Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

May 26, 2005 Joint Committee on Finance Paper #370

HMO Assessment and Rate Increase (DHFS -- Medical Assistance, BadgerCare and SeniorCare -- Eligibility, Payments, and Services)

[LFB 2005-07 Budget Summary: Page 241, #1]

CURRENT LAW

Wisconsin contracts with health maintenance organizations (HMOs) to provide comprehensive health care services to certain medical assistance (MA) and BadgerCare recipients to improve the quality of care they receive and to reduce costs the MA program would otherwise pay if these recipients received care from fee-for-service providers. As a condition of serving MA and BadgerCare enrollees, HMOs must be licensed by the Wisconsin Office of the Commissioner of Insurance (OCI) and meet MA standards for quality assurance, cultural competency, enrollment capacity, and coordination of care.

Capitation Payments. Under the MA and BadgerCare programs, the state provides a fixed monthly payment, or "capitation payment," to the HMO for each MA or BadgerCare recipient enrolled in the HMO to fund services the HMO provides to enrollees. The capitation amount varies, depending on where the enrollee lives, the age and gender of the enrollee, and for a woman, whether or not she is pregnant.

The Department of Health and Family Services (DHFS) determines HMO capitation rates for each calendar year, based on negotiations with HMOs and the amount of funding the agency is budgeted to support capitation payments. An HMO's willingness to participate in MA and BadgerCare depends on an HMO's assessment of the feasibility of serving MA and BadgerCare recipients under the terms of the contract and the level of capitation payments. In making this decision, HMOs determine whether the capitation payment represents an acceptable discount from the "fee-for-service equivalent." A "fee-for-service equivalent" is an actuarial calculation of what it would cost to serve MA and BadgerCare recipients under a fee-for-service model. Payments are

based on the expectation that, through the use of managed care, HMOs would be able to provide services at a discount to this fee-for-service equivalent estimate.

Federal regulations include requirements states must meet in setting capitation payments. Under these rules, capitation payments must be actuarially sound, meaning that they must: (a) be established in accordance with generally accepted actuarial principles and practices; (b) be appropriate for the population to be covered and the services provided; and (c) have been certified as meeting these requirements by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. Capitation payments that do not meet these requirements may not be funded with federal MA matching funds.

Provider Taxes. Federal MA rules define a health care-related tax as a licensing fee, assessment, or other mandatory payment that is related to health care items or services – meaning that at least 85% of the tax burden falls on health care providers. In general, health care-related taxes must be broad-based and applied uniformly to classes of providers in order for the revenue from the tax to be used as the state match for federal MA funds. HMOs that serve MA recipients are considered a class of providers. In addition, the tax may not violate certain hold harmless provisions specified in the rule.

A provider tax is considered to be "broad-based" if it is imposed with respect to all items or services in the class determined by non-federal, non-public providers in the state or is imposed with respect to all non-federal, non-public providers in the class. For example, any such tax on inpatient hospital services could not exempt certain types of private hospitals from the tax, based on the location, characteristics, or mix of patients at these hospitals.

If a state implements a health care provider tax, it must impose it uniformly. A tax is not considered to be uniformly imposed if the state provides for any credits, exclusions, or deductions for providers that have as their intent to return all or a portion of the tax paid or provides for a "hold harmless" provision.

If a provider tax does not meet the standards established in rule for being "broad-based" or "uniformly imposed," a state may seek a waiver from these requirements. However, if a state applies for such a waiver, it must demonstrate that the net effect of the tax and associated expenditures is redistributive in nature, and the amount of the tax is not directly correlated with MA payments. Further, states may seek a waiver to exempt rural and sole-community providers from a provider tax.

Current Status of HMO Enrollment. Currently, HMOs serve low-income families enrolled in MA and BadgerCare in 66 of Wisconsin's 72 counties. As of April, 2005, 14 HMOs were providing services to approximately 295,000 MA low-income family enrollees and approximately 58,500 BadgerCare enrollees. As a condition of serving low-income families enrolled in MA, HMOs must agree to also serve families enrolled in BadgerCare. The percentage of each HMO's total enrollees that are MA and BadgerCare enrollees varies, ranging

from 4.7% to 100% of total enrollment as of December 31, 2004. Two HMOs providing services to low-income families enrolled in MA and BadgerCare, Abri and Managed Health Services, serve only MA recipients. The attachment to this paper identifies the HMOs that currently enroll MA and BadgerCare recipients and enrollment figures for these HMOs as of December 31, 2004.

