

State Notes

TOPICS OF LEGISLATIVE INTEREST

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Health Insurance Claims Assessment (HICA) Primer **By Steve Angelotti, Associate Director**

Overview

There has been much discussion about the Health Insurance Claims Assessment (HICA) and the Medicaid managed care use tax and the two taxes' role in supporting the State's Medicaid budget. There also has been some confusion about HICA and its origins. This article is intended to clarify how HICA and the managed care use tax came about. The article also discusses the fiscal impact of both a 2018 sunset on HICA and the projected termination of the managed care use tax.

Background

While the Health Insurance Claims Assessment was enacted in 2011, its origin actually is rooted in medical provider taxes enacted in 2002 and 2003.

The Medicaid program is financed by a combination of State tax revenue and Federal matching funds. Federal law allows the use of broad-based medical provider taxes to provide the State match to support the Medicaid program. Federal statutory language enacted in 2002 included specific references to provider taxes on hospital services, long-term care services, physician services, and "Medicaid managed care organizations".

The State of Michigan first enacted provider taxes, under what are called Quality Assurance Assessment Programs (QAAPs), for hospital and long-term care services. Those QAAPs still exist today. The QAAPs impose a broad-based tax on medical providers; pursuant to Federal law, the tax may not exceed 6.0%. The State retains some of the revenue and uses the remaining revenue, combined with Federal Medicaid match, to increase Medicaid payment rates to those providers. As a result of the Federal match, the provider community as a whole is better off (as the Medicaid rate increase to the providers, in gross terms, exceeds the tax paid by the providers). Due to the retention, the State's General Fund also is better off. However, because of the broad-based nature of the tax, and because the Federal government does not allow "gaming" the tax to avoid net losers, some individual providers pay more in tax than they receive in a rate increase.

In the case of Medicaid managed care, the Federal statute did not specify "managed care organizations" but rather "Medicaid managed care organizations". This phrasing created a huge loophole, allowing states to tax just Medicaid health maintenance organizations (HMOs) and other Medicaid managed care providers such as the behavioral health pre-paid inpatient health plans (PIHPs). In other words, managed care provider taxes did not have to be broad-based and could be structured so as not to create any net losers.

Due to this loophole, Michigan established a Medicaid managed care QAAP in 2003. When Michigan instituted the Medicaid managed care QAAP, it could legally be limited to just the Medicaid HMOs and PIHPs, which meant that every entity taxed received a Medicaid rate increase that exceeded the entity's tax liability.

This loophole was closed in 2005, when the statute was changed to refer to "managed care organizations". States such as Michigan that had Medicaid managed care QAAPs were grandfathered, with the loophole phased out in 2009.

When 2009 arrived, the State of Michigan tried a different approach. The managed care QAAP was repealed and Michigan replaced it by changing the Use Tax Act. Medicaid HMOs and Medicaid PHIPs, both as defined in statute, were added to the list of entities subject to the State's 6.0% use tax. In effect, this continued the Medicaid managed care QAAP under a different name, one that technically did not qualify as a provider tax as it was part of a separate general tax.

The Federal government at first allowed the use tax approach, but then began to express strong concern that it was simply an extension of the Medicaid managed care QAAP. When Governor Snyder took office, it became clear to the Administration that there was a significant likelihood that the managed care use tax would be barred. There also was concern that, if the State persisted in collecting the tax, the Federal government could disallow the managed care use tax going back to its implementation in 2009, potentially costing the State hundreds of millions if not billions of dollars.

The Birth of HICA

Due to the concern discussed above, regarding the Medicaid managed care use tax, the Snyder Administration in 2011 proposed ending the managed care use tax and replacing the lost revenue with a 1.0% Health Insurance Claims Assessment, commonly known as HICA. The assessment would apply to paid health claims so, in effect, it was a tax on health insurers (with one significant exemption -- fee-for-service Federal programs such as Medicare and Veterans' services were exempted as the State cannot tax the Federal government). While the tax applied to health insurers, in effect they would pass it along to those who purchased health insurance, in particular employers who provide health care coverage to employees.

After a fair amount of discussion between legislators and the business community, the HICA legislation was enacted in 2011 and took effect on January 1, 2012, with a sunset in 2014. The HICA revenue was dedicated, via statute, to support the State's Medicaid program and to effectively supplant State General Fund/General Purpose (GF/GP) revenue.

HICA Revenue

There were slightly varying estimates of the expected annual revenue from HICA, ranging from \$375.0 million to \$400.0 million. Those estimates were far greater than the actual annual revenue, which was in the neighborhood of \$260.0 million. There were two main reasons for the overstated estimates: First, the estimates of the tax base underestimated the significant increase in out-of-pocket expenditures by patients, expenditures that were not subject to the tax. Second, many self-insured entities contracted with out-of-state insurers and the State did not have a means to collect taxes from those insurers.

Because of this shortfall, the State repeatedly had to fill the gap with other fund sources, such as GF/GP and Tobacco Settlement revenue. The Snyder Administration proposed increasing the HICA rate, at one point to 1.5%, at another point to a fluctuating rate that would ensure the collection of \$400.0 million. Subsequently, the Administration proposed a fee of \$25 per auto insurance policy, as part of a broader auto insurance reform measure, to fill the revenue gap. None of these proposals gained traction with the Legislature. However, a delay of the HICA sunset to January 1, 2018, was enacted.

Return of the Use Tax

The State of California, facing a budgetary shortfall, enacted a managed care use tax similar to the one that Michigan had used. The Snyder Administration asked the Federal government for permission to re-enact the managed care use tax. The Federal government, having allowed California to enact such a use tax, agreed to allow Michigan to do so for a then-unspecified limited time period.

