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

BILL ANALYSIS

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

Senate Bill 992 (Substitute S-1 as reported)
Senate Bills 993 and 994 (as reported without amendment)
Sponsor: Senator Ken Horn (S.B. 992)
Senator Peter MacGregor (S.B. 993)
Senator Mike Shirkey (S.B. 994)
Committee: Michigan Competitiveness

CONTENT

Senate Bill 994 would enact the "Insurance Provider Assessment Act" to institute a new multi-tiered health insurance tax, called the Insurance Provider Assessment (IPA), which would apply at varying rates to non-Medicaid health insurers, prepaid inpatient health plans (providers of Medicaid behavioral health services), and Medicaid physical health managed care services. The bill also would require the Department of Health and Human Services to request a waiver from the Centers for Medicare and Medicaid Services that would allow the IPA to be in effect for at least five years.

In addition, the bill would create the "Insurance Provider Fund" for the deposit of IPA revenue, and would require money in the Fund to be used to replace lost Health Insurance Claims Assessment revenue, to cover Medicaid actuarial soundness costs, and for other specified purposes.

Senate Bill 992 (S-1) would repeal the Health Insurance Claims Assessment (HICA) Act after the IPA waiver was granted or on October 1, 2018, whichever was later.

Senate Bill 993 would amend the Use Tax Act to delete a provision reinstating the Medicaid managed care Use Tax if the HICA Act is repealed or the HICA rate goes to 0.0%.

Senate Bills 992 (S-1) and 993 are tie-barred to Senate Bill 994.

The bills are described in greater detail below, following a discussion of managed care taxes, the HICA, and related issues.

Discussion

Background on the Managed Care Taxes 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 developed 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 on Medicaid HMOs and PHIPs 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 sunset date in the original HICA legislation has been extended and the HICA is now slated to expire on July 1, 2020.

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 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, 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 initially 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 of the 2013-14 legislative session (Public Acts 161 and 162 of 2014) 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 also 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 between 2011 and 2016, that $450.0 million threshold was reached. In effect, if the combined net GF/GP benefit of the HICA and the managed care Use Tax were to exceed $450.0 million in a given year, in the next year HICA payers would have received a credit refunding that excess. However, due to the diversion of Use Tax revenue due to changes in the personal property tax, the State has never had to pay any credits.

Actuarial Soundness

The "net" GF/GP benefit of the Medicaid managed care Use Tax took 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 organizations then take 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 of 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 went to the General Fund and $210.5 million went to the School Aid Fund.

While the Medicaid managed care Use Tax has been eliminated, the actuarial soundness concerns still apply to Medicaid managed care organizations subject to the HICA or any new health insurance taxes.

Expiration of the Managed Care Use Tax

The Federal government informed states with Medicaid managed care Use Taxes (California, Michigan, Ohio, and Pennsylvania) that it would no longer consider use of such taxes as being acceptable after the end of the 2015-16 legislative session, that is, after the end of calendar year 2016. Barring action to end the taxes, the Federal government would have reduced 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.

A package of bills that would have reinstated the managed care Use Tax and specified that the money be spent on non-Medicaid health programs was passed by the Legislature in October 2016 but was vetoed by Governor Snyder in November 2016. The Governor's stated concern was that the managed care Use Tax would not be sufficiently broad-based to pass Federal muster due to the fungibility issue.

Repeal of the Use Tax and Reversion of the HICA Rate

Subsequent to the vetoes, the Legislature passed Senate Bill 1172, which terminated the Medicaid managed care Use Tax on December 31, 2016. Governor Snyder signed the legislation (Public Act 390 of 2016) and collection of the Medicaid managed care Use Tax ended on that date. At that point, the HICA rate, pursuant to Public Act 162 of 2014, reverted from 0.75% to 1.0%. Senate Bill 1172 also included a provision reinstating the Medicaid managed care Use Tax effective July 1, 2020, or when the HICA is repealed or the HICA rate is reduced to 0.0%, whichever occurs first. This reinstatement provision was included to allow for easier reinstatement of the Medicaid managed care Use Tax if the Federal government once again deemed such a tax permissible.

Revenue from the HICA has grown steadily since the tax was originally enacted; total HICA revenue in FY 2016-17 was $318.0 million. The Governor's FY 2018-19 budget assumes total HICA revenue of $332.2 million.

