Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986

House Bill 5105 (as reported without amendment)
Sponsor: Representative Al Pscholka
House Committee: Appropriations
Senate Committee: Appropriations

CONTENT

Background on the Health Insurance Claims Assessment

The Health Insurance Claims Assessment (HICA) was enacted in 2011 and took effect on January 1, 2012. The HICA, which is a broad-based tax on paid health claims, was created after two other more narrowly tailored taxes on Medicaid managed care services came under Federal scrutiny. Those taxes are relevant to the development of HICA and the changes proposed in House Bill 5105.

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. Again, therefore, 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 on Medicare HMOs and PIHPs, 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. Thus, 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 on Medicare HMOs and PIHPs and implemented the 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.

The initial HICA statute had a sunset date of January 1, 2014. In 2013, that sunset was delayed to January 1, 2018. The statute also had a revenue cap of $400.0 million, adjusted each year by medical inflation.

Revenue

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 Use Tax and Changes to HICA

Effective July 1, 2013, the State of California implemented a 3.9375% sales tax on Medicaid health plans in that state to be in effect through 2016. The Snyder Administration then asked the Federal government whether it could reinstate the managed care use tax and was told that the State would be treated similarly to California. It should be noted that the California and Michigan managed care taxes did not require Federal approval; instead, the Federal government could block the proposal by stating disapproval.

The legislation, Public Act 161 of 2014, applied the 6.0% use tax beginning April 1, 2014, to Medicaid managed care organizations. One third of use tax revenue, pursuant to the Michigan Constitution, goes to the School Aid Fund and two thirds goes to the General Fund.

Tie-barred with this legislation were changes to the HICA. Amendments to the HICA statute reduced the HICA rate, effective July 1, 2014, from 1.0% to 0.75%. The 0.75% rate will revert immediately to the original 1.0% if and when the Federal government no longer allows revenue from the use tax to be used as State match for the Medicaid program.

The HICA statutory changes also created a new cap on revenue. Credits will be provided to HICA taxpayers if HICA revenue plus General Fund/General Purpose (GF/GP) use tax revenue in excess of the GF/GP revenue needed to cover use tax actuarial soundness exceeds $400.0 million adjusted for the medical inflation rate since 2011 but not to exceed $450.0 million. In effect, the credits will apply if HICA revenue plus the use tax revenue actually available to support ongoing Medicaid programming exceeds the trigger amount.

The credits for a prior year's revenue in excess of the cap will be paid in July of the subsequent year. Due to the timeline there was no excess revenue in calendar year 2014. At this point, it is projected that there will be excess revenue in calendar year 2015, which will be repaid with a credit in July 2016. It also appears that there will be excess revenue in calendar year 2016, which will be repaid with a credit in July 2017. The termination of collection of the use tax on Medicaid managed care organizations at the end of 2016 means that total net revenue will not exceed the cap in 2017, so there will be no credits paid after the credits for 2016 are paid.

Federal Communication on the Use Tax

The Federal government has told states with Medicaid managed care taxes that they will not support matching such revenue after the end of the legislative session beginning in 2015. After discussion with the Federal government, there was agreement that the end of the legislative session for Michigan means the end of calendar year 2016 (rather than the end of calendar year 2015).

Some have expressed the belief that the State could continue to collect the use tax. There has been recent communication from the Centers for Medicare and Medicaid Services to the Michigan House of Representatives confirming that the Federal government does not consider the managed care use tax a broad-based tax and that it is "inconsistent" with statute. The CMS noted that it, in July 2014, "advised states with a tax structure such as the use tax to make changes to the tax to ensure compliance with federal requirements as soon as possible, but no later than the end of the state's legislative session after the date of the letter". The CMS stated that a broad-based tax on "all [managed care] services" would likely meet Federal requirements. It should be noted that the HICA meets Federal requirements because, similar to the suggested tax on all managed care services, it is a broad-based tax on health services. (The difference between the HICA and a tax on all managed care services is that services provided under a fee-for-service model are also taxed under the HICA.)

Due to the Federal concerns, the Snyder Administration has made it clear that it will no longer collect the managed care use tax after December 31, 2016. At that point, the HICA rate will revert from 0.75% to 1.0%

House Bill 5105

House Bill 5105 would delay the HICA sunset from December 31, 2017, to September 30, 2025, or for 7-3/4 years. This would lead to greater HICA revenue in FY 2017-18 (full year rather than 1/4 of the fiscal year) and new HICA revenue in FY 2018-19 through FY 2024-25.

MCL 550.1733

FISCAL IMPACT

Impact on HICA Revenue

Under current policy, the expiration of collection of the Managed care use tax at the end of calendar year 2016 would lead to the HICA rate increasing to 1.0% on January 1, 2017. The HICA would continue at the 1.0% rate until the sunset of December 31, 2017. Enactment of House Bill 5105 would have no impact on direct HICA revenue until January 1, 2018. The bill would increase HICA revenue, offsetting an equal amount of GF/GP revenue, from FY 2017-18 through FY 2024-25.

In FY 2014-15, at a 0.75% tax rate, HICA revenue was $228.6 million. At the 1.0% rate that would be in effect after December 31, 2016, this would be a full-year amount of $304.8 million. Due to growth in health care coverage (in particular Medicaid expansion) and health care costs overall, the revenue base should continue to grow.

The Senate Fiscal Agency projects that full-year FY 2017-18 HICA revenue, at a 1.0% tax rate, would be $330.0 million. This would imply $82.5 million in HICA collections in the first quarter of FY 2017-18 pursuant to current statute. The SFA expects continued slow growth in revenue beyond that point, with projected FY 2018-19 revenue of $340.0 million and similar growth rates in subsequent years.

As such, the SFA projects that House Bill 5105 would increase HICA revenue by $247.5 million in FY 2017-18 (the $330.0 million full-year revenue less the $82.5 million that would be collected from October 1, 2017, to the current HICA sunset on December 31, 2017). The Senate Fiscal Agency projects that the bill would increase HICA revenue by $340.0 million in FY 2018-19. In each case, the HICA revenue would offset an equal amount of GF/GP funding in the State's Medicaid program.

Summary of Fiscal Impact

The Senate Fiscal Agency estimates that enactment of House Bill 5105 would reduce GF/GP costs by $247.5 million in FY 2017-18 and $340.0 million in FY 2018-19. The GF/GP savings would continue to slowly increase above the FY 2018-19 amount from FY 2019-20 through FY 2024-25, when the HICA would sunset.

Estimates of out-year HICA revenue are dependent on the rate of growth of demand for medical services. Other factors that could greatly affect the estimate of the HICA tax base include whether the Medicaid expansion continues and the expansion of managed care services under the Medicare/Medicaid dual eligible waiver.

Date Completed: 12-10-15 Fiscal Analyst: Steve Angelotti