Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bills 987, 988, 989, and 990 (as reported without amendment)
Sponsor: Senator Ken Horn (S.B. 987)
Senator Jim Stamas (S.B. 988)
Senator Peter MacGregor (S.B. 989)
Senator Mike Shirkey (S.B. 990)
Committee: Michigan Competitiveness

CONTENT

The bills would amend several statutes to create a new version of the Medicaid managed care Use Tax; direct that the GF/GP revenue from that tax be deposited in a new fund; limit expenditures from that fund to five programs that are not Medicaid programs; divert income tax revenue to reimburse Medicaid managed care actuarial soundness payments; change the Health Insurance Claims Assessment (HICA) sunset from July 1, 2020, to December 31, 2018; and reduce the HICA rate to 0.0% effective January 1, 2017, if the new Medicaid managed care Use Tax revenue were federally reimbursed. The bills would lead, if implemented fully, to a worsened GF/GP balance sheet in the range of $80.0 million to $90.0 million per year, but an improved School Aid Fund balance sheet in the range of $210.0 million to $220.0 million per year.

The bills are tie-barred.

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, and then uses the rest of the money, along with Federal Medicaid match, to increase Medicaid payment rates to the provider group.

In fiscal year (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 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 Medicaid mental health providers due to the loophole. Therefore, 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 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).

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 (Public Acts 141 and 142 of 2011), 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.

Revenue

Revenue from the HICA came in well below the $400.0 million in annual revenue that was originally projected. 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.

Return of the Medicaid Managed Care Use Tax

During 2013, the State of California received permission from the Federal government to reinstate, on a limited-term basis, its Medicaid managed care Use Tax through July 1, 2016. The State of Michigan sought and also received permission to reinstate the Medicaid managed care Use Tax, on an unspecified limited-term basis.

Due to concerns from the business community and health insurance companies about the HICA, the reinstatement of the Medicaid managed care Use Tax also led to changes to the HICA.

Senate Bills 893 and 913 (Public Acts 161 and 162 of 2014) of the 2013-14 legislative session reflected these changes. Senate Bill 893 reinstated the Medicaid managed care Use Tax at 6.0%. Senate Bill 913 reduced the HICA rate from 1.0% to 0.75% as long as the Federal government did not disallow the managed care Use Tax. Senate Bill 913 put a cap on net revenue from the combined HICA and the GF/GP portion of the managed care Use Tax: Total revenue from the HICA and the GF/GP portion of the managed care Use Tax, less the GF/GP cost of reimbursing managed care entities for the cost of the tax, could not exceed a certain threshold. This threshold was set at $400.0 million as adjusted for medical inflation since 2011, with the maximum threshold being $450.0 million. Due to inflation over the past five years, that $450.0 million threshold has been reached. In effect, if the combined net GF/GP benefit of the HICA and the managed care Use Tax exceeds $450.0 million in a given year, in the next year HICA payers will receive a credit refunding that excess.

Actuarial Soundness

The "net" GF/GP benefit of the Medicaid managed care Use Tax takes into account the GF/GP cost of reimbursing the Medicaid managed care Use Tax payers for that tax. This is due to the Federal requirement that Medicaid managed care entities be paid "actuarially sound" rates.

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 of the costs faced by the Medicaid HMOs and PIHPs is the Use Tax they pay and this cost must be recognized in the actuarial soundness process. 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 reimbursement is a Medicaid payment, with Federal Medicaid match involved. The Use Tax applies not only to managed care services provided to traditional Medicaid clients, but also to managed care services provided to expansion Medicaid clients in the Healthy Michigan Plan (HMP).

For instance, in FY 2015-16, with a Federal Medicaid match rate that is 65.15%, the $448.5 million in Use Tax paid by the Medicaid HMOs and PIHPs for traditional Medicaid was reimbursed with $156.3 million GF/GP and $292.2 million Federal Medicaid match. This was because the State is required to reimburse the Medicaid HMOs and PIHPs for the cost of the Medicaid managed care Use Tax. There was also a cost for the $183.0 million in taxes paid for expansion Medicaid, but, due to the 100% Federal match rate for expansion Medicaid through January 1, 2017, that cost was entirely federally funded.