The new managed care use tax was tied to changes in HICA. The HICA statute was changed to state that, as long as the managed care use tax was allowed by the Federal government, the HICA rate would be reduced from 1.0% to 0.75%. Furthermore, a cap on total net revenue from the combined managed care use tax and HICA of \$450.0 million was established. Revenue in excess of that amount effectively would be returned to HICA payers via rebates in the subsequent year.

Phase-Out of the Use Tax

The Federal government has informed the State that it will no longer support the managed care use tax after the end of the 2015-2016 legislative session. If Federal policy is not changed, this effectively means that the use tax will expire on January 1, 2017.

Three things will happen if the Medicaid managed care use tax expires: First, the State will see a net reduction in GF/GP use tax revenue of \$190.0 million in fiscal year (FY) 2016-17 and \$253.0 million in FY 2017-18 compared with the amount collected in FY 2015-16. Second, the State will see a net reduction in School Aid Fund use tax revenue of \$153.0 million in FY 2016-17 and \$204.0 million in FY 2017-18, compared with the amount collected in FY 2015-16. Finally, the HICA rate will increase from 0.75% to 1.0% on January 1, 2017, thereby increasing HICA revenue by \$60.0 million in FY 2016-17 and offsetting an equivalent amount of GF/GP revenue.

The net impact will be a total GF/GP budget that is worse off by \$130.0 million in FY 2016-17 and \$253.0 million in FY 2017-18. However, the FY 2017-18 figure does not take into account the HICA sunset.

The HICA Sunset

Under the statute, HICA is scheduled to expire on January 1, 2018. If it takes effect, that expiration will result in a net reduction in HICA revenue of \$130.0 million in FY 2017-18 compared with FY 2015-16 and a net reduction in HICA revenue of \$212.0 million in FY 2018-19 compared with FY 2015-16 once the full expiration is annualized. That reduction in revenue will result in an increase of GF/GP costs of \$130.0 million in FY 2017-18 and \$212.0 million in FY 2018-19.

If No Changes Are Made

If no changes are made to the HICA statute, the expiration of the managed care use tax and sunset of the HICA statute will result in an increase in GF/GP costs for Medicaid of \$130.0 million in FY 2016-17, \$383.0 million in FY 2017-18, and \$465.0 million in FY 2018-19, compared with the FY 2015-16 appropriations. Furthermore, there will be a decrease in School Aid Fund revenue of \$153.0 million in FY 2016-17, and \$204.0 million in FY 2017-18 and FY 2018-19 due to the expiration of the managed care use tax.



There are other cost pressures within the Department of Health and Human Services (DHHS) tied to Medicaid. The State must begin to pay 5.0% of the cost of Medicaid expansion on January 1, 2017, a match that increases to 6.0% on January 1, 2018. The Senate Fiscal Agency (SFA) estimates that this will increase GF/GP costs by \$143.0 million in FY 2016-17 and \$218.0 million in FY 2017-18.

Overall, assuming no changes in the HICA statute and the expiration of the managed care use tax, the SFA estimates that it will cost more than \$600.0 million in additional GF/GP revenue in FY 2017-18 to run the Medicaid program, including the Medicaid expansion, as it currently exists compared with FY 2015-16. This will put pressure on the overall State budget at a time when there are other pressing needs, such as transportation funding.

If the HICA sunset were delayed, the pressure would be alleviated by approximately \$330.0 million or so per year. If the HICA rate were increased to 1.3%, as the Snyder Administration has proposed, then the net GF/GP demand would be reduced by approximately \$430.0 million.

Misunderstandings about HICA and Medicaid Expansion

There have been recent newspaper editorials implying that HICA was enacted in association with the expansion of Medicaid and that HICA was intended to fund the State's eventual share of the expansion costs. These implications are incorrect.

The *Detroit Free Press* stated, in a September 15, 2015, editorial, "[w]hen Michigan expanded its Medicaid program in 2012, as part of the federal Affordable Care Act, the legislature repealed the use tax it had previously levied to fund the state's portion of the program's costs". The editorial is incorrect. The original Medicaid managed care use tax was repealed in 2011. The Health Insurance Claims Assessment was created in 2011. The decision to expand Medicaid was made in 2013. There was no linkage. In fact, in 2011, the Medicaid expansion was viewed as basically being mandatory; it was only after a U.S. Supreme Court decision in June 2012 that expansion effectively became optional.

Furthermore, the State will not face any costs from expansion of Medicaid until 2017. Therefore, even if HICA were intended to pay for the State's share of expansion costs, the first five years of HICA revenue, from 2012 to 2016, could not have been used to cover then-nonexistent State expansion costs. In reality, HICA was created to maintain current levels of Medicaid funding once it became apparent that the Federal government was no longer going to support the first iteration of the Medicaid managed care use tax. The Health Insurance Claims Assessment was not tied to Medicaid expansion at all.

Conclusion

There are significant cost pressures on the State budget related to many issues. The anticipated expiration of the Medicaid managed care use tax, the sunset of HICA, and the requirement that the State help match the costs of Medicaid expansion beginning January 1, 2017, will greatly increase those GF/GP cost pressures, by well over half a billion dollars per year. Delaying the sunset on HICA or increasing the HICA rate would alleviate those pressures. There have been misunderstandings about the purpose of HICA; it was not created to cover the costs of Medicaid expansion, but rather to fill a funding hole tied to the 2011 repeal of the Medicaid managed care use tax.