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BILL ANALYSIS

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Senate Bill 348 (Substitute H-2 as passed by the House)
Sponsor: Senator Roger Kahn M.D.
Senate Committee: Appropriations
House Committee: Appropriations

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CONTENT

Background on Managed Care Provider Taxes

Federal law permits the use of "broad-based" provider taxes to support Medicaid services. Until 2006 these taxes were capped at 6.0%, but the cap was reduced in 2006 to 5.5%. 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 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. So, 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 two entities subject to the State's 6.0% Use Tax. This was, technically, not a provider assessment, 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. With a Medicaid match rate that is 66.14% in FY 2011-12, the $388.4 million in taxes paid by the Medicaid HMOs and PIHPs would effectively cost roughly $131.5 million GF/GP and $256.9 million Federal Medicaid match. So while the Use Tax brings in $388.4 million in revenue, its net benefit to the State's financial situation is $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.

The CMS is again looking at the Use Tax and the Snyder Administration states that new rules will likely soon be issued barring the State from using this sort of approach, which has put the State in the position of considering new ways to support its Medicaid programming.

Proposed Elimination of the HMO/PIHP Use Tax

In order to head off Federal action, Governor Snyder's proposed FY 2011-12 Department of Community Health (DCH) budget assumed elimination of the HMO/PIHP Use Tax as of October 1, 2011, and its replacement on that date with a 1.0% paid health claims assessment. The enacted DCH budget reflects concurrence with the Governor's proposal.

Implementing Legislation

Senate Bill 348 (H-2) would create a 1.0% paid health claims assessment.

Senate Bill 348 (H-2)

Senate Bill 348 (H-2) would create the "Health Insurance Claims Assessment Act" to implement, effective January 1, 2012, a 1.0% assessment on eligible paid health claims. The assessment would be paid to the State by the entity paying the health claim, in most cases the insurer, HMO, or third party administrator.

Exemptions

Several broad categories of paid health claims would be exempted from the assessment. As the State cannot compel the Federal government to pay taxes, payments made by the Federal Medicare program (including Medicare Advantage and Medicare Part D pharmaceutical coverage), Federal Veterans Administration, and fee-for-service Medicaid would not be subject to the assessment. Furthermore, Federal employee health insurance paid claims would not be subject to the assessment. A proposed waiver included in the FY 2011-12 budget to integrate services and payment streams for those dually eligible for Medicare and Medicaid would not be exempted, to the extent permitted by the Federal government, from the assessment.

Additionally, out-of-pocket expenditures by individuals, such as copayments, coinsurance, and deductibles, would not be subject to the assessment. Services provided in the State of Michigan to individuals who are not residents of Michigan would be exempt, as would services provided to Michigan residents outside the State of Michigan. Casualty insurance payments, such as medical coverage for automobile insurance and workers' compensation insurance, would be exempt.

Nonexempt Payments

In general, claims paid by group and individual health insurance companies, with the exception of those providing Medicare Advantage, Medicare Part D, and Federal employee coverage, would be subject to the assessment. Furthermore, third party administrators and stop loss insurance providers for self-funded health insurance plans would be subject to the assessment for paid health claims. Payments made by Medicaid managed care entities (the Medicaid HMOs and PIHPs previously subject to the Use Tax) would be subject to the assessment. The assessment would apply to regular reimbursement for medical services received but would not apply to care or case management, disease management, utilization review, and general administrative expenses.

Reduced Rate for Certain Firms

Commercial carriers that meet the conditions of MCL 500.3717 would be subject to an assessment of 0.1%. The most notable of these conditions is a requirement that eligible insurers have less than $18.0 million in capital and surplus. At this time, it appears that only three small

insurers would meet this requirement. (Section 3717 of the Insurance Code sets criteria for the exemption of commercial carriers from Chapter 37 (Small Employer Group Health Coverage) of the Code.)

Cap on Annual Assessment Per Individual

Senate Bill 348 (H-2) includes a cap on the assessment per individual of $10,000. This cap would mean that an insurance company would not have to pay an assessment on any claims that exceed $1.0 million for an individual, as $10,000 is 1.0% of $1.0 million. The cap would have a minor impact on total revenue, as very few individuals exceed $1.0 million in medical claims in a given year.