Broad-Based Provider Taxes

The Federal government has certain criteria for provider taxes: 1) the taxes must be applied to all providers in a provider class, 2) the taxes must be applied at the same rate to each provider, and 3) the taxes cannot be structured to ensure no net losers. The Federal government does provide an exception to uniformity requirements of 1) and 2): If the distribution of a tiered tax meets a certain statistical test (described in 42 CFR 433.68(e)) the Federal government must approve the tax because such a tax would be considered sufficiently broad-based to meet Federal muster.

During 2005, the State changed the long term care quality assurance assessment program (QAAP) tax to a tiered approach to reduce the liability for small nursing homes, many of which do not accept Medicaid. The non-Medicaid homes were subject to the tax but did not benefit from the Medicaid rate increase associated with the tax, so reducing the liability was a way to lessen the impact of the tax. The tiered tax features a lower rate on nursing homes with 39 or fewer beds and a separate lower rate on nursing homes with more than 51,000 Medicaid bed days. This three-tier tax met the Federal statistical requirement while providing QAAP tax rate relief to certain non-Medicaid nursing homes, so it was deemed permissible by the Federal government.

The long term care example indicates that states do not have to institute single-rate provider taxes; if they can develop a multi-tiered tax that meets the statistical requirement they may be able to reduce the impact of the tax on low Medicaid or non-Medicaid payers.

While the Federal statistical test for multi-tiered taxes is complex to describe, the basic approach is to compare the impact of a multi-tiered tax to that of a flat (single rate) tax on the same entities. The comparison is of the slope of a linear regression of the percent of each taxable entity's share of the total tax versus the amount of each taxable entity's Medicaid revenue. If the ratio of the slope of this calculation for the multi-tiered tax to the slope of this calculation for the flat rate tax is at least 1.00, then the Federal government must approve the multi-tiered tax as the tax would meet the requirement that it be broad-based.

A HICA Replacement that Meets Federal Muster

The most significant concern that the business community has had with the HICA was that it was a broad-based tax that effectively increased the cost of health insurance for individuals and businesses that purchased the insurance. This led to support for reinstatement of the managed care Use Tax in both 2013 and 2016.

The State could opt to replace the HICA with a single-rate health insurance tax that would tax all insurance, whether Medicaid or private insurance. Such a tax, while acceptable to the Federal government, would be largely similar to the HICA; it would apply across a broad range of insurance entities whether Medicaid or non-Medicaid. While there would be differences from the HICA in terms of net impact, the tax would lead to the same business community concerns that exist with the HICA.

A different approach would involve crafting a multi-tiered health insurance tax that would replace the HICA, would meet the Federal statistical test, and would reduce the effective tax on private insurance well below the level associated with the HICA.

This approach has been implemented in California, which created a new managed care tax, with a higher rate on Medicaid health plans than on non-Medicaid health plans and with a reduction in state taxes on health insurers. Even though it is a multi-tiered tax, it met the Federal statistical requirements and thus had to be approved by the Federal government and was implemented during 2016.

Senate Bill 994

Tax Structure

Senate Bill 994 would enact the Insurance Provider Assessment Act to institute a new multi-tiered health insurance tax, applied to insurer member months at varying rates, in Michigan. The tax would be known as the Insurance Provider Assessment (IPA).

The bill would exempt a number of insurance entities from the tax, including disability, accident, death and dismemberment, long-term care, Federal benefits (such as Medicare, TriCare, and Federal employee health), dental, vision, prescription, and other forms of limited health insurance. The bill also would exempt self-funded plans, which represent a large portion of the employee insurance market. The IPA would take effect on the first day of the calendar quarter in which the Department of Health and Human Services (DHHS) Director informed the Secretary of State and the Department of Treasury in writing that the Federal government had approved a waiver or October 1, 2018, whichever was later.

The intent of the bill would be to create a tax that, like California's, taxes Medicaid managed care at a higher rate than the rate applied to commercial insurance, permitting a net reduction in private health insurance taxes without a reduction in net revenue to the State while meeting the Federal statistical requirements.

The bill would attempt to accomplish this by applying a flat $2.40 per member month tax on non-Medicaid health insurers subject to the tax, a flat $1.20 per member month tax on prepaid inpatient health plans (PIHPs, the public entities that provide Medicaid behavioral health services in Michigan), and a two-level tax on Medicaid physical health managed care services. ("Member month" would mean the total number of individuals for whom a health insurer or Medicaid managed care provider has recognized income for a month.)

