Legislative Analysis

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PAUSE COLLECTION OF MEDICAID MCO USE TAX

Senate Bill 1172 (S-1) as passed by the Senate
Sponsor: Sen. Ken Horn

Analysis available at
http://www.legislature.mi.gov

House Committee: Appropriations
Senate Committee: Michigan Competitiveness
Complete to 12-5-16

SUMMARY:

Senate Bill 1172 would stop the collection of the state's Use Tax on Medicaid Managed Care Organizations (MCOs) effective December 31, 2016. The bill would reinstate the Medicaid MCO Use Tax on July 1, 2020 or earlier if either of the following occur:

- The effective date of an amendment to repeal section 3 of the Health Insurance Claims Assessment (HICA) Act.
- The effective date of an amendment to the HICA Act that reduces HICA to 0%.

(MCL 205.93f)

FISCAL IMPACT:

Senate Bill 1172 would have no fiscal impact to FY 2016-17, since the FY 2016-17 enacted budget assumes the Medicaid MCO Use Tax will not be collected after December 31, 2016 and the HICA rate will automatically increase from 0.75% to 1.0%. While the increase in the HICA rate will partially offset the loss of Use Tax revenue, a net increase of approximately $140 million per year in regular GF/GP funds will be needed to maintain the Medicaid program. Additionally, the School Aid Fund will experience a loss of approximately $200 million per year. Since these changes occur on a calendar year basis, the enacted FY 2016-17 budget had to account for roughly three-quarters of these changes.

If no changes are made to the Use Tax Act to remove the sunset date of July 1, 2020, then the Medicaid MCO Use Tax would be reinstated on that date. Without federal permission to reinstate the Use Tax, there would be no net fiscal impact. As the state would collect approximately $680 million in Medicaid MCO Use Tax, but would then have to appropriate an additional $680 million to support the increased actuarial soundness payments to reimburse the MCOs for the cost of the Use Tax.

While resuming collection of the Use Tax would have no net fiscal impact, School Aid Fund revenues would increase by approximately $225 million, since one-third of Use Tax collections are deposited into the School Aid Fund. Conversely, State general fund/general purpose revenues would decline by approximately $225 million.

BACKGROUND INFORMATION:

Medicaid Financing

Medicaid is a joint federal-state health care safety net program. The traditional Medicaid program provides physical and mental health coverage to approximately 1.7 million individuals in the state—generally pregnant women, parents and children, and the aged, blind, and disabled, with incomes below varying thresholds. For FY 2016-17, the traditional Medicaid program is funded at a match rate of 65.15% federal and 34.85% state.

The expanded Medicaid program under the Healthy Michigan Plan provides coverage to approximately 600,000 additional adults at up to 138% of the federal poverty level and is currently funded 100% by the federal government. This match rate will drop to 95% effective January 1, 2017 and will continue to phase down until it reaches 90% in 2020.

The FY 2016-17 Medicaid budget totals $16.7 billion. Of that total, $12.1 billion is funded by the federal government, and the remaining $4.6 billion consists of state match funds. The largest portion of those state match funds are GF/GP funds ($2.5 billion), but Michigan has implemented a number of restricted financing mechanisms to reduce state GF/GP funding requirements and to boost reimbursement rates for Medicaid providers.

These restricted funding sources include provider assessments levied on hospital and nursing home receipts under the state's Qualified Assurance Assessment Program (QAAP), the Medicaid Benefits Trust Fund (which receives revenue primarily from cigarette tax revenue), the Health Insurance Claims Assessment, special financing funds claimed against contributions from public and university hospitals, and the Merit Award Trust Fund (which receives revenue from the state's share of tobacco settlement revenue). Restricted funds appropriated for total Medicaid costs from these and other smaller sources total $2.1 billion.[1]

History of Federal and State Changes Related to Medicaid Financing

The process by which the federal government provides Medicaid match funds to states is outlined in Section 1903 of the federal Social Security Act. In general, any state payments for medical assistance approved under the state's Medicaid State Plan are eligible for federal reimbursement (typically at the state's Federal Medical Assistance Percentage [FMAP]). The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (PL 102-234) did, however, add subsection (w) to Section 1903 requiring federal financial participation to be reduced based on any impermissible provider-related donation or health care-related tax received by that state.

[1] For additional background information on the state's Medicaid program, and the factors allowing for effective flat GF/GP appropriations for the program over the last 15 years, see this October 2015 HFA report: http://www.house.mi.gov/hfa/PDF/CommunityHealth/Michigan_Medicaid_Program_Oct2015.pdf.

The Social Security Act requires a health care-related tax to meet three criteria in order to be permissible:

- The tax must be broad-based with respect to all items or services in a provider class.
- The tax must be uniformly imposed through the state.
- The tax cannot have a hold harmless provision.

The act included separate provider classes for hospital services, nursing facilities, physician services, services of *health maintenance organizations* (HMOs), among others. The act does permit states to request a waiver, under certain conditions, if the tax is not broad based or imposed uniformly.