Pass-Through of Costs

An insurance carrier required to file rates with the Insurance Commission would be permitted to pass through the assessment to groups or individuals purchasing insurance from the carrier without a rate filing with the Commissioner of Financial and Insurance Regulation. Carriers would have to develop a methodology for determining the pass-through, subject to certain conditions, and would have to inform the Commissioner of the methodology used.

Collection and Enforcement

Each carrier and third party administrator would have to file with the Department of Treasury on April 30, July 30, October 30, and January 30 a return for the preceding calendar quarter as well as payment of the amount of assessment due, for claims for services provided during that quarter. The determining date would be the service date, not the payment date. Carriers and third party administrators would be required to keep four years of records. The Department of Treasury would be allowed to require returns, require individuals to make statements under oath, or require individuals to keep certain records.

If a return were not filed or if proper records were not kept, the Department could determine the amount of the assessment based on its own information, with the carrier or third party administrator facing the burden of proof to refute the assessment.

The Department would be directed to promulgate rules to implement the proposed Act.

The assessment would not be considered a tax for the purposes of the insurance taxes collected pursuant to the Insurance Code.

If the Department determined that a carrier or third party administrator failed to pay an assessment, interest, or penalty, it would be required to inform the Commissioner of Financial and Insurance Regulation. The Commissioner could suspend or revoke, after notice and hearing, the certificate of authority to transact insurance as well as the insurance license for the carrier or third party administrator.

Health Insurance Claims Assessment Fund

The revenue collected from the assessment would be deposited in the Health Insurance Claims Assessment Fund, which the bill would create within the Department of Treasury. Money from the Fund would be Restricted revenue and would be used to support the Medicaid program, or pay credits if the revenue cap were exceeded.

Department of Treasury Implementation Costs

Senate Bill 348 (H-2) would appropriate $1.0 million in FY 2010-11 to the Department of Treasury to begin implementation of the paid health claims assessment. This funding would be a work project and could be carried forward to subsequent fiscal years. The Department of Treasury would be required to report annually to the Legislature the revenue collected under the tax. The Department also would have to develop a "dashboard" to inform citizens of the compliance, effectiveness, and efficiency of carriers subject to the Act.

Limitation on Total Revenue

The assessment rate could not exceed 1.0%. If the amount collected in any year exceeded $400.0 million adjusted by medical inflation, then credits would be applied to offset the amount owed by insurers in subsequent years.

Sunset Provision

The paid health claims assessment outlined in Senate Bill 348 (H-2) would expire on January 1, 2014.

The bill is tie-barred to Senate Bill 347, which would eliminate the HMO/PIHP Use Tax.

FISCAL IMPACT

The Revenue Estimate

The Senate Fiscal Agency's (SFA's) approach to making an estimate of claims assessment revenue was to project calendar year 2012 health care expenditures in Michigan, then to remove expenditures that would not be subject to the claims assessment. Senate Bill 348 (H-2) would not assess payments made by the Federal government; therefore, Medicare, Veterans Affairs, Federal employee health benefits, and Medicaid fee-for-service payments would not be assessed. Furthermore, the assessment would not apply to out-of-pocket expenses for individuals (such as copayments, deductibles, and coinsurance). Also, casualty insurance (in particular automobile insurance medical coverage and workers' compensation medical payments) would be exempt.

Using 2004 Michigan data available from the Federal government and the Kaiser Family Foundation, 2009 national health care cost growth data, and medical inflation estimates, the SFA estimates that total health expenditures in Michigan will be $81.1 billion in 2012. The SFA also estimates that Medicare expenditures in Michigan will be $22.0 billion in 2012. According to the Center for Healthcare Research and Transformation, 2004 out-of-pocket costs, which would be exempt from assessment under Senate Bill 348 (H-2), were 13.8% of total health care costs in Michigan. Applying that to the $81.1 billion figure yields an estimated $11.1 billion in out-of-pocket costs in 2012, although given the general increase in out-of-pocket payments (such as copayments and deductibles) in recent years, $12.1 billion is a more reasonable estimate.