This two-level tax on Medicaid physical health managed care would include a flat tax of $1.20 per member month for member months beyond an unspecified number (the threshold number of member months will be called "X" for purposes of this discussion) and an unspecified per member month variable tax rate (called "$Y") for the first X member months. In effect, the first level of the tax would tax each Medicaid physical health managed care health plan at a rate $Y per member month for the first X member months for that given health plan. For

months beyond the first X months, each Medicaid health plan would be taxed at a flat rate of $1.20 per member month.

The reason for this variability would be to ensure that the IPA met the Federal statistical test. The bill would require that the values of X and $Y be set in order "to achieve a result of between 1.00 and 1.02 on the statistical test imposed by [CMS]". This flexibility would be necessary as changing conditions in the insurance market and in Medicaid could cause a value of X and $Y that met the statistical test in FY 2018-19 fail to meet that test in FY 2019-20.

While these two values would have the potential of being arbitrary, the entities being taxed, the Medicaid health plans, must be paid actuarially sound rates. Even if the value of $Y (or the threshold number of member months X) increased between years, the Medicaid health plans would be no worse off financially as the State would be required to make the health plans whole for the cost of the tax. (Similarly, if the tax rate or threshold decreased the Medicaid health plans would not realize a windfall.)

After discussions with the State Budget Office, there is one concrete example, based on relatively recent data and using round numbers, that more clearly illustrates how this setup would work. A tax rate of $60 per member month (the value that one would substitute for "$Y"), with a threshold of 1.0 million member months (the value that one would substitute for "X") would likely be close to meeting the statistical test if it did not actually meet the test's requirements.

For the purposes of this example, assume there is a Medicaid health plan with 2.5 million member months (which would reflect just under 210,000 covered individuals over a full year). The variable tax of $60 per member month (the value of "$Y") would apply to the health plan's first 1.0 million member months (the value of "X") while the upper level tax of $1.20 per member month would apply to all member months beyond 1.0 million (2.5 million less 1.0 million = 1.5 million). The health plan would be taxed $60 per member month for the first 1.0 million member months (for a total of $60.0 million) and $1.20 per member month for the next 1.5 million member months (for a total of $1.8 million). The total tax on the Medicaid health plan would be $60.0 million plus $1.8 million or $61.8 million.

The following year it could be the case that the statistical test, due to updated data, would require changes in the values of X and $Y. For further purposes of this example, assume that the values change so that X is set at 1.1 million member months and $Y is set at $55 per member month. In that case, the Medicaid health plan would be taxed at $55 per member month on its first 1.1 million member months ($55 times 1.1 million = $60.5 million) and at $1.20 per member month on its next 1.4 million member months ($1.20 times 1.4 million = $1.56 million), with the total tax now being $62.06 million. This would mean a slight increase in the taxes paid by the health plan, but that cost would effectively be reimbursed by the State through actuarial soundness. While the values of X and $Y that would be set for the tax would vary from year to year, it is unlikely that they would fluctuate greatly unless there were some major changes to the health insurance market.

The taxes on commercial insurance and the PIHPs would be more straightforward. In each case the tax would be a flat amount per member month ($2.40 per member month for commercial insurance and $1.20 per member month for the PIHPs), with the tax owed being calculated by multiplying the number of member months by the rate.

Insurance Provider Fund

Revenue from the IPA would be deposited in a new Insurance Provider Fund to be created in the Department of Treasury. Revenue deposited in the Insurance Provider Fund would first

be used to replace net lost HICA revenue tied to Senate Bill 992, to cover the Medicaid actuarial soundness costs for Medicaid managed care organizations subject to the IPA, to cover administrative costs of the program up to 0.5% of total revenue, and to increase physical health Medicaid HMO capitation rates by $14.0 million plus the Federal Medicaid match on $14.0 million in State funds (estimated to be about a 1.0% increase in rates). The bill specifies that amount of net lost HICA revenue replaced could not exceed $315.0 million in FY 2018-19 and $240.0 million in FY 2019-20.

