GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Priority Health and
Priority Health Insurance Co.,
Petitioners,

MICHIGAN TAX TRIBUNAL

v

MOAHR Docket Nos. 16-000784-R
and 16-000785-R

Michigan Department of Treasury,
Respondent.

Presiding Judge
Preeti Gadola

FINAL OPINION AND JUDGMENT ON REMAND

INTRODUCTION

Petitioners, Priority Health and Priority Health Insurance Co., appeal Final Assessment Nos. UJ62218 and UJ62404 levied by Respondent, Michigan Department of Treasury, covering the 2012 tax year. Thomas M. Amon, Attorney, represented Petitioners, and David W. Thompson and Scott L Damich, Assistant Attorneys General, represented Respondent. A hearing of this matter was held on September 22-23, 2020. Petitioners' witnesses were Nicholas Gates, Deborah Avery, and Cindy Brink. Respondent's sole witness was Christopher Potts.

The hearing of this matter occurred pursuant to a remand order from the Court of Appeals (COA). Petitioner, Priority Health (PH) is a nonprofit Michigan health maintenance organization and Petitioner, Priority Health Insurance Company (PHIC) is its wholly owned subsidiary. Petitioners provide insurance coverage for prescription drugs, among other insurance coverages. This case pertains to prescription drug coverage.

Petitioners contracted with third-party pharmacy benefit managers (PBMs) to administer and coordinate their prescription drug benefit program. Petitioners utilized Argus Health Systems, Inc. to manage pharmacy claims payments, and also contracted with Express Scripts, ICORE and CDMI to administer rebates on prescription drugs. Petitioners provided their rebate PBMs with the details of their paid claims and the PBMs would determine if they qualified for rebates. If the claim qualified, the drug manufacturer paid the rebate to the PBM, which in turn paid the rebate to Petitioners.

Petitioners challenged the final assessments for tax due pursuant to the Health Insurance Claims Assessment Act (HICAA)[1] The HICAA imposes a 1% tax on all paid claims made by health insurance companies in Michigan. Petitioners argued that the tax base for HICAA, paid claims, is defined as "actual payments, *net of recoveries* made to a health and medical services provider . . . by a carrier, third party administrator, or excess loss or stop loss carrier."[2] The term recoveries is not defined by statute and Petitioners argued that "recoveries" included pharmaceutical rebates which should be subtracted from paid claims. Respondent argued that pharmaceutical rebates are not recoveries.

On May 22, 2017, the parties filed cross motions for summary disposition pursuant to MCR 2.116 (C)(10). On June 12, 2017, responses to the motions were filed. This Tribunal Judge denied both motions for summary disposition, but pursuant to a Motion for Reconsideration, the Tribunal Chair granted summary disposition in favor of Respondent. Petitioners appealed this matter to the COA, it reversed the Tribunal's

[1] MCL 550.1731 *et seq.*
[2] MCL 550.1732(s). Emphasis added.

final opinion granting summary to Respondent, and remanded the case to the Tribunal for further proceedings.

The COA found that the Tribunal correctly concluded that pharmaceutical rebates constitute recoveries under HICAA, rebates must be traced to specific paid claims, and that Petitioners did provide evidence that there was a genuine issue of material fact when viewed in the light most favorable to Petitioners.[3] The Court found, "Gates[4] testified that petitioners used a reasonable estimate to determine the portion of pharmaceutical rebates that related to taxable claims and could therefore be considered 'recoveries.' In an attempt to clarify whether Petitioners were capable of tracing the rebates to specific claims as required by the statute, respondent's attorney,"[5] questioned Mr. Gates and he replied in the affirmative, that Petitioners had the detail to trace rebates to claims from ICORE, but did not have the detail to trace rebates to claims from Express Scripts.[6] The COA noted in a footnote that, "[i]n their brief on appeal, petitioners allege that they have obtained necessary rebate detail from their PBMs, but we note the records were not produced for this Court's review, nor were they part of the Tribunal's record. In any event, it will be up to the Tribunal, and not this Court, to determine whether the documents obtained by petitioners are sufficient to support their calculations of recoveries or paid claims."[7] As such, it is the Tribunal's instruction in this matter to determine the sufficiency of the documents.

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[3] *Priority Health v Dep't of Treasury and Priority Health Insurance Co v Dep't of Treasury*, unpublished per curiam opinion of the Court of Appeals, issued October 30, 2018 (Docket No. 341120), pp.6, 7.
[4] Mr. Gates is Vice President of Finance at PH.
[5] *Priority Health, supra* at 6-7.
[6] *Priority Health, supra* at 7.
[7] *Priority Health, supra* at fn 7.

