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BILL ANALYSIS

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Senate Bill 1172 (as introduced 11-10-16)
Sponsor: Senator Ken Horn
Committee: Michigan Competitiveness

Date Completed: 11-29-16

CONTENT

The bill would amend the Use Tax Act to direct that the Medicaid managed care Use Tax no longer be collected upon written notification and explanation from the Federal government that the Use Tax revenue is not permissible, and that Federal Medicaid match funding will be reduced on a date certain. The tax would no longer be collected on that date certain or when Federal reimbursement was actually reduced, whichever occurred first. If, subsequent to such Federal notification, the Federal government provided the State with written notification that such a tax is permissible and match funding is available, then the tax would be reinstated.

MCL 205.93f

BACKGROUND

The State of Michigan first instituted a Medicaid managed care Use Tax in 2009 to replace a Medicaid managed care quality assurance assessment program that had been barred by the Federal Deficit Reduction Act. The Centers for Medicare and Medicaid Services (CMS) initially allowed the tax, but began to question the validity of the approach. Due to fears of new rules that could prevent the State from continuing the tax and concerns about potential retroactive disallowances, 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).

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.

Senate Bills 893 and 913 (Public Acts 161 and 162 of 2014) reinstated the Use Tax and reduced the HICA rate from 1.0% to 0.75% for as long as the Federal government did not disallow the Use Tax.

Over the last two years, the Federal government has informed states with Medicaid managed care taxes (California, Michigan, Ohio, and Pennsylvania) that it would 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. The expectation is that the Federal government will reduce its Medicaid reimbursement to states that continue to collect the tax by the amount of state revenue benefit the states receive from the existence of the tax.

Michgan's FY 2016-17 Department of Health and Human Services budget reflected an assumed expiration of the Medicaid managed care Use Tax on January 1, 2017. The net impact of these changes on Use Tax and HICA revenue and payments to Medicaid managed care organizations would make the State worse off by $123.6 million GF/GP and $155.4 million School Aid Fund (SAF) in FY 2016-17. These changes were fully accounted for in the budget.

Senate Bills 987, 988, 989, and 990

A package of bills was introduced and passed by the Legislature this fall to continue the Use Tax during calendar year 2017 and beyond in a way believed to be more acceptable to the Federal government. The proposed bills segregated and allocated the Use Tax funding to ensure that none of the Medicaid managed care Use Tax revenue would be used to support Medicaid programs. Governor Snyder vetoed the package, expressing concern that the Federal government would not find the approach taken acceptable.

Current Statute

The statute does not specify an expiration date for the Medicaid managed care Use Tax. As such, the administration believes that the tax would have to continue to be collected even though, assuming the Federal government makes clear its disapproval, there would be no net benefit to the State from the tax. Under Federal rules governing Medicaid managed care actuarial soundness, the State would have to reimburse the Medicaid managed care organizations for the cost of the tax.

In effect, assuming Federal disapproval, the most likely outcome would be as follows: the State would collect full-year Use Tax revenue of about $630.0 million ($420.0 million GF/GP and $210.0 million SAF), then would spend approximately $170.0 million GF/GP and $460.0 million in Federal Medicaid match to reimburse those managed care costs under actuarial soundness requirements, and then the Federal government would reduce Medicaid reimbursement by approximately $460.0 million (increasing GF/GP costs) to reflect its disapproval of the Medicaid managed care Use Tax.

While the net result of the above adjustments would lead to no net impact on the combined GF/GP and SAF budgets (although there would be a shift of $210.0 million between GF/GP and SAF), it would create a complex series of transactions and would appear to violate the spirit of previously stated Federal intentions.

It does not appear that the State has yet received the sort of specific written notification and explanation from the Federal government that would be required by Senate Bill 1172. There have been statements from the CMS to the states with Medicaid Merged Care Use Tax indicating disapproval, but it appears that a further statement would be necessary to trigger the language in the bill.

FISCAL IMPACT

The fiscal impact of the legislation depends on which of several scenarios occurs.

In the first case, the bill would be enacted and the Federal government would provide the written notification and explanation required by the bill, with the effective date of January 1, 2017. There would be no fiscal impact, as the FY 2016-17 budget assumed expiration of the Medicaid managed care Use Tax on January 1, 2017.

In the second case, the bill would be enacted and the Federal notification and explanation would reflect a different effective date, likely later than January 1, 2017. The fiscal impact would be beneficial to the State, by approximately $32.0 million combined GF/GP and SAF per month of delay.

In the third case, the bill would be enacted and the Federal government would not provide notification and explanation (or, alternatively, would provide specific approval to continue the Medicaid managed care Use Tax). The Medicaid managed care Use Tax would continue and the State would be better off by $32.0 million for each month that the tax continued. Furthermore, the HICA rate would continue at 0.75% instead of going to 1.0% on January 1, 2017.

In the fourth case, the bill would be enacted and the Federal government initially would provide the notification and explanation, then, at a later date, again allow reimbursement. There would be no fiscal impact during the period that the tax was disallowed, but the State would see a net benefit of $32.0 million combined GF/GP and SAF for each month after the tax was re-allowed.

Finally, if the legislation were not enacted but the Federal government disapproved continuation of the Medicaid managed care Use Tax, there would be no net fiscal impact on combined GF/GP and SAF revenue, but there would be a complex series of transactions that would lead to an effective Federal disallowance that would offset any gain (as described in the "Current Statute" section above). These transactions would include continued taxation of Medicaid managed care organizations without any net benefit to them or to the State.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.