determining the tax base itself required taking 2009 national health care cost data, adjusting it to Michigan information, and then trending it forward to 2012. This involved not just estimating total health care costs, but also estimating exempted costs such as Medicare and out-of-pocket costs. Second, the volume of claims paid by out-of-State insurers that were not subject to the HICA was far larger than originally believed and is likely in the range of $5.0 billion or more, leading to a reduction of HICA revenue in the range of $50.0 million.

In the end, HICA revenue has been much lower than what was projected by the SFA and the Administration. The revenue also has fallen far short of the amount necessary to trigger the proportional credits, so the concerns of some that revenue would exceed $400.0 million have not come to fruition either.

For FY 2013-14, base HICA revenue projected by the Michigan Department of Treasury is $285.5 million, well short of the $400.0 million built into the FY 2013-14 DCH budget. For FY 2014-15, base HICA revenue is projected to be $290.0 million, again well short of the $400.0 million assumed in the Governor's FY 2014-15 DCH budget. The budget also assumed additional HICA revenue tied to Medicaid expansion, $7.9 million in FY 2013-14 and $20.2 million in FY 2014-15.

Senate Bill 608, the FY 2013-14 supplemental (Public Act 34 of 2014), included boilerplate language directing that, on September 30, 2014, any remaining HICA shortfall be filled using funding from the Roads and Risks Reserve (which presently contains $115.0 million). Therefore, barring any other action, the HICA shortfall for FY 2013-14 will be addressed at the end of the fiscal year.

For FY 2014-15, the Senate Appropriations Committee and House Appropriations Committee versions of the DCH budget included $110.0 million GF/GP to cover the projected shortfall. The Snyder Administration has not signed off on this approach and, after discussions, suggested reinstatement of the Managed Care Use Tax, which is reflected in Senate Bills 893 and 913.

Senate Bill 893 (S-3)

Senate Bill 893 (S-3) would amend the Use Tax Act to reinstate the Use Tax for Medicaid managed care organizations, including the Medicaid health plans handling the Medicaid population prior to the April 1, 2014, expansion of Medicaid, the Medicaid PIHPs handling mental health services, and the managed care entities providing services to the Medicaid expansion population.

There is a belief among the Snyder Administration that the Federal government will not block this Use Tax reinstatement, at least in the medium term. Effective July 1, 2013, the State of California implemented a 3.9375% sales tax on Medicaid health plans in that state that will be in effect for three years. The measure did not require Federal approval; instead the Federal government could block the proposal by stating disapproval, which it has not done. The Administration has expressed confidence that a similar tax in Michigan also would receive approval, at least for several years.

The bill would apply the 6% Use Tax, beginning April 1, 2014, to a tax base estimated at almost $9.1 billion in FY 2014-15, with one-third of the revenue, pursuant to the Michigan Constitution, going to the School Aid Fund and two-thirds of the revenue going to the General Fund.

Senate Bill 913 (S-2)

Senate Bill 913 (S-2) would amend the Health Insurance Claims Assessment Act to reduce the HICA rate from 1.0% to 0.75%, effective July 1, 2014. The rate would revert to the original 1.0% retroactive to the first day of the previous fiscal year quarter, if the Federal government informed the State that revenue from the Use Tax that would be collected pursuant to Senate Bill 893 (S-3) could not be used as State match for the Medicaid program. The bill also would retain the system of proportional credits in the original HICA legislation. Those credits originally applied to HICA revenue in excess of $400.0 million adjusted for the medical inflation rate since 2011. The revised approach would provide credits if HICA revenue plus GF/GP Use Tax revenue in excess of the GF/GP revenue needed to cover Use Tax actuarial soundness exceeded $400.0 million adjusted for the medical

inflation rate since 2011 but not to exceed $450.0 million. In effect, the credits would apply if HICA revenue plus the Use Tax revenue actually available to support ongoing Medicaid programming exceeded the trigger amount.

The bills are tie-barred.

MCL 205.93f (S.B. 893)
MCL 550.1733 (S.B. 913)

FISCAL IMPACT

Senate Bill 893 (S-3)

Estimating the revenue from the Use Tax for Medicaid managed care organizations requires an estimate of the tax base for FY 2013-14 and FY 2014-15, that is, the appropriation to various Medicaid managed care line items.

In building the FY 2014-15 budget, the State Budget Office (SBO) included adjustments to reflect updated estimates of FY 2013-14 expenditures from various Medicaid line items as well as the estimates for FY 2014-15. These numbers appeared to be reasonable and were used by the Senate and House Subcommittees on DCH in building their versions of the DCH budget, so they are used in this analysis.