During 2004, "other" health care expenditures (mostly Veterans Administration/VA benefits and casualty insurance, both of which would be exempt from the assessment) were estimated at 3.7% of total health care expenditures. Applying that percentage to the $81.1 billion total figure would lead to an "other" estimate of $3.0 billion. This "other" category would cover costs such as VA benefits, auto insurance, and workers' compensation that would be exempt from the claims assessment.

Two categories remain: Federal employee health benefits and Medicaid fee-for-service payments. (The bills would subject Medicaid managed care entities to the assessment.) The latter is already budgeted in FY 2011-12 at $5.8 billion. Research indicates that there are about 66,000 Federal employees in Michigan, so assuming an average cost of $10,000 per employee for active employees, dependents, and retiree health costs leads to an estimated $660.0 million in expenditures.

The total of each of these categories is $22.0 billion (Medicare) plus $12.1 billion (out of pocket) plus $3.0 billion (VA, auto insurance, worker's comp) plus $5.8 billion (Medicaid fee for service) plus $0.7 billion (Federal employees). The total of these exempted categories is $43.6 billion of the $81.1 billion, leaving $37.5 billion subject to the assessment.

The above process is an indirect way to derive an assessment base figure, with numerous assumptions and significant potential variance. If Medicare in Michigan grew by 1.0% more per year between 2009 and 2012 than assumed above, the estimated assessment base would drop by over $600.0 million. If overall health care expenditures grew by 1.0% more per year between 2009 and 2012 than assumed above, the estimated assessment base would increase by over $2.0 billion even if one assumed out-of-pocket costs grew proportionately as well. If out-of-pocket expenditures grew at an even faster rate from 2004 to 2012, then the base would be smaller.

The SFA is therefore not comfortable stating "the assessment base is definitely $37.5 billion; therefore a 1.0% assessment would raise almost exactly $375.0 million in 2012". There is significant potential variance in the assessment base estimate and it could prove to be higher or lower by several billion

dollars, thus affecting the revenue estimate by tens of millions.

On the other hand, the $375.0 million figure does represent the SFA's most informed estimate of the actual revenue. The SFA would not state that the Administration's estimate of $396.9 million in revenue is wrong; actually the relative closeness of the two estimates indicates that the Administration's estimate is a good-faith projection of likely revenue. However, for the purposes of this discussion, the SFA estimate of $375.0 million in revenue in 2012 will be used.

The bill includes a provision that would permit application of the assessment, to the extent allowed by the Federal government, to a proposed waiver to integrate services and payment streams for those dually eligible for Medicare and Medicaid. This new system, if approved, would be implemented on April 1, 2012, halfway through FY 2011-12. Combined Medicare and Medicaid annual spending on dually eligible individuals in Michigan is in the range of $4.0 billion, or $2.0 billion over the second half of FY 2011-12. If this waiver were implemented and the Federal government allowed the entire payment stream to be subject to the assessment, the revenue collected could increase by up to $20.0 million in FY 2011-12. Because this number is dependent on Federal approval of the waiver and Federal permission to apply the assessment to services using Medicare funds, it is not included in the SFA revenue estimate.

The FY 2011-12 Fiscal Impact of Senate Bill 348 (H-2)

The estimated revenue of $375.0 million covers 12 months of calendar year 2012 and therefore nine months of fiscal year 2011-12. The actual paid health claims assessment revenue in FY 2011-12 would be $281.3 million, which would offset GF/GP. This is in comparison to the assumed revenue of $396.9 million in the FY 2011-12 DCH budget, resulting in a net revenue loss of $115.6 million.

Senate Bill 347 would result in a net gain for the State of $124.7 million. The impact of the two bills on the FY 2011-12 DCH budget as enacted would be a net gain for the State of $124.7 million less $115.6 million or $9.1 million GF/GP.