The Court also found, “the accounting required in this case to determine the precise dollar amount that petitioner set off against its total paid claims for HICAA taxation purposes is akin to the computation of damages in a regular civil court case, which is usually held to be an issue of fact.”[8] “The amount of tax that petitioner has to pay under HICAA is a type of damages that involves mathematical computation. This is best done by the fact-finder at trial where the methodology on both sides can be vetted and specific calculations analyzed.”[9]

The Tribunal has carefully considered the parties’ witness testimony, evidence, post-hearing briefs, and computations, and finds the documents[10] supplied by Petitioner to be sufficient and the computations, accurate. As a result, it finds Assessment Nos. UJ62218 and UJ62404 levied by Respondent, Michigan Department of Treasury, shall be cancelled.

PETITIONERS’ CONTENTIONS

Petitioners contend that that the issue on remand from the COA is narrow. They contend the Tribunal already resolved the sole legal question, that pharmaceutical rebates can constitute recoveries pursuant to the HICAA. Petitioners claim the Tribunal concluded that if sufficient records are produced to demonstrate that prescription drug rebates relate to actual payments made, those rebates can be deducted from Petitioners’ HICAA tax liability. Petitioners allege the COA determined the calculation is “akin the computation of damages.”[11] Petitioners claim that they have obtained “detailed data for each of its 2012 pharmacy rebates, reconciled that data with its own pharmacy

[8] *Priority Health, supra* at 7 (internal citations omitted).
[9] *Priority Health, supra* at 7.
[10] Documents were provided in electronic format.
[11] See Petitioner’s Post-Hearing Brief (Pet’s Brief) at 2.

claims records, demonstrated that the rebates in question match to individual pharmacy claims, and calculated the exact amount of rebates relating to HICA-taxable claims."[12] Petitioners request that the Tribunal cancel the assessments levied by Respondent.

PETITIONER'S ADMITTED EXHIBITS

PX-1: Affidavit of Magellan Records Custodian Authenticating PH_2012_Detail.xlsx

PX-2: Rebate Detail from Magellan labeled PH_2012_Detail. xlsx

(submitted electronically under seal)

PX-3 ICORE Final Rebate v. 2.xlsx (submitted electronically under seal) (Columns P-AH added from Priority data).

PX-4: Affidavit of ESI Records Custodian authenticating documents furnished

PX-5: Affidavit of ESI Records Custodian authenticating ESI_2012_PH_Rebate_Data, Updated. xlsx.

PX-6: Rebate detail from ESI labeled ESI 2012_PH_Rebate_Data_Updated.xlsx.

PX-7: ESI 2012_PH_Rebate_Data.xlsx (submitted electronically under seal). (Exhibit P-5 with K, L and M added by Ms. Avery).

PX-8: Final ESI Rebates.xlsx. (Columns K-W added from Priority Data)

PX-9: Summary Detail Reconcilation.xlsx

PX-10: Argus and ESI Audit Reports (submitted under seal)

PX-11: Audit Report from PH and PHIC.

PX-12: Treasury's Response to Petitioner's Requests to Admit and Interrogatories.

PX-13: Treasury's Response to Petitioner's Discovery Requests on Remand.

PX-14: National Council for Prescription Drug Programs State Code Guide.

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[12] Pet's Brief, at 2.

PX-15: Tax Preparation Documents Reflecting HICA Estimate.

PX-16: Informal Conference and Order of Determination.

PX-17: Annual Returns for HICA for PH and PHIC.

PX-18: Final Assessments issue by Respondent Under Appeal.

PX-19: 2012 RX claims.txt (submitted electronically under seal).

PETITIONER'S WITNESSES:

Nicholas Gates

Mr. Gates is Vice President of Finance at Priority Health. His role is to oversee financial reporting records, including tax filings. His job functions apply to both PH and PHIC, a subsidiary of Priority Health.

Mr. Gates is a CPA and while employed at Ernst and Young conducted audits. He was also employed as a senior accountant for PH, and over the last sixteen years, he's worked in various financial roles at PH, including director of financial reporting and subsequently vice president of finance. He also obtained a MBA through Michigan State University.[13]

Mr. Gates is familiar with PH's and PHIC's management of their pharmacy benefit claims and rebates, and testified that their paid claims data was provided to their rebate PBMs, of which Express Scripts is the largest. When Express Scripts received the data, it would determine the rebates that were due back to PH and PHIC. In 2012, Express Scripts considered the rebate information proprietary so PH and PHIC only received cash receipts, but no claim level detail.[14]

[13] Transcript, Volume one (Tr. Vol 1) at 25-27.
[14] Tr. Vol 1 at 27-28.