Table 1 shows the estimated expenditures for each managed care line item for all of FY 2013-14, for the second half of FY 2013-14 (as the Use Tax would take effect April 1, 2014), and for all of FY 2014-15.

Table 1

Fiscal Impact of Senate Bill 893 (S-3)
Use Tax for Medicaid Managed Care Services

	FY 2013-14	Tax Base for FY 2013-14 (1/2 year)	FY 2014-15
Estimated Expenditures for Health Plan Services	$4,549,416,600	$2,274,708,300	$4,593,832,100
Estimated Expenditures for HMP Physical Health	628,888,300	628,888,300	2,022,840,000
Estimated Expenditures for Medicaid Behavioral Health	2,138,265,400	1,069,132,700	2,206,980,600
Estimated Expenditures for Medicaid Substance Abuse	41,534,100	20,767,100	43,115,300
Medicaid Expansion Behavioral Health	85,090,100	85,090,100	221,400,000
TOTAL	$7,443,194,500	$4,078,586,500	$9,088,168,000
Apply 6% Tax (divide base by 0.94 and subtract)		$260,335,300	$580,095,800
Remove 2% Slated for School Aid Fund		(86,778,400)	(193,365,300)
Remaining Use Tax going to the General Fund		$173,556,900	$386,730,500
GF/GP Cost of Actuarial Soundness		$72,331,900	$150,537,300
Net GF/GP Revenue from Tax		$101,225,000	$236,193,200

The total tax base for the second half of FY 2013-14 is estimated at $4.08 billion. The total tax revenue base for all of FY 2014-15 is estimated at $9.09 billion. The estimated tax revenue for FY 2013-14 is $260.3 million and the estimated tax revenue for FY 2014-15 would be $580.1 million.

This revenue is not the revenue that would be available to help address the HICA shortfall. There are two significant adjustments, one tied to the State Constitution and one linked to

the Federal requirement that payments to Medicaid managed care entities be actuarially sound.

First, the Michigan Constitution requires that 2% of the 6% use tax be directed to the School Aid Fund. Therefore, one-third of the revenue ($86.8 million in FY 2013-14 and $193.4 million in FY 2014-15) would go to the School Aid Fund rather than the General Fund. This would leave Medicaid managed care use tax revenue at $173.6 million in FY 2013-14 and $386.7 million in FY 2014-15.

Second, the taxes would increase costs for Medicaid managed care providers by $260.3 million in FY 2013-14 and $580.1 million in FY 2014-15. This increase in costs would be a legitimate cost of doing business and, being one imposed by the State, has always been reimbursed through an increase in Medicaid rates. This actuarial soundness adjustment would cost $72.3 million GF/GP in FY 2013-14 and $150.5 million GF/GP in FY 2014-15. These GF/GP costs would apply to the traditional Medicaid lines, as the Healthy Michigan Program (Medicaid expansion) line items are 100% Federally funded, so the actuarial soundness adjustment for those lines would not cost any GF/GP dollars.

After the actuarial soundness adjustment was made, the remaining tax revenue available to help address the HICA shortfall would be $101.2 million in FY 2013-14 and $236.2 million in FY 2014-15.

As noted above, the General Fund would not be the only recipient of the revenue from Senate Bill 893 (S-3). The School Aid Fund would see an increase of $86.8 million in FY 2013-14 and $193.4 million in FY 2014-15, so that fund source would realize a significant increase due to the legislation.

HICA Changes in Senate Bill 913 (S-2)

Senate Bill 913 (S-2) would reduce the HICA rate to 0.75% effective July 1, 2014, with a trigger stating that the rate would revert to 1.0% if, at any time, the Federal government ruled that revenue from the Use Tax could not be used as State match for the Medicaid program.

Projected revenue from the HICA for FY 2013-14 is $285.5 million with an additional $7.9 million from Medicaid expansion expenditures. Projected revenue from the HICA for FY 2014-15 is $290.0 million with an additional $20.3 million from Medicaid expansion expenditures, as shown in Table 2.

Table 2

Fiscal Impact of Senate Bill 913 (S-2), Reduction in HICA Rate

	FY 2013-14	FY 2014-15
HICA Revenue Full Year	$285,500,000	$290,000,000
Revenue from Medicaid Expansion	7,920,600	20,203,700
Total HICA tax base	$293,420,600	$310,203,700
HICA Revenue Subject to Rate Reduction	75,335,300	310,203,700
Reduction in HICA Revenue due to Rate Reduction	(18,833,800)	(77,550,900)
Total Estimated HICA Revenue if SB 913 (S-1) Enacted	$274,586,800	$232,652,800

Reducing the HICA rate from 1.0% to 0.75% for the final quarter of FY 2013-14 would reduce HICA revenue by $18.8 million. Reducing the HICA rate would reduce FY 2014-15 HICA revenue by $77.6 million.

