MEMORANDUM

HOUSE FISCAL AGENCY

DATE: February 24, 2015

TO: House Appropriations Committee

FROM: Kyle I. Jen, Deputy Director, and Kevin Koorstra, Senior Fiscal Analyst

RE: Health Insurance Claims Assessment

This memorandum provides background information on Medicaid financing and the Health Insurance Claims Assessment (HICA). The FY 2015-16 Executive Budget Recommendation proposes two statutory changes that would increase HICA resources by $180.1 million. The Executive Recommendation uses those increased resources to offset an equal amount of General Fund/General Purpose (GF/GP) funds.

Medicaid Financing

Medicaid is a joint federal-state health care safety net program. The base Medicaid program provides physical and mental health coverage to approximately 1.7 million individuals in the state—generally parents and children, and the aged, blind, and disabled with incomes below varying thresholds. In FY 2014-15, the base program is funded at a match rate of 65.54% federal and 34.46% state. The expanded Medicaid program under the Healthy Michigan Plan that became effective in April 2014 provides coverage to over 500,000 additional adults at up to 138% of the federal poverty level and is currently funded 100% by the federal government.

The FY 2014-15 base Medicaid budget totals $12.7 billion. Of that total $8.4 billion is funded by the federal government, and the remaining $4.3 billion consists of state match funds. The largest portion of those state match funds are GF/GP funds ($2.3 billion), but over the last decade-plus Michigan has implemented a number of restricted financing mechanisms to reduce state GF/GP funding requirements and boost reimbursement rates for Medicaid providers.

These restricted funding sources include provider assessments levied against hospital and nursing home receipts under the state's Qualified Assurance Assessment Program (QAAP),[1] the Medicaid Benefits Trust Fund (which receives revenue primarily from cigarette tax revenue), the Health Insurance Claims Assessment, special financing funds claimed against contributions from public and university hospitals, and the Merit Award Trust Fund (which receives revenue from the state's share of tobacco settlement revenue). Restricted funds appropriated for base Medicaid costs from these and other smaller sources total $1.9 billion in FY 2014-15.

Health Insurance Claims Assessment

The HICA was created by Public Act 142 of 2011. The assessment replaced the imposition of the state's existing 6.0% use tax on Medicaid managed care organizations (MCOs), which had itself replaced a QAAP assessment levied on Medicaid MCOs in 2009. The transition from the QAAP financing mechanism to the use tax mechanism was driven by a change in federal law. The transition from the use tax mechanism to the HICA was driven by concerns that the federal government would

[1] In addition to the proposed HICA changes described in this memorandum, the FY 2015-16 Executive Recommendation also proposes to expand the hospital provider assessment to fund the Graduate Medical Education and Special Rural Hospital payments at restored levels, offsetting $77.1 million in GF/GP appropriations in the original FY 2014-15 budget.

cease to permit the use tax on Medicaid MCOs as a source of Medicaid match funds due to its narrow applicability (the fact that the tax was levied only on Medicaid MCOs, rather than all MCOs).

As originally enacted, the HICA was levied beginning January 1, 2012, at a rate of 1.0% on claims by health insurers and similar organizations. It was estimated that the assessment would raise roughly $400 million in revenue per year, to be used as a fund source for the state's Medicaid match. Revenue collections for the assessment were capped at that level (with an adjustment for medical inflation in future years).

Actual HICA collections, however, were realized at a much lower level: $270.5 million in the first full fiscal year of collections (FY 2012-13). This created an annual shortfall of roughly $130 million in the Medicaid budget. The gap between the original estimate and actual collections was due to several factors, including out-of-state policies being larger than expected and an under-estimation of the impact of increasing health care deductibles and co-pays (which are not taxed).

To the fill the gap in collections, one-time fund sources were identified. For FY 2011-12, savings from GF/GP lapses in the Community Health budget were utilized to cover the shortfall. For FY 2012-13, one-time resources available in the Merit Award and Medicaid Benefits trust funds were appropriated to offset the shortfall.

Reinstatement of the Use Tax on Medicaid MCOs

During FY 2013-14, the Administration indicated the federal government would allow reinstatement of the 6.0% use tax on Medicaid MCOs on a temporary basis. The Legislature took this action via Public Act 161 of 2014, effective April 1, 2014. Companion legislation, enacted as Public Act 162 of 2014, reduced the HICA rate from 1.0% to 0.75%, but with a provision that the rate will automatically revert to 1.0% if the federal government informs the state that the use tax on Medicaid MCOs will no longer be permitted as a source of state match for the Medicaid program. The $400 million cap on HICA collections (adjusted for medical inflation) was modified to apply to the combination of HICA collections and the net GF/GP impact of the use tax mechanism. The amended statute prohibits the inflation-adjusted cap from exceeding $450 million.

The use tax on Medicaid MCOs is estimated to create a net GF/GP benefit of $223.2 million in FY 2014-15 ($373.7 million in GF/GP revenue less $150.5 million GF/GP in actuarial soundness payments the state must make to Medicaid MCOs to offset the impact of the tax). Additionally, the School Aid Fund will receive an estimated $186.8 million from the tax.

The impact of the reinstatement of the use tax on Medicaid MCOs, in combination with one-time funds available from the Roads and Risks Reserve Fund in FY 2013-14, resolved the HICA shortfall for FY 2013-14 and continues to do so for FY 2014-15.

The State of Michigan has, however, been notified by the federal government (through the Center for Medicare and Medicaid Services in the U.S. Department of Health and Human Services) that it will no longer permit the use tax mechanism beyond December 31, 2016. (Formal notification stated that "the tax will need to be sunsetted by the end date of the State's next legislative session or by 12/31/15." That end date has reportedly been subsequently extended by one year under the interpretation that Michigan's legislative session runs for two years.)

Beginning January 1, 2017, then, revenue from the use tax on Medicaid MCOs will no longer be available, affecting three quarters of FY 2016-17. The HICA rate will revert to 1.0% at that time, but the HICA then sunsets in its entirely on January 1, 2018, under current law.

FY 2015-16 Executive Recommendation

The Executive Budget Recommendation for FY 2015-16 proposes three statutory changes to HICA, effective October 1, 2015:

- Increase the HICA rate from 0.75% to 1.3%. This would increase FY 2015-16 HICA revenue by an estimated $162.8 million—from a projected base of $237.2 million to a projected level of $400.0 million.
- Remove the statutory cap on combined HICA and use tax revenue. This would allow the state to utilize $17.3 million in HICA revenue that would otherwise be rebated to entities paying the HICA.
- Eliminate the January 1, 2018 sunset for the assessment.

In combination, the first two changes above would increase state resources from the HICA by $180.1 million in FY 2015-16. Under the FY 2015-16 Executive Recommendation, the state would collect both increased HICA revenue and revenue from the use tax on Medicaid MCOs for a period of five quarters (all of FY 2015-16 and the first quarter of FY 2016-17).

The Executive Recommendation appropriates the additional HICA resources to offset $180.1 million in GF/GP funds currently appropriated for the Medicaid program. As a result, absent the proposed statutory changes (or an alternate increase in funding dedicated to the Medicaid program) the Legislature would need to identify $180.1 million in GF/GP reductions within the Executive Recommendation to ensure the FY 2015-16 budget is balanced.