Furthermore, the Use Tax itself is split between the General Fund and the School Aid Fund. Michigan's Constitution requires two-thirds of the Use Tax revenue to go to the General Fund with the rest going to the School Aid Fund. Therefore, of the estimated $631.5 million in managed care Use Tax revenue in FY 2015-16, $421.0 million will go to the General Fund and $210.5 million will go to the School Aid Fund.

The net benefit of the Medicaid managed care Use Tax to the State's GF/GP balance sheet in FY 2015-16 is estimated to be $264.7 million: $421.0 million from the tax less $156.3 million

GF/GP needed to reimburse the Medicaid HMOs and PIHPs for the tax. The net benefit to the State's School Aid Fund balance sheet is estimated to be $210.5 million.

Expiration of the Current Managed Care Use Tax

The Federal government, over the last two years, has informed states with Medicaid managed care Use Taxes (California, Michigan, Ohio, and Pennsylvania) that it will no longer consider use of such taxes as being acceptable after the end of the current legislative session, that is, after the end of calendar year 2016. What this means is that the Federal government can be expected to reduce Medicaid reimbursements to states that continue to collect the tax by the amount of state revenue benefit the states receive from the existence of the tax.

Medicaid is a shared State/Federal program. The Federal government does not directly reimburse Medicaid services. Instead, the State reimburses and then bills the Federal government for the Federal share of the costs. Because of this arrangement, the Federal government could reduce reimbursements, effectively increasing State GF/GP costs for Medicaid. In order to avoid these reductions, the State would have to seek a change in the law by Congress or successfully sue the Federal government on the ground that the reduction was not justified under current law and regulation.

There have been arguments advanced that, since the Medicaid managed care Use Tax revenue goes into the General Fund and the School Aid Fund and not directly into the Medicaid program, the money is not being used to support Medicaid. The Federal government has argued that, since GF/GP revenue is fungible, the money is in effect supporting Medicaid.

The FY 2016-17 Department of Health and Human Services budget reflects an assumed expiration of the Medicaid managed care Use Tax on January 1, 2017. There are three impacts tied to this expiration built into the budget: 1) a loss of GF/GP and School Aid Fund revenue of (combined) about $466.1 million over the final three quarters of FY 2016-17; 2) a reduction in actuarial soundness costs of $125.5 million GF/GP for the final three quarters of FY 2016-17; and 3) an increase in HICA revenue of about $61.6 million as the rate would revert from 0.75% to 1.0% effective January 1, 2017. The net impact of these changes would make the State worse off by $123.6 million GF/GP and $155.4 million School Aid Fund in FY 2016-17.

Senate Bill 988 would amend the Michigan Trust Fund Act to create the "Health Services Fund" in the State Treasury. The Fund could receive money or assets from any source. Surplus funds would not lapse to the General Fund at the end of the fiscal year but would remain in the Health Services Fund.

The bill would limit the annual expenditure of the Fund, upon appropriation, to the following purposes in the following order of priority: 1) $2.0 million to the Safe Drinking Water Revolving Fund to assist water suppliers in satisfying the requirements of the Federal Safe Drinking Water Act and for distribution of low-interest loans and grants to qualified water suppliers; 2) $100.0 million to support the Community Mental Health (CMH) non-Medicaid budget line, with at least 5.0% of the funds being used to support statewide adverse childhood experience intervention services; 3) $30.0 million to support local public health departments for non-Medicaid services; 4) $150.0 million in FY 2016-17 and $204.0 million in each subsequent fiscal year to support the Federal Medicare Pharmaceutical Program; and 5) the balance to support clinical and mental health services in the Department of Corrections.

The bill would prohibit the use of any revenue from the Fund to pay any Medicaid benefits or support the Medical Services Administration.

In effect, the bill would direct that the GF/GP portion of the Medicaid managed care Use Tax revenue be placed in a Restricted fund, to be spent on five specific programs, none of which is a Medicaid program, to supplant GF/GP support. While three of the programs are in the Department of Health and Human Services, each of the programs is a clearly defined non-

Medicaid program. The Federal Medicare Pharmaceutical Program is the State's reimbursement of the estimated State share of the costs of Medicare Part D services provided to those dually eligible for Medicare and Medicaid. Prior to the creation of Medicare Part D, pharmaceutical services for "dual eligibles" were provided through the Medicaid program. Those services are now provided by Medicare, the reimbursement is a strictly GF/GP payment, and the program funded by the line is not a Medicaid program.