GOVERNOR

Increase MA and BadgerCare benefits funding by $36,114,600 (-$14,787,200 GPR, $21,868,500 FED, and $29,033,300 SEG) in 2005-06 and $81,159,100 (-$27,741,000 GPR, $49,719,800 FED, and $59,180,300 SEG) in 2006-07 to reflect the net fiscal effect of the Governor's proposal to: (a) create an assessment on the gross revenues of HMOs; (b) deposit all revenue from the assessment to the MA trust fund to fund a rate increase and pay HMOs back for the assessments they pay; and (c) replace base GPR funding for MA benefits with SEG revenues from the MA trust fund.

Statutory Provisions

Impose on each HMO that has a contract with DHFS to provide health care to MA and BadgerCare recipients, for the privilege of doing business in the state, an annual assessment of 6% of the HMO's gross revenues for the current calendar year. Require that all assessment revenue be deposited into the MA trust fund.

HMO Filings with OCI. Require each of these HMOs to file with OCI annually, by March 1, a statement of the gross revenues for the HMO for the immediately preceding calendar year. Specify that this provision would first apply to annual statements for 2006 that are due on March 1, 2007. Provide that if an HMO fails to file a report by March 1, DHFS may withhold MA payments until the report is filed. Require DHFS to determine the amount of each HMO's assessment, based on the statement that the HMO files with OCI. Require each HMO to pay one-fourth of the total assessment quarterly.

Assessment Payments -- 2006. Provide that payments of assessments on HMOs that have contracts to provide health care to MA and BadgerCare recipients in 2006 would be made as follows: (a) on March 31, 2006, payment based on the HMO's estimated gross revenues for the period January 1, 2006 to March 31, 2006; (b) on June 30, 2006, payment based on the HMO's actual gross revenues for the period of January 1, 2006 to March 31, 2006; (c) on September 30, 2006, payment based on the HMO's actual gross revenues for the period of April 1, 2006, to June 30, 2006; and (d) on December 31, 2006, payment based on the HMO's actual gross revenues for the period of July 1, 2006, to September 30, 2006.

Assessment Payments -- 2007 and Subsequent Years. Provide that, for 2007 and every year thereafter: (a) on March 31, payment is due based on estimated gross revenues for the HMO for the period January 1 to March 31 of that year, and permit DHFS to adjust the payment

amount to ensure that payments made for the previous calendar year equaled an assessment of six percent of the HMO's actual gross revenues for the immediately preceding calendar year; (b) on June 30, payment is due based on actual gross revenues for the HMO for the period January 1 to March 31 of that year; (c) on September 30, payment is due based on actual gross revenues for the HMO for the period April 1 to June 30 of that year; and (d) on December 31 payment is due based on actual gross revenues for the HMO for the period July 1 to September 30 of that year. Specify that certain current law provisions in Chapter 77 relating to tax deficiency and refund determinations, interest and penalties for late taxes, refunds of less than $2, testimony and disclosure, timely mailings, and the collection of delinquent sales and use taxes, apply to the HMO assessment, except that the assessment revenue would be deposited to the MA trust fund. Direct DHFS to levy, enforce, and collect the assessment and develop and distribute forms necessary for levying and collection, and to establish procedures and requirements for levying the assessment.

Permit an affected HMO to contest an action by DHFS by submitting a written request for a hearing to the Division of Hearings and Appeals in the Department of Administration within 30 days after the date of the action by DHFS. Provide that any order or determination made by the Division is subject to judicial review, as prescribed under Chapter 227 of the statutes.

Funding and Revenue

Assessment Revenue. Estimate that $29,033,300 in 2005-06 and $59,180,300 in 2006-07 would be collected in assessment revenue for deposit to the MA trust fund.

Redistribute Assessment. Provide $32,742,000 ($12,903,000 SEG and $19,839,000 FED) in 2005-06 and $69,098,100 ($26,618,300 SEG and $42,479,800 FED) in 2006-07 to redistribute a portion of the assessment revenue to the HMOs.

Rate Increases. Provide $3,372,500 ($1,343,000 GPR and $2,029,500 FED) in 2005-06 and $12,061,00 ($4,821,000 GPR and $7,240,000 FED) in 2006-07 to provide a 1.1% annual capitation rate increase to HMOs that provide services to HMOs that serve low-income families enrolled in MA and BadgerCare.

Replace Base GPR Funding with SEG. Provide $16,130,200 SEG in 2005-06 and $32,562,000 SEG in 2006-07 and decrease GPR funding by corresponding amounts to replace GPR funding currently budgeted for MA benefits with SEG revenues from the MA trust fund.