"Net lost HICA revenue" refers to the reduction in HICA revenue due to repeal less the actuarial soundness costs for Medicaid managed care organizations that pay the HICA. In other words, the net lost HICA revenue would reflect the net increase in GF/GP costs for the State if the HICA were repealed. This would include the GF/GP costs of replacing the lost HICA revenue dollar-for-dollar less the GF/GP savings from no longer having to cover, under actuarial soundness, the cost of the HICA for Medicaid managed care organizations. While the majority of HICA revenue is collected from employee-based insurance, a significant portion is collected from Medicaid managed care organizations. The FY 2018-19 Executive, Senate, and House DHHS budgets assume about $332.2 million in HICA revenue, with an estimated GF/GP actuarial soundness cost of just over $17.2 million, so the net HICA revenue assumed in the FY 2018-19 budget is about $315.0 million.

The unallocated funds in the Insurance Provider Fund would be set aside in a Restricted fund and could be used only as appropriated by the Legislature. The unallocated revenue would not lapse to the General Fund at the end of the fiscal year.

The bill would require an annual report on administrative costs. The Director of the Department of Insurance and Financial Services (DIFS) could revoke an insurer's authority to operate in Michigan for failure to pay the IPA or any penalties.

Other Provisions

The bill would direct the DHHS, if it had not already done so, to request a waiver from the Centers for Medicare and Medicaid Services for a period of not less than five years to waive the broad-based and uniformity provisions of Title XIX (the Federal Medicaid statute). This waiver, if approved, would allow the IPA, if it initially met the Federal statistical requirements, to be in effect for at least five years without the statute having to be revised.

The bill also would direct the DHHS, within 30 days of the effective date of the proposed Act, to notify the Department of Treasury on the number of member months and the rate to be imposed on the member months (the values of X and $Y discussed above) and to identify the PIHPs subject to the assessment.

The bill would require the Department of Insurance and Financial Services, within 30 days of the effective date of the Act, to give the Department of Treasury a list of insurance providers subject to the IPA.

The DHHS and DIFS would have to inform the Department of Treasury by May 15 of each year the number of member months for each insurance provider and the assessment information necessary for Treasury to calculate the assessment. In turn, the Department of Treasury would have to inform each provider of the number of member months and the rate imposed. Tax payments would be due quarterly on July 30, October 30, January 30, and April 30.

The Department of Treasury would have to retain at least four years of records related to the IPA and would be allowed to assess taxes on managed care organizations that failed to file a

return or provide appropriate records. Insurance providers would be required to keep accurate and complete records as required by the Department. The Department would be required to report to the Legislature on the revenue collected and the costs incurred for administration and compliance.

Senate Bill 992 (S-1)

Senate Bill 992 (S-1) would repeal the HICA Act on the first day of the calendar quarter in which the DHHS Director informed the Secretary of State that the CMS had approved the waiver for the IPA or October 1, 2018, whichever was later. The HICA, under current statute, is slated to expire on July 1, 2020.

Senate Bill 993

Senate Bill 993 would amend the Use Tax Act to delete the provision reinstating the Medicaid managed case Use Tax if the HICA is repealed or the HICA rate is reduced to 0.0%. This provision would no longer be necessary as the IPA would effectively supplant the HICA.

MCL 550.1733 (S.B. 992)
MCL 205.93f (S.B. 993)

FISCAL IMPACT

Due to the repeal of the HICA under Senate Bill 992 (S-1), the bills would result in an indirect reduction in State and Local costs for health insurance. The Senate Fiscal Agency (SFA) estimates that these cost savings would include $4.0 million for State government, $9.0 million for local government, $4.0 million for public universities, $1.2 million for community colleges, and $20.0 million for public schools.

The SFA estimates that the Insurance Provider Fund established by Senate Bill 994 would accrue $114.6 million in FY 2018-19 and an additional $198.0 million in FY 2019-20.

Senate Bill 992 (S-1), by repealing the HICA, would reduce HICA revenue by $332.2 million in FY 2018-19 with an offset of $17.2 million GF/GP due to reduced actuarial soundness costs, thereby increasing GF/GP costs by a net $315.0 million. The bill would reduce HICA revenue by approximately $255.0 million in FY 2019-20 with an offset of $15.0 million GF/GP due to reduced actuarial soundness costs, thereby increasing GF/GP costs by $240.0 million in FY 2019-20. The lesser reduction in FY 2019-20 is because the HICA, due to its statutory expiration date of July 1, 2020, would be in effect only for the first three quarters of that fiscal year. These GF/GP cost increases would be offset by the specific dedication of revenue to offset these cost increases from the new tax that would be established by Senate Bill 994, so there would be no net GF/GP impact from the HICA repeal.