Senate Bill 989 would amend the Use Tax Act. Section 3f of the Act establishes the Medicaid managed care Use Tax, beginning January 1, 2014, with no ending date. The bill would sunset that tax on December 31, 2016. A new tax, imposed on the same entities (Medicaid managed care organizations and Prepaid Inpatient Health Plans) at the same rate, would be established on January 1, 2017.

The bill also would require collections from the new Medicaid managed care Use Tax to be deposited in the proposed Health Services Fund. Revenue deposited into the Fund could not be used to reimburse any Medicaid services or to support the Medical Services Administration.

The bill effectively would reinstate the Medicaid managed care Use Tax, but would make clear that none of the revenue could be used to support any Medicaid-related activities, whether those activities were services or administration.

Senate Bill 990 would amend the Income Tax Act to divert an amount of income tax revenue equivalent to the estimated GF/GP revenue from the Medicaid managed care Use Tax to the Medicaid Benefits Trust Fund to be used to support actuarially sound payments for Medicaid managed care organizations. The amount of revenue used to support actuarial soundness (roughly $420.0 million full year) would exceed the amount necessary to cover the increased GF/GP actuarial soundness costs of the new Medicaid managed care Use Tax (roughly $170.0 million full year). Therefore, the funding would be used effectively to cover the costs of ensuring actuarially sound payments related to the new Medicaid managed care Use Tax as well as the State share of general Medicaid managed care costs.

Senate Bill 987 would amend the Health Insurance Claims Assessment Act. The sunset date for the HICA was changed from December 31, 2017, to July 1, 2020, under Public Act 50 of 2016. Senate Bill 987 would move that sunset date to December 31, 2018, changing the 30-month extension enacted by Public Act 50 to a 12-month extension.

The bill also would reduce the HICA rate to 0.0% beginning January 1, 2017, as long as the new Medicaid managed care Use Tax was in effect. If the Federal government determined that the Medicaid managed care Use Tax revenue would not be federally reimbursed, after all waivers had been denied and all appeals exhausted, the HICA rate would revert to 1.0%.

The Larger Picture

The legislation would institute a new version of the Medicaid managed care Use Tax. The GF/GP money from the Medicaid managed care Use Tax would be put into a Restricted fund and its use would be limited to specific non-Medicaid programs to offset GF/GP costs. The School Aid Fund revenue would, as before, be used for educational programs, which also would not be Medicaid-related.

The State's share of the actuarial soundness cost of the Medicaid managed care Use Tax would be paid from a diversion from the State's income tax, thereby further ensuring that no revenue from any portion of the Medicaid managed care Use Tax would be used to support Medicaid costs.

Assuming the Federal government does not disapprove this approach, the HICA rate would drop to 0.0% on January 1, 2017. The HICA itself would be repealed effective December 31, 2018.

MCL 550.1733 (S.B. 987)
MCL 12.252 & 12.256 (S.B. 988)
MCL 205.93f & 205.11 (S.B. 989)
MCL 206.51f (S.B. 990)

FISCAL IMPACT

In order to estimate a fiscal impact, one must look at two scenarios. The first assumes full implementation of the legislation. The second assumes that the Federal government states its disapproval of the revised tax and makes clear its intention to reduce Medicaid reimbursement to the State.

Fiscal Impact of the Package

If the legislation were enacted and took effect, several changes would have an impact on GF/GP revenue and spending and School Aid Fund revenue.

1) Beginning January 1, 2017, the State would receive new Medicaid managed care Use Tax revenue that formerly would have been treated as GF/GP revenue but instead would be deposited as Restricted revenue in the proposed Health Services Fund. This would have no direct GF/GP impact compared to the current status quo.

2) Beginning January 1, 2017, revenue in the Health Services Fund would be used to support five non-Medicaid programs and would offset GF/GP expenditures in those budget lines, leading to GF/GP savings equal to the amount of new non-School Aid Use Tax revenue.

3) Beginning January 1, 2017, a portion of the State's income tax, equivalent to the GF/GP portion of the Medicaid managed care Use Tax, that would have previously accrued to the General Fund instead would go to the Medicaid Benefits Trust Fund, as Restricted revenue, to support Medicaid managed care actuarial soundness costs. This would reduce available General Fund revenue.

