Legislative Analysis

CREATE THE INSURANCE PROVIDER ASSESSMENT ACT

Phone: (517) 373-8080
http://www.house.mi.gov/hfa

Senate Bill 992 (S-1) as passed by the Senate
Sponsor: Sen. Ken Horn

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

Senate Bill 993 as passed by the Senate
Sponsor: Sen. Peter MacGregor

Senate Bill 994 as passed by the Senate
Sponsor: Sen. Mike Shirkey

House Committee: Michigan Competitiveness
Senate Committee: Michigan Competitiveness
Complete to 5-21-18

SUMMARY:

Taken together, Senate Bills 992, 993, and 994 would repeal the Health Insurance Claims Assessment Act; remove a provision in the Use Tax Act that provides for the reinstatement of the Medicaid managed care use tax in certain circumstances; and create the Insurance Provider Assessment Act, a new health care-related tax with a fixed and variable rate structure.

The bills continue a series of legislation in recent years that has modified the state taxation of managed care organizations (MCOs) and other health insurers (see **BACKGROUND**, below).

Senate Bills 992 and 993 are each tie-barred to Senate Bill 994, which means that they cannot take effect unless SB 994 is also enacted.

Senate Bill 992 would repeal the Health Insurance Claims Assessment Act, an act that imposes a 1.0% assessment on health care claims paid by carriers and third party administrators. The repeal would occur on the first day of the calendar quarter in which the Director of the Department of Health and Human Services (DHHS) notifies the Secretary of State that the Federal Centers for Medicare and Medicaid Services (CMS) has approved its request for a waiver of the broad-based and uniformity provisions regarding health care-related taxes in title XIX of the Social Security Act (Medicaid), for implementation of the Insurance Provider Assessment Act or October 1, 2018, whichever is later.

The bill would also delete provisions that will increase the HICA assessment rate to 1.0% if the state's Medicaid managed care use tax is deemed by the federal government to not be reimbursable.

The bill would state that, after January 1, 2017 and until the first day of the calendar quarter in which the waiver has been approved or October 1, 2018, whichever is later, the HICA assessment rate is 1.0%.

MCL 550.1733 and proposed MCL 550.1731a

Senate Bill 993 would amend the Use Tax Act to delete a provision that reinstates the state's Medicaid managed care use tax on July 1, 2020, or in the event that HICA is repealed or the rate is reduced to 0.0%, whichever is sooner.

MCL 205.93f

Senate Bill 994 would create the Insurance Provider Assessment Act ("Act"), to account for the repeal of HICA and the elimination of the triggering event to reinstate the Medicaid managed care use tax.

The bill would require DHHS, if it has not already done so, to submit an application to CMS to request a waiver, for a period of not less than 5 years, of the broad-based and uniformity provisions regarding health care-related taxes in the federal Social Security Act, relating to the assessment imposed by the Act, by October 1, 2018.

Federal Waiver Application Statistical Test

For purposes of calculating federal Medicaid reimbursement, federal law requires a health care-related tax to meet specific criteria. Specifically to this act, the tax must be "broad-based," meaning that it must be imposed with respect to a class of health care items or services or with respect to providers of health care items or services, and it must be "imposed uniformly," meaning that the amount of the tax imposed must be the same for every provider providing items or services within a class.

Federal law allows states to submit a waiver application to request that a health care-related tax be treated as broad-based and uniform if the state health care-related tax can meet certain statistical thresholds as outlined in federal regulations. The statistical tests require the slope of the linear regression line of the proposed tax structure (B2) to be not greater than the slope of the linear regression line if the tax were structured broadly and uniformly (B1). This statistical test ensures that states do not structure a health care-related tax that places an inordinate amount of the tax liability onto Medicaid providers, and therefore on the federal government. If the outcome of the analysis results in B1/B2 greater than or equal to 1, CMS must approve the waiver.

Assessment Calculation and Rate

Within 30 days of the effective date of the bill, DHHS would notify the Department of Treasury of the number of ***member months*** and the rate to be imposed on the member months for FY 2018-19, and identify the specialty prepaid health plans subject to the assessment. At the same time, the Department of Insurance and Financial Services (DIFS) would provide Treasury with a list of insurance providers by tier subject to the assessment.

> ***Member months*** is defined as the total number of individuals for whom the ***insurance provider*** has recognized revenue for 1 month. If revenue is recognized only for part of a month for an individual, a prorated partial member month could be continued. Members months would be determined by DIFS and do not include individuals enrolled in short-term medical, 1-time limited duration, noncomprehensive medical, specified disease, limited benefit, accident only,

accidental death and dismemberment, disability income, long-term care, Medicare supplement, stand-alone dental, dental, Medicare, Medicare advantage, Medicare part D, vision, prescription, other individual write-in coverage, federal employee health benefit Tricare, other group write-in coverage, credit, stop loss, excess loss, administrative services only, or administrative services contracts.

Insurance provider is defined as a Medicaid managed care organization or a health insurer.