If one assumes that the Executive's estimate of $396.9 million in full-year FY 2011-12 revenue is correct, then a January 1, 2012, implementation would result in $297.7 million in revenue during FY 2011-12, for a revenue loss of $99.2 million compared to what was assumed in the FY 2011-12 DCH budget. Given the net gain from Senate Bill 347 of $124.7 million, the impact of the two bills on the FY 2011-12 DCH budget as enacted would be a net gain of $124.7 million less $99.2 million, or $25.5 million GF/GP.

FY 2012-13 and Beyond

The revenue from the assessment should grow by approximately 3% to 4% per year; therefore, the revenue from the assessment in FY 2012-13 should be roughly $390.0 million. This would be slightly less than the $396.9 million in revenue built into the FY 2011-12 budget, so there would be a slight GF/GP cost increase between FY 2011-12 and FY 2012-13. In future years the revenue would continue to grow by $15.0 million to $20.0 million per year and GF/GP costs would drop by an equivalent amount. The 2014 expansion of Medicaid mandated by the Federal health reform legislation could increase assessment revenue by another $20.0 million.

The SFA believes it is possible but not probable that revenue would exceed $400.0 million as adjusted by medical inflation; therefore, the SFA does not foresee implementation of the trigger requiring that credits be paid to insurers in future years.

Other State Departmental Fiscal Considerations

Senate Bill 348 (H-2) would appropriate $1.0 million GF/GP in FY 2010-11 to the Department of Treasury to begin implementation of the assessment. This funding would partially offset the projected net gain of $9.1 million in GF/GP revenue compared to the FY 2011-12 original DCH appropriation.

Actuarial Soundness

The Medicaid HMOs and PIHPs would be subject to the 1.0% health claims assessment, which would increase their expenditures by $47.2 million Gross and $16.0 million GF/GP in FY 2011-12. One could argue that the State would be responsible for providing the necessary funding to cover the actuarial soundness costs. It should be noted that the FY 2011-12 DCH budget includes $75.0 million Gross and $25.4 million GF/GP to cover actuarial soundness. Whether this funding could be used to cover paid health claims assessment costs is a matter of interpretation, though it is clear that there was more money added than would be needed to make any actuarial soundness adjustment related to the claims assessment.

Impact on State and Local Government as Employers

There is one final consideration: the impact of the claims assessment on public employers, in particular State government, public universities, community colleges, school districts, and local governments. Many of these entities self-insure, so they would face the cost, through their third party administrators, of the assessment directly. Other entities purchase insurance but it is reasonable to assume that most if not all of the paid claims assessment costs would be passed on to the employer.

As shown in Table 1, the SFA has developed estimates of expenditures for health care coverage and cost of the assessment for State government, universities, community colleges, local governments, and school districts.

The total fiscal impact of the claims assessment on State government, including public universities and community colleges, would be $7.9 million GF/GP. The total fiscal impact on school districts would be $20.0 million. The total fiscal impact on local units of government would be $8.0 million.

Conclusion

Senate Bills 347 and 348 (H-2), based on the SFA's revenue estimate, would lead to a slight improvement in the State's fiscal situation compared to the enacted FY 2011-12 DCH budget of roughly $5.0 million GF/GP. This is even after taking into account administrative funding provided to the Department of Treasury. If one accepts the Executive's revenue estimate, the improvement would be roughly $21.0 million GF/GP.

The question of whether the actuarial soundness adjustments included in the FY 2011-12 DCH budget would be sufficient to cover costs has not yet been resolved. There is the potential of up to $16.0 million GF/GP in costs due to actuarial soundness requirements.

The impact of the claims assessment on State and local government as employers would be an estimated cost increase of $7.9 million for State entities and $28.0 million for local entities, including school districts.

Fiscal Analyst: Steve Angelotti

Table 1

	Estimated Paid Health Claims	Cost of 1.0% Assessment
State Government Gross Costs	$620,000,000	$6,200,000
State Government GF/GP Costs	$320,000,000	$3,200,000
Universities	$370,000,000	$3,700,000
Community Colleges	$100,000,000	$1,000,000
Local Governments	$800,000,000	$8,000,000
School Districts	$2,000,000,000	$20,000,000
TOTAL (using State GF instead of Gross)	**$3,590,000,000**	**$35,900,000**

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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.