4) Beginning January 1, 2017, the HICA rate would drop to 0.0% and the HICA itself would be repealed effective December 31, 2018. This would increase GF/GP costs as the portion of Medicaid supported with HICA would have to be supported with GF/GP revenue.

5) Beginning January 1, 2017, the School Aid Fund would receive increased revenue from the new Medicaid managed care Use Tax. This would result in a direct benefit to the School Aid Fund.

The numbers displayed in the tables reflect the net impact on the State's GF/GP and School Aid Fund balance sheets. In other words, an action that would reduce GF/GP revenue (such as the diversion of income tax revenue) is portrayed as a positive number as the State would need more GF/GP dollars to maintain current programming, all other things being held constant. An action that would reduce GF/GP costs (such as the use of Restricted Health Services Fund revenue to supplant GF/GP support in various lines) is portrayed as a negative number, as the State would need less GF/GP support to maintain current programming.

Table 1 displays the fiscal impact of the Health Services Fund. The State would see a GF/GP benefit from the use of Medicaid managed care Use Tax revenue, funneled through the Health Services Fund, to supplant GF/GP dollars used to support five specifically designated non-Medicaid programs. The net GF/GP fiscal impact would be positive, resulting in a reduced need for GF/GP funding.

Table 1

Health Services Fund		
Fiscal Year	Projected Health Services Fund Revenue	Change to GF/GP Balance Sheet Due to Use of Health Services Fund Revenue
FY 2016-17	$310,700,000	$(310,700,000)
FY 2017-18	422,552,000	(422,552,000)
FY 2018-19	431,003,000	(431,003,000)
FY 2019-20	439,623,100	(439,623,100)

Table 2 displays the fiscal impact of the diversion of income tax revenue to support actuarial soundness payments. The State would face an increase in GF/GP costs due to the income tax diversion, as the reduced GF/GP revenue would be only partly recouped due to the use of diverted revenue to offset current GF/GP actuarial soundness costs. The new actuarial soundness costs tied to the Medicaid managed care Use Tax would equal in magnitude the change to the balance sheet, which would reflect greater net costs.

Table 2

Impact of Income Tax Diversion				
Fiscal Year	Reduced GF/GP Revenue Due to Income Tax Diversion	Medicaid Managed Care Use Tax Actuarial Soundness Costs	GF/GP Savings Due to Diverting Income Tax Revenue to Offset Current non-Use Tax Actuarial Soundness Costs	Net Change to State GF/GP Balance Sheet Due to Income Tax Diversion
FY 2016-17	$310,700,000	$(125,542,100)	$(185,157,900)	$125,542,100
FY 2017-18	422,552,000	(173,880,500)	(248,671,500)	173,880,500
FY 2018-19	431,003,000	(178,958,100)	(252,044,900)	178,958,100
FY 2019-20	439,623,100	(186,537,300)	(253,085,800)	186,537,300

Table 3 displays the impact of the HICA changes. Assuming full implementation of the bills, the HICA rate would drop to 0.0% on January 1, 2017, and the HICA would be repealed on December 31, 2018.

Table 3

Impact of HICA Changes		
Fiscal Year	Reduction in HICA Revenue	Net Change to State GF/GP Balance Sheet due to HICA Changes
FY 2016-17	$(246,600,000)	$246,600,000
FY 2017-18	(334,560,000)	334,560,000
FY 2018-19	(341,251,200)	341,251,200
FY 2019-20	(261,057,200)	261,057,200

In effect, there would be no HICA revenue from January 1, 2017, onward, which would lead to increased GF/GP costs and a worsening GF/GP balance sheet.

Table 4 displays the overall impact of the bills on the State's GF/GP balance sheet.

Table 4

Overall Impact of Legislation on GF/GP Balance Sheet

Fiscal Year	Change to GF/GP Balance Sheet Due to Use of Health Services Fund Revenue	Net Change to State GF/GP Balance Sheet Due to Income Tax Diversion	Net Change to State GF/GP Balance Sheet due to HICA Changes	Net Impact of Legislation on State GF/GP Balance Sheet
FY 2016-17	$(310,700,000)	$125,542,100	$246,600,000	$61,442,100
FY 2017-18	(422,552,000)	173,880,500	334,560,000	85,888,500
FY 2018-19	(431,003,000)	178,958,100	341,251,200	89,206,300
FY 2019-20	(439,623,100)	186,537,300	261,057,200	7,971,400

The State's GF/GP balance sheet would be worse off in each of the fiscal years displayed.