Senate Bill 993 would have no fiscal impact.

Estimating the impact of the IPA established by Senate Bill 994 requires an estimate of the lower level tax rate on Medicaid managed care organizations (the value of $Y discussed above) and the threshold member months (the value X discussed above) above which the $1.20 per member month rate would apply.

The most recent IPA model provided by the State Budget Office appears to include reasonable values for X and $Y. The value assumed for $Y is $58.26 per member month and the value assumed for X is 1,031,506 member months.

If those values are used, and currently estimated member months for Medicaid and commercial insurance are used, the tax on Medicaid managed care organizations would generate $500.4 million. The tax on Medicaid PIHPs would generate $32.6 million. The tax on commercial insurance would generate $68.5 million. Total tax revenue in FY 2018-19 would be $601.6 million (the value is slightly higher due to rounding). The Senate Fiscal Agency estimates a slight increase in revenue in FY 2019-20 to $613.0 million. Table 1 reflects these estimates.

Table 1

INSURANCE PROVIDER FUND REVENUE		
	FY 2018-19	**FY 2019-20**
Estimated IPA revenue	$601,600,000	$613,000,000
Use of tax revenue to offset net lost HICA revenue	(315,000,000)	(240,000,000)
Use of tax revenue to offset net actuarial soundness costs of IPA	(155,000,000)	(158,000,000)
Set-aside for physical health capitation rate increase	(14,000,000)	(14,000,000)
Treasury maximum admin. costs (0.5% of remainder)	(3,008,000)	(3,008,000)
Net Deposit into Insurance Provider Fund	**$114,592,000**	**$197,992,000**

The tax would have some offsets before remaining funds would be deposited in the Insurance Provider Fund: 1) $315.0 million in FY 2018-19 and $240.0 million in FY 2019-20 to offset net lost HICA revenue. 2) $14.0 million in each year to support an increase in Medicaid managed care organization rates. 3) About $155.0 million in FY 2018-19 and $158.0 million in FY 2019-20 to support the State's share of the actuarial soundness costs of the tax for Medicaid managed care entities (with the rest supported by Federal Medicaid match). 4) A maximum of $3.0 million each year to reflect the provision requiring 0.5% of the FY 2018-19 revenue to be provided to the Department of Treasury for administrative costs.

The end result would be a significant amount of Restricted money available in the Insurance Provider Fund.

The repeal of the HICA would lead to a secondary effect on State and local government. While the HICA applies to health insurers, the costs are passed along to those purchasing the insurance, including State and local governments in their role as employers. The SFA estimates that the State, as an employer, spends about $400.0 million GF/GP per year on health insurance, meaning that its indirect HICA costs are 1.0% of that total or $4.0 million. The SFA estimates that universities have indirect HICA costs of roughly $4.0 million and that community colleges have indirect HICA costs of $1.2 million. Because self-funded plans would not be taxed under this legislation and most large employers (including public entities) self-fund their insurance, termination of the HICA and its replacement with the IPA would reduce State costs by roughly $4.0 million GF/GP. University and community college costs would be reduced by $4.0 million and $1.2 million, respectively.

Local entities also would see savings. The SFA estimates that total indirect local government costs for HICA approach $9.0 million and total indirect school district costs exceed $20.0 million. While some local governments and school districts may not self-fund, even those districts would face a much lower tax under the IPA than under the HICA, so total savings for local governments would approach $9.0 million and school district savings would approach $20.0 million.

Conclusion

The bill package, due to the reduction in State employee health insurance costs, would result in a marginal benefit to the State's GF/GP balance sheet. The largest potential GF/GP impacts, the need to use GF/GP dollars to supplant lost net HICA revenue, and the actuarial soundness costs of the IPA, would be fully offset with IPA revenue.

State and local government, universities, community colleges, and school districts would see savings due to the end of the HICA.

The bill would create a new Restricted fund into which the SFA estimates $114.6 million would accrue in FY 2018-19 and $198.0 million would accrue in FY 2019-20.

Date Completed: 5-16-18 Fiscal Analyst: Steve Angelotti