DISCUSSION POINTS

1. The Governor's proposal provides a means by which the state could increase federal MA matching funds by creating a permissible provider tax, using a portion of the combined tax and federal MA revenues to increase MA payments to HMOs, and replace base GPR funding for the MA program with additional revenues that would be deposited to the MA trust fund. By using this

method, the state could effectively increase the amount of federal funding that would be available to support MA benefits without increasing GPR funding for the program. Further, HMOs would receive higher MA payments that would more than offset the amount the industry would pay, in the aggregate, in HMO assessments.

2. Other states have successfully implemented federally approved assessments on HMOs. Further, Wisconsin uses provider taxes as a means to support the state's share of its MA program to a much lesser extent than other states.

3. However, the administration's proposal is based on two key assumptions: (a) that current HMOs that serve MA recipients would respond to the assessment by creating subsidiaries that only serve MA and BadgerCare recipients and would not discontinue their participation in these programs; and (b) that the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) would find this method of claiming federal MA matching funds to be permissible under federal MA law and CMS policy. Each of these issues is addressed in this paper.

Response by HMOs

4. In order to minimize the amount of the assessment they would pay, the administration assumes that HMOs would reorganize by creating separately licensed MA-only HMOs. HMOs would incur several types of costs if they chose to reorganize. First, each HMO would pay a one-time $800 charge to file the Certificate of Incorporation and the Certificate of Authority with OCI. Further, each new HMO would be required have $1.2 million, or three percent of its premium revenue, whichever is greater, to meet the required surplus/capital requirement. HMOs would incur additional costs to conduct feasibility studies and to purchase legal and auditing services. HMOs may find these requirements prohibitive and no longer serve MA and BadgerCare recipients. If this occurs, state MA costs may increase because some recipients currently enrolled in HMOs may instead receive services on a fee-for-service basis.

5. There is evidence to suggest that some HMOs would discontinue serving MA and BadgerCare recipients if the Governor's proposed HMO assessment were enacted. Representatives from Health Tradition Health Plan, Group Health Cooperative-Eau Claire, Group Health Cooperative-South Central Wisconsin, Unity, Security Health Plan, Network, I-Care, Abri Health Plan, and Dean Health Plan have indicated, in writing, that, if the Legislature approves the Governor's proposal, they would likely end service to MA and BadgerCare recipients. As of April, 2005, these HMOs were servings approximately 115,400 MA and BadgerCare recipients. Representatives from Atrium and United Health Care testified at the Committee's public budget hearings that their HMOs might stop serving MA and BadgerCare recipients if the assessment were enacted. As of April, 2005, these two HMOs were serving approximately 93,000 MA and BadgerCare recipients.

6. If any of the HMOs that currently serve both MA and BadgerCare recipients and commercial payers did not reorganize into MA-only subsidiaries, the revenue the state would collect from the assessment would be much greater, since it would then include the non-MA revenue of

those HMOs. However, this is unlikely to occur. HMOs that choose not to reorganize would more likely discontinue serving MA recipients so that they would not be subject to the HMO assessment.

7. Currently, DHFS requires most MA and BadgerCare recipients to obtain care through HMOs if more than one HMO is available for the recipients to choose from in the recipients' geographical area. If some HMOs stopped serving these recipients, DHFS would no longer be able to require many MA recipients to receive their care through HMOs. Some recipients would then receive their care on a fee-for-service basis, which is, on average, more costly to the state.

8. Finally, HMOs are concerned that, because the federal provider tax provisions require states to redistribute the tax revenue, there would be "winners and losers." At this time, it is not known how DHFS would adjust HMO payments to comply with these federal requirements.

9. Because the assessment would be implemented by January 1, 2006, OCI would need to license all the subsidiary companies by that time. OCI staff indicate that it would take four to six months to license approximately seven to eight MA-only HMOs. Currently one OCI position is responsible for all domestic licensing, and OCI estimates that that position's workload would likely double. Administrative rules require that OCI respond to a license request within 90 days. In summary, OCI indicates that it could meet this workload, even though no additional resources would be provided to the agency for this purpose.

HMOs that Provide Long-Term Care Services

10. Organizations that currently serve MA recipients that require long-term care would also be subject to the HMO assessment. These organizations provide comprehensive health care and other supportive services to enable individuals to remain in the community. These organizations include I-Care and Program for All-Inclusive Care for the Elderly/Wisconsin Partnership Project (PACE/WPP), which serve only MA recipients. As of April, 2005, I-Care had approximately 6,100 enrollees and PACE/WPP had approximately 2,300 enrollees. The administration assumes that the SSI managed care expansion, which began in Milwaukee in April, 2005, will proceed, and the estimate of projected tax revenue generated from that group is included in the administration's revenue estimate.

