State Notes

TOPICS OF LEGISLATIVE INTEREST

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Governor Snyder's Health Claims Tax Proposal
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Introduction

Governor Rick Snyder has proposed ending the 6.0% Use Tax applied to Medicaid managed care organizations (also known as Medicaid health maintenance organizations or HMOs) and Prepaid Inpatient Health Plans (PIHPs). The Medicaid HMOs provide physical health coverage to the vast majority of Medicaid clients. The PIHPs, which are composed of Community Mental Health organizations, provide mental health and substance abuse coverage to all Medicaid clients. The revenue from the current 6.0% Use Tax, $388.4 million, goes to the State's General Fund. While it is not a dedicated Restricted fund source, in effect the dollars are used to support the State's Medicaid program and draw down Federal Medicaid match dollars.

The Snyder Administration has assumed, based on discussions with the Federal government and the Centers for Medicare and Medicaid Services (CMS), that CMS will soon issue rules barring the State from receiving Medicaid match dollars on the Use Tax revenue.

The Snyder Administration has, therefore, proposed ending the Use Tax effective September 30, 2011. In its place, the Administration has proposed instituting a 1.0% tax on paid health claims, under what would be known as the "Health Insurance Claims Assessment Act". The Administration has stated that "the assessment would apply to all health insurers in the state, including self-funded employer plans".

The Governor's intent in proposing this tax shift is to find a new tax that would raise a comparable amount of revenue while meeting Federal muster. As the new tax would be broad-based (akin to the provider taxes on hospitals and nursing homes), it appears there would be little risk of disapproval from CMS.

History of Managed Care Provider Taxes

Federal law permits states to use "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, and then uses the rest of the money, along with Federal Medicaid match, to increase Medicaid payment rates to the provider group. Most providers receive more from the Medicaid rate increase than they pay in the tax, so there are many more net winners than net losers. This is why the hospital, nursing home, and Medicaid managed care provider groups have been supportive of provider taxes.

In fiscal year (FY) 2001-02, Michigan instituted a provider tax, also known as a "Quality Assurance Assessment Program" or "QAAP", on the nursing home industry. In FY 2002-03, the State instituted QAAPs for hospital services and Medicaid managed care organizations (Medicaid 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.

An example might help illustrate this. Suppose a Medicaid HMO received $200.0 million in capitation payments from the State, that the QAAP tax rate was 5.5%, and that the Medicaid match rate was 60.0%. The Medicaid HMO then would pay a tax of $11.0 million ($200.0 million times 5.5%) to the State. The State would retain $1.0 million of the revenue to offset General Fund/General Purpose (GF/GP) dollars, then would take the remaining $10.0 million, combined with $15.0 million in Federal match, and increase payments to the HMO by $25.0 million. The HMO would pay $11.0 million in tax but have its total Medicaid reimbursement increased by $25.0 million, so its net revenue would go up by $14.0 million. Since the State would retain $1.0 million to offset GF/GP dollars, it would be better off by $1.0 million. The only loser in this scenario would be the Federal government, which would spend an additional $15.0 million.

The State instituted a QAAP for Medicaid mental health services, provided by the 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. 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 searched for a new approach.

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, but simply an expansion of the Use Tax base. The proposal received initial approval from CMS, though it was understandably dubious about the proposal, which effectively duplicated a QAAP without actually being a QAAP.

As noted above, CMS is again looking at the Use Tax and, according to the Administration, it is likely that CMS will soon issue new rules barring the State from using this sort of approach, which puts the State in the position of potentially searching for a new way to support its Medicaid programming.

Background on Actuarial Soundness

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.

The actuarial soundness requirement came about because Medicaid HMOs would bid against each other for contracts, and then would be unable to stay fiscally solvent due to the low level of their bids. This approach created problems in Michigan as well as other states, as some Medicaid HMOs were on the verge of going under financially, which was a serious risk for the State and the providers paid by those HMOs, not to mention the Medicaid clients served by those HMOs.

Since 2005, 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.

An interesting 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. Therefore, while the Use Tax generates $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.

Fiscal Impact

The repeal of the Use Tax on Medicaid HMOs and PIHPs without any replacement would lead to an increase in the State's deficit of $256.9 million GF/GP.

The Governor's proposed 1.0% paid health claims tax would raise an estimated $396.9 million in Restricted revenue. This revenue would be dedicated to support the Medicaid program and would offset GF/GP funds in Medicaid. Thus, the fiscal impact of the paid health claims tax would be a reduction in the State's deficit of $396.9 million GF/GP.

The net impact of the Governor's proposal on the State deficit would be a decrease in the deficit of $140.0 GF/GP compared with continuing current policy. There would be a slight increase in total tax revenue, from $388.4 million in FY 2010-11 to $396.9 million in FY 2011-12, or $8.5 million, so the statement from the Administration that the new tax would be basically cost neutral relative to taxes collected by the State is accurate. However, there also would be the reduction in spending of $131.5 million GF/GP because the State would no longer have to cover the costs of the Use Tax. The $8.5 million in additional revenue combined with the $131.5 million GF/GP in reduced spending leads to the net reduction of the deficit of $140.0 million GF/GP.

