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Background on the Insurance Provider Assessment

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Since 2003, the State of Michigan has taxed managed care entities to provide revenue to support the State's Medicaid program. At first, because of loopholes in Federal law, these taxes were limited to Medicaid managed care organizations (MCOs). Due to a Federal requirement that capitation rates paid to Medicaid MCOs be actuarially sound, the State raised capitation rates to reimburse the Medicaid MCOs for the cost of the taxes, so the Medicaid MCOs effectively were held harmless.

In later years, due to changes in Federal law and clarification of Federal limitations, the taxes have become more broad-based, going beyond taxation of Medicaid MCOs to taxation of health insurance in general. In 2011, one such broad-based tax, the Health Insurance Claims Assessment (HICA), a tax on paid health claims, was enacted. The HICA was understandably unpopular among the entities being taxed as HICA increased the cost of health insurance and was particularly unpopular among businesses that purchase health insurance for employees.

In May 2018, the Legislature passed and Governor Snyder signed legislation replacing the HICA with a new two-tiered tax called the Insurance Provider Assessment (IPA). After Federal approval of the IPA in December 2018, the HICA was repealed retroactive to October 1, 2018, and the IPA went into effect retroactive to October 1, 2018.

This article is intended to provide a brief background on how the State got to this position and to outline the differences between the HICA and the IPA.

Background

Federal law permits the use of "broad-based" provider taxes (known as Quality Assurance Assessment Programs (QAAPs) in Michigan), capped at 6.0%, to support Medicaid services. Quality Assurance Assessment Programs apply to an entire provider group. The State retains some of the money, and then uses the rest of it, along with Federal Medicaid match, to increase Medicaid payment rates to the provider group. The Federal law authorizing state provider taxes originally 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". This allowed Michigan to limit the MCO QAAP, first implemented in fiscal year (FY) 2002-03, to just Medicaid MCOs. Due to actuarial soundness requirements, the State reimbursed the Medicaid MCOs for the cost of the tax using a mix of Federal Medicaid match and State General Fund/General Purpose. The effect was a large revenue gain for the State, as the tax collected was all State revenue while the reimbursement was mostly Federal Medicaid match revenue, which led to a net savings for the State equal to the Federal match.

The Deficit Reduction Act of 2005 phased out the Medicaid MCO loophole in 2009. The State of Michigan then created a new Medicaid MCO tax by subjecting Medicaid MCOs to the State's already existing 6.0% Use Tax. In effect, this allowed the State to continue a tax similar to the Medicaid MCO QAAP.

HICA

By 2011, the Federal government raised concerns about the managed care Use Tax and also suggested that there could be disallowances retroactive to 2009. The Snyder Administration proposed eliminating the Medicaid MCO Use Tax and replacing it with a 1.0% tax on paid health claims, a tax that

later became known as the HICA. Federal law and rules allow broad-based flat rate health taxes to be used to directly or indirectly offset State Medicaid match costs. Federal rules also allow for tiered taxes that meet certain statistical tests to be used. The HICA, however, was a flat tax and, as such, met Federal requirements. As noted, the HICA was unpopular with the business community as it was an indirect tax collecting revenue in the range of $200 million per year from employers.

Return of the Medicaid MCO Use Tax

In 2013, the State of California received permission from the Obama Administration to reinstate, on a limited-term basis, a Medicaid MCO Use Tax through July 1, 2016. The State of Michigan then sought and received permission to do so as well, also on a limited term basis through the end of calendar year 2016. The HICA rate was reduced to 0.75% for the duration of the renewed Medicaid MCO Use Tax. When the tax expired at the end of 2016, the HICA rate reverted to its original 1.0% rate.

The Insurance Provider Assessment (IPA)

In late 2017, the State Budget Office worked on creating a replacement for the HICA. The general idea was to create a two-tiered tax that met Federal statistical tests. The first tier would be a relatively higher tax on Medicaid MCOs and the second tier would be a relatively low tax on private insurance. Because this tax was designed specifically to meet a complex Federal statistical test, it had to receive Federal approval even though the tax rates on Medicaid MCOs were much higher than the tax rates on private insurance. After much discussion and some minor changes, the new IPA was enacted in the spring of 2018, received Federal approval in late 2018, and took effect retroactive to October 1, 2018.

Differences between the HICA and the IPA

The HICA taxed, at a flat 1.0% rate, all paid health claims other than those of Federally-funded programs like Medicare, fee-for-service Medicaid, and Veterans Administration benefits (as States may not tax the Federal government). The IPA taxes Medicaid MCOs at a rate of roughly $60 per member month for the first one million member months and $1.20 per member month beyond that point. Private insurance is taxed at $2.40 per member month. Medicaid behavioral health services are taxed at $1.20 per member month. These values were not arbitrary; they were chosen specifically to ensure that the IPA meets the Federal statistical test.

The net impact is a significant increase in taxes paid by Medicaid MCOs, but, due to the actuarial soundness requirement, the MCOs are fully reimbursed for the tax increase and are held harmless. There also is a significant decrease (about two-thirds) in taxes paid by private insurers. In effect, the IPA greatly reduces taxes paid by private insurance, and thus reduces the indirect costs faced by businesses that purchase health insurance for their employees.

The change from the HICA to the IPA also results in a net increase in State revenue. The HICA was estimated to bring in $315.0 million in FY 2018-19 if it had continued. The IPA, once the increased State share of actuarial soundness costs are netted out, will bring in about $430.0 million in net revenue in FY 2018-19.

Conclusion

The IPA represents a new approach to taxing health insurance. This approach, like the HICA, conforms to Federal law and regulation, but one that taxes private insurance at a much lower rate than the HICA, leads to an indirect tax reduction to employers, and increases net revenue for the State.