Health insurer is defined as an insurer authorized under the Insurance Code to deliver, issue for delivery, or renew in Michigan a health insurance policy. It includes a health maintenance organization, but does not include a state department or agency administering a plan under the Social Welfare Act or a person administering a self-funded plan.

Beginning on the first day of the calendar quarter in which the director of DHHS notifies the Secretary of State and Department of Treasury in writing that the federal waiver has been approved for implementation of the Act or October 1, 2018, whichever is later, an annual assessment would be levied and imposed on the number of member months for each insurance provider reported on its annual financial statement filed with DIFS or DHHS, whichever is applicable, for the previous calendar year.

The following rates and circumstances would apply:

For tier 1, a Medicaid contracted health plan's member months supported with federal Medicaid funds, variable and fixed rates as follows:

- For the number of member months and the dollar amount necessary per member month, as determined each year by DHHS, to achieve a result of between 1.00 and 1.02 on the statistical test imposed by CMS (described above).
- For each remaining member month not assessed as above, $1.20 per member month.

For tier 2, a health insurer's member months not supported with federal Medicaid funds, $2.40 per member month.

For tier 3, a specialty prepaid health plan's member months supported with federal Medicaid funds, $1.20 per member month.

Information Sharing and Assessment

For the initial year of implementation, Treasury would notify each insurance provider between June 15, 2018 and October 15, 2018 of the number of member months and the rate imposed on the member months and of its assessment, prorated for 2 quarters, due based on the insurance provider's member months from the calendar year. The initial assessment would be payable in 2 equal installments, with payments due to Treasury by January 30, 2019 and April 30, 2019.

Beginning May 15 and each May 15 thereafter, DIFS and DHHS would make available to Treasury the number of member months for each insurance provider and the necessary assessment information for Treasury to calculate the assessment, including the number of member months and the rate to be imposed to meet the federal statistical test.

After June 1 but before June 15 of each year after implementation, Treasury would notify each insurance provider of the number of member months and the rate imposed and of its annual assessment due under the Act based on the insurance provider's member months for the previous calendar year. The assessment would be payable on a quarterly basis, submitted to Treasury on July 30, October 30, January 30, and April 30. If one of those dates fell on a Saturday, Sunday, state holiday, or banking holiday, payments would be due on the next succeeding business day. Treasury could require payment of the assessment by an approved electronic funds transfer.

Recordkeeping and Administration

An insurance provider liable for the assessment would keep accurate and complete records and documents as could be required by Treasury. Records required would be retained for a period of 4 years after the assessment to which the records apply is due or as otherwise provided by law.

If an insurance provider failed to file a return or keep proper records, or if Treasury believed that records kept or returns filed were inaccurate or incomplete and that additional assessments are due, Treasury could compute the amount of the assessment due from the insurance provider based on information that is available to Treasury. An assessment would be considered prima facie correct, and an insurance provider would have the burden of proof for refuting the assessment.

Treasury would administer the assessment as a tax under the Act and the revenue act; if any part of the revenue act conflicted, the provision of the Act would apply. Treasury would be authorized to promulgate rules to implement the Act under the Administrative Procedures Act.

The assessment would not be considered an assessment or burden for purposes of the tax, or as a credit toward or payment in lieu of the tax, under a provision regarding foreign insurers in the Insurance Code.

Treasury would submit an annual report to the state budget director, the Senate and House appropriations committees, and the Senate and House fiscal agencies not later than 120 days after May 15 that states the amount of revenue collected from insurance providers under the Act for the preceding fiscal year and the costs incurred for administration and compliance requirements.

Insurance Provider Fund

All money received and collected under the Act would be deposited by Treasury in the Insurance Provider Fund. The fund would be created within the state treasury and administered by Treasury for auditing purposes. The state treasurer could receive money

or other assets from any source for deposit into the fund. Interest and earnings from fund investments would be credited to the fund.

Treasury could spend money from the fund, upon appropriation, only for one or more of the following purposes:

- Beginning in FY 2018-19, $14.0 million for actuarially sound capitation rates to Medicaid managed care organizations, and the amount necessary to support this payment each fiscal year thereafter.
- For FY 2018-19, not more than $315.0 million to offset the net revenue lost from repealing HICA. For FY 2019-20, not more than $240.0 million for this purpose.
- Beginning in FY 2018-19, an amount not exceeding 0.5% of the annual remittances (approximately $3.0 million) under the Act for Treasury's administrative and compliance costs, subject to annual appropriation by the legislature.
- The balance remaining after these appropriations would be transferred to a separate restricted account within the fund and only used as appropriated by the legislature.

Money in the fund at the close of the fiscal year would remain in the fund and not lapse to the general fund.

Finally, Treasury would provide the director of DIFS with written notice of any final determination that an insurance provider has failed to pay an assessment, interest, or penalty when due. DIFS could suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in Michigan, or the license to operate in Michigan, of any provider that fails to pay an assessment due. A suspension of a certificate of authority to transact insurance or operate in Michigan would not be withdrawn unless any delinquent assessment, interest, or penalty had been paid.