This also means that, if the Governor's other budgetary and tax proposals are adopted as recommended, rejection of the Use Tax replacement would put the overall budget out of balance. If the Governor's budget were based on the assumption that the Use Tax will not be overturned by the Federal government, it would still be out of balance by $140.0 million GF/GP. This is because the budget would have to include $131.5 million GF/GP in additional spending above the Governor's FY 2011-12 recommendation to reimburse the Medicaid HMOs and PIHPs for the Use Tax due to actuarial soundness requirements. Furthermore, net revenue would be $8.5 million less than in the Governor's proposed budget.

If the paid health claims tax were not implemented and the Use Tax were later effectively outlawed by the Federal government, the budget would be out of balance by $396.9 million GF/GP. This is because, while the budget would be the same as the Governor's on the Use Tax revenue and costs, the $396.9 million in revenue from the health insurance paid claims tax would not be collected.

Provisions of the Proposed "Health Insurance Claims Assessment Act"

The State Budget Office (SBO) included a brief issue paper describing the proposed health insurance paid claims tax as well as proposed legislation to implement the tax with its February 17, 2011, budget presentation materials. The State Budget Office has stated that this reflects the original proposal and that SBO is still working on the details, so there could be minor changes made to its proposal.

The tax would apply to any insurer or health maintenance organization regulated by the State as well as any nonprofit dental care corporation defined in statute. Self-funded employer plans also would be subject to the tax.

Most health claims paid by insurers would be subject to the tax, but the proposal would exempt certain claims, including accident coverage, disability income, and long-term care insurance, and Medicare payments.

Those assessed under the tax would have to make monthly payments to the State Department of Treasury by the 15th of each month to cover the previous month's paid claims.

The revenue raised by the tax would be classified as Restricted revenue and would be placed in the Health Insurance Claims Assessment Fund and used to support the Medicaid program, with a small amount set aside to cover the cost of administering the tax.

Potential Issues

Leaving aside the potential difficulties in getting political support for a new tax, there are several possible issues related to the proposal.

- **Estimated Revenue.** The revenue assumed from implementation of the tax is based on a rough good-faith estimate of the tax base. As with any new type of tax, there is a significant plus or minus on the revenue estimate, which could be higher or lower by tens of millions of dollars.

- **The Actuarial Soundness Requirement and the New Tax.** The tax would apply to health claims paid by health maintenance organizations. Medicaid HMOs and PIHPs presumably would qualify as health maintenance organizations and thus their paid claims would be subject to the health insurance paid claims tax. These entities pay claims that likely exceed $5.0 billion annually. Therefore, their liability under the new tax would be at least $50.0 million. Due to the actuarial soundness requirement, the State likely would have to reflect these costs in its setting of actuarially sound rates. Any such adjustment would have a cost of about $17.0 million GF/GP, which was not accounted for in the Governor's FY 2011-12 budget presentation.

- **Timing.** Another concern would be logistical problems in implementing the tax by October 1, 2011, in particular if action on the proposed tax were delayed until the summer or even the early fall.

- **Federal Action.** It is possible that new rules effectively eliminating the Medicaid HMO and PIHP Use Tax will not be implemented. It is also possible, though less likely, that such rules would be implemented and applied retroactively to some point prior to October 1, 2011, in which case the State would face a potential retroactive liability even if a new tax were enacted.

Options

The Legislature, as with any budgetary or tax issue, has a number of options.

1. **Make No Changes.** The Legislature could simply assume that the Federal government will allow the Medicaid HMO and PIHP Use Tax to continue. In that case, the State would continue making $131.5 million GF/GP payments to support the Medicaid HMO and PIHP tax costs and would see a slight increase in GF/GP costs due to receiving $388.4 million in Use Tax revenue rather than $396.9 million in paid health claims assessment revenue. The net fiscal impact would be a hole of $140.0 million GF/GP as compared with the Governor's Recommendation for the FY 2011-12 budget.

   If the Use Tax were later effectively barred by the Federal government, the $131.5 million GF/GP payments would no longer be necessary but the $388.4 million in Use Tax revenue would no longer be collected. The net fiscal impact in that case would be a hole of $396.9 million GF/GP compared with the Governor's Recommendation.

2. **Accept the Proposal as Written.** In this case, the Legislature would concur with the Governor's Recommendation and there would be no change to the Governor's budget. It should be noted that the Governor's Recommendation included no adjustment for the potential need to cover the Medicaid HMOs' and PIHPs' costs under the new tax.

3. **Revise the Proposal.** The Legislature could choose to change the health insurance paid claims tax rate or expand or contract the tax base. These changes would have the effect of increasing or decreasing the revenue collected.

Conclusion

This is a very complex issue, made all the more complex by the impact of the actuarial soundness requirement. That requirement sets up a paradoxical situation in which the old and new taxes are pretty much revenue neutral in terms of tax dollars collected, but not revenue neutral to the State's fiscal situation. The issue is also complex because each of the options outlined above would have a significant impact on the State's balance sheet as well as a major impact on health insurers.