Table 5 displays the impact of the legislation on the School Aid Fund (SAF) balance sheet.

Table 5

Impact of Legislation on School Aid Fund

Fiscal Year	Increase in School Aid Fund Revenue due to New Use Tax	Net Impact of Legislation on SAF Balance Sheet
FY 2016-17	$155,350,000	$(155,350,000)
FY 2017-18	211,276,000	(211,276,000)
FY 2018-19	215,501,500	(215,501,500)
FY 2019-20	219,811,550	(219,811,550)

Due to new School Aid Fund revenue from the Medicaid managed care Use Tax, with no corresponding expenditure increases, the School Aid Fund balance sheet would be significantly better off, with surplus revenue.

Year-by-Year Discussion

In FY 2016-17, with the provisions taking effect for the final three fiscal quarters, the State would see a reduction in GF/GP costs of $310.7 million due to the new Medicaid managed care Use Tax revenue supplanting GF/GP funding for five specific non-Medicaid programs. The State would see a net reduction of $125.5 million in available GF/GP revenue from the income tax due to the diversion of income tax revenue to support the actuarial soundness costs. The State would see increased GF/GP costs of $246.6 million to offset lost HICA revenue. The net impact of these changes is that the GF/GP balance sheet would be worse off by $61.4 million. More than offsetting this would be an increase in available School Aid Fund revenue of $155.4 million due to the School Aid Fund portion of the new Medicaid managed care Use Tax.

The net impact would be greater in FY 2017-18 as the provisions would be in effect for a full year. The GF/GP balance sheet would be worse off by $85.9 million while the School Aid Fund balance sheet would be better off by $211.3 million.

In FY 2018-19, the GF/GP balance sheet would be worse off by $89.2 million while the School Aid Fund balance sheet would be better off by $215.5 million.

Finally, in FY 2019-20, the GF/GP balance sheet would be worse off by $8.0 million while the School Aid Fund balance sheet would be better off by $219.8 million. The GF/GP situation would be improved in FY 2019-20 as the HICA, under current law, expires on July 1, 2020, so the new legislation would reduce HICA revenue only for the first three quarters of FY 2019-20 rather than the entire fiscal year.

Fiscal Impact if the Federal Government Disapproved of the Medicaid Managed Care Use Tax

The only effective change would be the change in the sunset on the HICA. Instead of expiring on July 1, 2020, the HICA would expire on December 31, 2018. The Senate Fiscal Agency estimates that the earlier sunset would reduce HICA revenue by $255.9 million in FY 2018-19 and $261.1 million in FY 2019-20. This would result in a corresponding increase in GF/GP costs of $255.9 million in FY 2018-19 and $261.1 million in FY 2019-20.

Notes on Assumptions in the Fiscal Analysis

1) The FY 2015-16 and FY 2016-17 numbers for HICA revenue, Use Tax revenue, and the actuarial soundness costs for the Use Tax are based on the Medicaid expenditure consensus agreement reached among the State Budget Office, the House Fiscal Agency, and the Senate Fiscal Agency on May 10, 2016.

2) The Medicaid managed care Use Tax revenue estimate in years after FY 2016-17 reflects the FY 2016-17 first quarter consensus number inflated by 2.0% each year.

3) The HICA revenue estimates for FY 2017-18 and subsequent years are based on the consensus FY 2016-17 HICA estimate inflated by 2.0% each year.

4) The Medicaid managed care Use Tax actuarial soundness cost GF/GP estimates after FY 2016-17 are based on the consensus FY 2016-17 figure inflated by 2.0% each year and adjusted for changes in Medicaid match rates. The Federal Funds Information for States estimates that the traditional Medicaid Federal match rate will decline from 65.15% in FY 2016-17 to 64.70% in FY 2017-18. This analysis assumes that, lacking better information, the match rate will continue at 64.70% after FY 2017-18. The Federal match rate for Medicaid expansion will drop from 100.0% to 95.0% on January 1, 2017, 94.0% on January 1, 2018, 93.0% on January 1, 2019, and 90.0% on January 1, 2020. As noted above, the actuarial soundness GF/GP cost estimates take into account these match rate changes.

Date Completed: 5-26-16 Fiscal Analyst: Steve Angelotti

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