11. In addition to receiving MA payments, PACE/WPP also receive Medicare payments, which would be subject to the assessment under AB 100. Since the administration's intent is to tax only MA revenue, and not Medicare revenue, its assessment revenue estimates were calculated by excluding Medicare revenue PACE/WPP receives. If the Committee chooses to adopt the Governor's recommendation to create an HMO assessment, it could modify the bill to specify that the assessment would only be applied to non-Medicare revenue to reflect the administration's intent. If the Medicare revenue of PACE/WPP were included in calculating the amount of the assessment, revenue from the assessment would increase slightly from the Governor's estimates, and PACE/WPP would pay slightly more in assessment revenue than other HMOs that serve only MA recipients.

Michigan's Experience

12. The State of Michigan implemented a 6% assessment on HMOs that serve MA recipients in 2003. The Michigan Office of the Commissioner of Insurance reports that it was able to license five MA-only HMOs in three to six months by reallocating staff resources. According to the Office, five HMOs subsequently established MA-only subsidiaries. During the first two years after Michigan created the assessment, the state used all assessment revenue to fund rate increases for HMOs because many of the HMOs were going into receivership due to low MA capitation rates. Michigan retained $15 million of the revenue in 2005. Since the implementation of the assessment, HMO enrollment has increased by about 100,000 recipients so that currently 900,000 of the state's current 1.4 million recipients are in managed care. The state currently has managed care in all counties except one.

13. Based on discussions with staff from Michigan's MA program, in approving Michigan's state plan amendment, CMS wanted to ensure that the distribution of revenue under the Michigan proposal was not based proportionately on the amount paid by each HMO. Michigan MA staff indicate that the state had to make several modifications to its payment formula to meet CMS requirements for approval.

Compliance with Federal Policy

14. If the Governor's proposal is enacted, DHFS would need to seek approval from CMS to implement the assessment. CMS would review the way in which the state would levy the assessment and how DHFS would distribute payments to ensure that the state conforms with federal laws and regulations relating to provider taxes and payments to managed care organizations. Under the Governor's recommendations, revenue from the assessment would be used to reduce base GPR support for MA and BadgerCare and increase HMO capitation payments.

15. It is not known whether CMS would approve the assessment. In his fiscal year 2005-06 budget, the President proposed reducing the maximum allowable tax rate states can assess as provider taxes, from the current rate of 6% to 3%. Further, the President recommended additional limitations on mechanisms, such as provider taxes, that states currently use to claim more federal funding. Therefore, it is possible that federal law may change and no longer allow MA-only HMOs to be recognized as a class of providers for purposes of an assessment. Even if federal law were to remain the same, CMS might not approve the HMO assessment, since it is the type of mechanism that CMS is trying to prevent states from implementing. HMOs are concerned that, even if they reorganized in the manner anticipated by the administration, federal law or policy changes might disallow the funding mechanism proposed by the administration.

16. In summary, the main arguments against this proposal relate to: (a) the possibility that CMS may not permit the state to implement this provision, or, if it does, the mechanism might be short-lived, due to potential changes in federal law; (b) the possibility that some HMOs would not reorganize and instead decide to stop serving MA recipients, which may increase MA and BadgerCare benefits costs. Because of the way the assessment is structured to, in aggregate,

redistribute the assessment payments back to the HMOs while also generating federal matching funds to help support other MA benefits costs, there is no reason for the state to enact an assessment rate that is less than the federal maximum (6%), since the only effect of such a change would be to decrease the amount of federal revenue the assessment would generate.

ALTERNATIVES

1. Approve the Governor's recommendations, but specify that the assessment would be applied to non-Medicare revenues received by HMOs to reflect the administration's intent.

2. Delete provision.

Alternative 2	SEG-REV	GPR	FED	SEG	TOTAL
2005-07 REVENUE (Change to Bill)	- $88,213,600				- $88,213,600
2005-07 FUNDING (Change to Bill)		$42,528,200	$42,528,200	$88,213,600	$117,273,700

Prepared by: Marlia Moore
Attachment

ATTACHMENT

Wisconsin HMOs Medical Assistance/BadgerCare Enrollment
As of December 31, 2004

	Total Enrollment	Medicaid Enrollment	Percent of Medicaid to Total
Abri	815	815	100.0%
Atrium	51,845	28,363	54.7
Dean	214,373	12,052	5.6
GHC-EC	21,932	13,914	63.4
GHC-SC	51,353	2,800	5.5
Health Tradition	29,565	5,626	19.0
I-Care	6,046	6,046	100.0
Mercy Care	31,478	8,879	28.2
MHS	117,872	117,872	100.0
Network	119,125	47,912	40.2
Security	111,431	19,911	17.9
UHC*	304,939	84,394	27.7
Unity	74,744	3,524	4.7
Valley	12,488	992	7.9
Total	1,148,006	353,100	30.76%