BACKGROUND:

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 1.73 million individuals in the state—generally pregnant women, parents and children, and the aged, blind, and disabled, with incomes below varying thresholds. For FY 2018-19, the traditional Medicaid program is funded at a match rate of 64.45% federal and 35.55% state.

The expanded Medicaid program under the Healthy Michigan Plan provides coverage to approximately 670,000 adults at up to 138% of the federal poverty level. For FY 2018-19, the Healthy Michigan Plan is funded at a match rate of 93.25% federal and 6.75% state.

The FY 2018-19 Medicaid budget totals $17.1 billion. Of that total, $12.1 billion is funded by the federal government, and the remaining $5.0 billion consists of state match funds. The largest portion of those state match funds are GF/GP funds ($2.8 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 $2.2 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.

Specific to health care-related taxes, a permissible tax must meet three criteria:

- 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 (as described above).

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*,

[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.

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

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, Senate Bill 748 (2002 PA 304), amended by House Bill 6327 (2002 PA 621), 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), $263.0 million in Medicaid MCO QAAP was assessed, resulting in a net provider benefit of $154.0 million and a state retainer benefit of $88.0 million.[3]

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 their newly impermissible health care-related taxes by October 1, 2009.

Michigan responded with House Bill 5192 (2008 PA 440), 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 $383.0 million in revenues. These revenues allowed the state to continue providing Medicaid MCOs with reimbursement rates comparable 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 risking the loss of federal Medicaid revenue, the Governor proposed an alternate approach: the Health Insurance Claims Assessment (HICA).

Senate Bill 347 (2011 PA 141) sunsetted the MCO Use Tax beginning April 1, 2012, and Senate Bill 348 (2011 PA 142) 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 that a 1.0% HICA would generate between $375.0 million to $400.0 million in revenues. However, actual HICA revenues were closer to $270.0 million, requiring the state to identify other resources

[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.

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

Senate Bill 893 (2014 PA 161) reinstated the 6% Medicaid MCO Use Tax effective on April 1, 2014, and Senate Bill 913 (2014 PA 162) reduced HICA from 1.0% to 0.75% beginning July 1, 2014. In the Centers for Medicare and 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 reminds the State that in order to comply with the requirements, the tax will need to be sunset by the end date of the State's next legislative session or by 12/31/15." December 2016 is the end date that applied to Michigan. In FY 2015-16 (the last full fiscal year with this iteration of the MCO Use Tax), the Medicaid MCO Use Tax generated $620.6 million in revenues.

Current Tax Structure

The current managed care-related tax is HICA at 1% and with a sunset date of July 1, 2020 as established under House Bill 5105 (2016 PA 50). HICA revenues for FY 2018-19 are projected at $332.2 million and for FY 2019-20 are projected at $254.1 million (which reflects HICA collections for only 3/4 of the fiscal year).

FISCAL IMPACT:

Assuming federal approval by October 1, 2018, Senate Bills 992, 993, and 994 would increase state resources by an estimated $115.0 million in FY 2018-19, $195.0 million in FY 2019-20, and $440.0 million thereafter, as shown in the following table:

Estimated Increase/(Decrease) in State Resources

Millions of $

	FY 2018-19	FY 2019-20	FY 2020-21
Estimated IPA Revenues	602	613	624
Medicaid Actuarial Soundness Costs for IPA	(155)	(161)	(167)
Net Revenue Loss of Repealing HICA before July 1, 2020 Sunset	(315)	(240)	0
Set Aside for Medicaid MCO Rate Increase	(14)	(14)	(14)
Treasury Administrative Costs	(3)	(3)	(3)
Total Net Increase/(Decrease) in State Resources	**115**	**195**	**440**

[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 underestimation of the impact of increasing health care deductibles and co-pays (which are not taxed).

Data provided by the State Budget Office indicate that by providing the state with flexibility to set dollar amounts for the first number of Medicaid contracted health plan's member months so that B1/B2 is between 1.00 and 1.02, the IPA can meet the statistical test outlined in federal regulations and that CMS would be required to approve this health care-related tax. Projected FY 2018-19 IPA revenues total $602.0 million, and HFA estimates an annual growth rate of approximately 2%.

For IPA costs incurred by Medicaid MCOs, federal actuarial soundness costs related to the new IPA would require $155.0 million in state funds in FY 2018-19, with federal Medicaid matching funds paying the remaining actuarial soundness costs. Due to higher state match rates in FY 2019-20 and FY 2020-21, the state costs of actuarial soundness increase to an estimated $161.0 million and $167.0 million, respectively.

Net HICA revenue loss (i.e., HICA collections less Medicaid actuarial soundness costs) total $315.0 million in FY 2018-19 and $240.0 million FY 2019-20. With current law sunsetting HICA on July 1, 2020, there is no cost to repeal HICA in FY 2020-21 and thereafter.

The bills also earmark $14.0 million for Medicaid MCO rates and $3.0 million for administrative and compliance costs.

There is no cost to repeal the Medicaid MCO Use Tax.

The repeal of HICA could result in indirect state and local unit of government savings if those units have self-funded health insurance plans, which have to currently pay HICA but would not have to pay IPA.

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