Net Fiscal Impact on the DCH Budget

Table 3 shows the net fiscal impact of the two bills. The FY 2013-14 budget assumes $407.9 million in HICA revenue, including the HICA revenue related to Medicaid expansion. The FY 2014-15 budget assumes $420.2 million in HICA revenue, again including Medicaid expansion HICA revenue.

The estimated HICA revenue without the bills is $293.4 million in FY 2013-14 and $310.2 million in FY 2014-15, leading to the already-noted HICA shortfalls of $114.5 million in FY 2013-14 and $110.0 million in FY 2014-15.

The HICA rate cut in Senate Bill 913 (S-2) would reduce HICA revenue by $18.8 million in FY 2013-14 and $77.6 million in FY 2014-15, thus reducing HICA revenue to $274.6 million in FY 2013-14 and $232.7 million in FY 2014-15.

Table 3

Net Fiscal Impact of Senate Bills 893 (S-3) and 913 (S-2) on DCH Budget

	FY 2013-14	FY 2014-15
HICA Revenue Assumed in Base DCH Budget	$400,000,000	$400,000,000
Assumed HICA Revenue tied to Medicaid Expansion	7,920,600	20,203,700
Total HICA Revenue Assumed in DCH Budget	$407,920,600	$420,203,700
Estimated HICA Revenue without any action	$293,420,600	$310,203,700
Estimated HICA Shortfall	$(114,500,000)	$(110,000,000)
Estimated HICA Revenue if SB 913 (S-2) is Enacted	$274,586,800	$232,652,800
Increase in Available GF/GP Revenue if SB 893 (S-3) Enacted	$101,225,000	$236,193,200
Total HICA Plus Use Tax GF if both bills enacted	$375,811,800	$468,846,000
Total HICA Revenue Assumed in DCH Budget	$407,920,600	$420,203,700
Surplus/(Shortfall) in DCH Budget if Bills Enacted	$(32,108,800)	$48,642,300
Estimated revenue cap (maximum of $450.0 million)	$450,000,000	$450,000,000
Revenue in excess of cap (credited to subsequent year)	$0	$18,846,000

Senate Bill 893 (S-3) would lead to a net increase, prior to any credits, in available GF/GP revenue of $101.2 million in FY 2013-14 and $236.2 million in FY 2014-15.

The HICA revenue plus net Use Tax GF/GP revenue would be $375.8 million in FY 2013-14 and $468.8 million in FY 2014-15. As noted, assumed HICA revenue was $407.9 million in FY 2013-14 and $420.2 million in FY 2014-15.

While a precise estimate of medical inflation in 2015 cannot yet be made, it appears, based on the 2012 National Health Expenditures Accounts report issued by the Centers for Medicare and Medicaid Services (CMS), that medical inflation was 3.8% in 2012. The CMS estimate for 2013 is 4.0% growth, for 2014 is 6.1% growth, and for 2015-2022 is 6.2% per year. This would lead to growth from 2011-2014 of 14.5% and from 2011-2015 of 21.6%.

The revenue cap of $400.0 million would thus be adjusted upward by 14.5% for FY 2013-14, or to $458.1 million. The revenue cap for FY 2014-15 would be adjusted upward by 21.6%, or to $486.6 million. However, the limit of $450.0 million would reduce the cap in both years to $450.0 million.

The cap would have no impact on FY 2013-14 revenue as $375.8 million is far less than the cap. The estimated revenue in FY 2014-15, $468.8 million, would be above the $450.0 million limit; therefore, it is projected that there would be $18.8 million in credits paid out in FY 2015-16 due to excess revenue in FY 2014-15.

Therefore, the bills as written would reduce the effective HICA shortfall to $32.1 million in FY 2013-14 and provide $48.6 million in revenue beyond what was budgeted in FY 2014-15 with $18.8 million in credits to be paid out in FY 2015-16. Senate Bill 893 (S-3) would increase School Aid Fund revenue by $86.8 million in FY 2013-14 and $193.4 million in FY 2014-15.

Revenue numbers in subsequent years would depend on the changes in the tax base, in particular, growth in the Medicaid expansion caseload, economic changes resulting in increases or decreases in the traditional Medicaid caseload, and the potential expansion of managed care services under the Medicaid/Medicare dual eligible waiver.

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