Over the last two decades, various federal and state actions have resulted in frequent changes in Michigan's use of assessments from managed care organizations (MCOs) and other health insurers as a Medicaid financing tool, as outlined below.[2] To comply with the federal requirement that Medicaid managed care rates be actuarially sound, the state has reimbursed Medicaid MCOs for the costs related to each of these assessments. Because these reimbursements are financed with both state and federal funds, the revenue received under the assessments has exceeded the state-funded reimbursement costs, creating a net benefit to the state.

Creation of Medicaid MCO QAAP

The federal Balanced Budget Act of 1997 (PL 105-33) replaced the health maintenance organization provider class with the term *Medicaid managed care organizations*, effectively allowing a tax on only Medicaid managed care, rather than all managed care, to qualify as a broad based, permissible health care-related tax. As a result many states implemented a Medicaid-only MCO tax.

In Michigan, 2002 PA 304 (Senate Bill 748), amended by 2002 PA 621 (House Bill 6327), created a Quality Assurance Assessment Program (QAAP) on Medicaid MCOs based in part on the argument that Medicaid reimbursements were lagging behind medical inflation and medical providers were finding it too costly to accept Medicaid beneficiaries. The Medicaid MCO QAAP and any associated federal financial participation were used to supplement GF/GP-funded Medicaid payments to ameliorate these concerns. In FY 2007-08 (the last full fiscal year with MCO QAAP) $263 million in Medicaid MCO QAAP was assessed, resulting in a net provider benefit of $154 million and a state retainer benefit of $88 million.[3]

[2] The term "managed care organization" includes both traditional HMOs and Prepaid Inpatient Health Plans (PIHPs), through which Medicaid mental health services are funded.

[3] The net provider benefit is the amount of supplemental payments, including federal financial participation, less assessed MCO QAAP. QAAPs also include some portion of state retainer used to offset GF/GP.

Shift to Medicaid MCO Use Tax

The federal Deficit Reduction Act of 2005 (PL 109-171) replaced the Medicaid managed care organization provider class with the term *managed care organizations* and required states with Medicaid-only MCO taxes to revise or replace those impermissible health care-related taxes by October 1, 2009.

Michigan responded with 2008 PA 440 (House Bill 5192), which repealed the Medicaid MCO QAAP and instead made medical services provided by Medicaid MCOs subject to the 6% Use Tax beginning April 1, 2009. In FY 2010-11 (the last full fiscal year with this iteration of the MCO Use Tax), the Medicaid MCO Use Tax generated $383 million in revenues. These revenues allowed the state to continue providing Medicaid MCOs with comparable reimbursement rates to the rates provided with the repealed Medicaid MCO QAAP without having to utilize state funds from other sources or tax non-Medicaid MCO receipts.

Shift to Health Insurance Claims Assessment

In 2011, the Governor became concerned that the federal government intended to declare that the Medicaid MCO Use Tax was not a permissible health care-related tax. Eight states faced possible federal action: California, Georgia, Kentucky, Michigan, Missouri, Ohio, Oregon, and Pennsylvania. Rather than risk loss of federal Medicaid revenue, the Governor proposed an alternate approach: the Health Insurance Claims Assessment (HICA).

2011 PA 141 (Senate Bill 347) sunset the MCO Use Tax beginning April 1, 2012 and 2011 PA 142 (Senate Bill 348) created HICA beginning January 1, 2012. HICA applies, with certain exceptions, to all health insurance claims in the state, including both Medicaid-funded claims and privately-funded claims. Initial forecasts assumed a 1.0% HICA would generate between $375 million to $400 million in revenues. However, actual HICA revenues were closer to $270 million, requiring the state to identify other resources to keep the Medicaid program whole.[4] The FY 2011-12 budget relied on GF/GP lapses, the FY 2012-13 budget relied on restricted revenue fund balances, and in FY 2013-14 the state reinstituted the Medicaid MCO Use Tax.

Reinstatement of Medicaid MCO Use Tax

2014 PA 161 (Senate Bill 893) reinstated the 6% Medicaid MCO Use Tax effective on April 1, 2014 and 2014 PA 162 (Senate Bill 913) reduced HICA from 1.0% to 0.75% beginning July 1, 2014. In the Centers for Medicare & Medicaid Services (CMS) approval letter dated September 25, 2014 for these public acts, CMS noted its concern with the Medicaid MCO Use Tax: "Consistent with the guidance in the State Health Official letter [14-001, issued July 25, 2014], CMS reminded the State that in order to comply with the requirements, the tax will need to sunset by the end date of the State's next legislative session or by 12/31/15." December 2016 is the end date that applies to Michigan.

[4] The gap between the original estimate and actual collections was due to several factors, including out-of-state policies being larger than expected and an under-estimation of the impact of increasing health care deductibles and co-pays (which are not taxed).

Under the FY 2016-17 enacted budget assumptions, the Medicaid MCO Use Tax will not be collected after December 31, 2016 and the HICA rate will automatically increase from 0.75% to 1.0% under current law. While the increase in the HICA rate will partially offset the loss of Use Tax revenue, a net increase of approximately $140 million per year in regular GF/GP funds are needed to maintain the Medicaid program. Additionally, the School Aid Fund will experience a loss of approximately $200 million per year. Since these changes occur on a calendar year basis, the enacted FY 2016-17 budget had to account for roughly three-quarters of these changes.

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