Mr. Gates testified that PH and PHIC calculated their PBM rebates as allowable recoveries, by commencing with their pharmacy rebate accrual and using their claims data to determine what percentage of the pharmacy claims were subject to the Health Insurance Claims Assessment (HICA). This was the case because HICA is only applicable to claims for individuals domiciled in Michigan. Mr. Gates testified Petitioners' estimates were reasonable and "consistent with how we report financial accounting records and similar to the industry standard where it specifically states that pharmacy rebates are netted with pharmacy claims [and] we believe this was the best estimate[ ] based on the records that we had at the time."[15] Mr. Gates testified that during Respondent's audit process, conducted by Mr. Potts, "[o]ther than looking at the records that we had on hand there no other disputes around our estimation method."[16] Mr. Gates was directed to Petitioner's Exhibit 11, Respondent's audit report, which read, "the taxpayer has written specific queries to access their claims database for the exclusions allowed under the HICA Act and to accrue for claims that are subject to HICA. After a review of their procedures the auditor was satisfied that the taxpayer has established proper procedures to account for the HICA fee."[17]

During cross-examination, Mr. Gates answered in the affirmative, when he was questioned whether the rebate PBMs paid all of the rebates collected from the pharmaceutical manufactures, back to Petitioners.[18]

[15] Tr. Vol 1 at 43.
[16] Tr. Vol 1 at 48.
[17] Tr. Vol 1 at 53.
[18] Tr. Vol 1 at 63, 66.

Deborah Avery

Ms. Avery is a lead financial analyst for PH and PHIC. She has been employed by Petitioners for twenty-one years and her role is to analyze data. She is also a "conversion person, so in other words I know how systems work together and how the back end data works so when projects come up or we're converting computer systems it's my role to make sure [we can get the data out of] the computer systems that we need to."[19] Ms. Avery testified that she deals with PH and PHIC's data systems, daily.[20] Prior to her employment at PH, she was employed by Blue Care Network for twelve years in the claims department and as a data analyst.

For the subject litigation, Ms. Avery was requested to "take the rebate spreadsheet information that she had received and if we could, you know, match it up against what's in our data system."[21] Ms. Avery answered in the affirmative, that she was able to complete the matching.[22] She testified, "[w]e have all our claims, our pharmacy claims and our medical claims in our data warehouse system and it is at the fill level, it's at the data server fill level. It's every claim that came in."[23] She further testified,

> we get the file from the PBMs, . . . and back in 2012 it was Argus. The data that we get on those files is prescription ID. We would get the pharmacy ID letting us know where the prescription was filled. We have the member information on it. We have the amount that we paid, if there is any co-pays, if there was any deductibles for the claim, and you know, there is other . . . information, like how many pills [there] are, the drug manufacturer, all of that information is pulled into our system.[24]

[19] Tr. Vol 1 at 113.
[20] Tr. Vol 1 at 115.
[21] *Id.* The "she" Ms. Avery is referring to is Ms. Brink, Director of Financial Reporting and Analysis for PH and PHIC.
[22] *Id.*
[23] *Id.*
[24] Tr. Vol 1 at 115-116.

Ms. Avery replied in the affirmative when questioned if the data she previously described is relied upon by Petitioners in conducting their everyday business.[25]

Ms. Avery testified she was given rebate spreadsheets from ICORE, CDMI (Magellan)[26] and Express Scripts, and matched the PBM rebates with PH and PHIC's claims by using four columns of data. She testified the four columns were, fill date, NDC, or national drug category, NABD, which is the pharmacy ID, and the prescription ID (pharmacy Rx number) which the pharmacy assigned.[27] Additional data included a unique identifier to a particular member, their state of residence at the time of the fill, whether the pharmacy was mail order, which PH and PHIC insurance product (different co-pays and benefits, for example), the amount PH and PHIC paid, and specific information about who was financially responsible to pay the claim. With the Express Scripts data Ms. Avery answered in the affirmative that she removed some leading zeros and, "the first maybe couple digits of the number."[28] "Because . . . our system won't bring in leading zeros."[29] The "[s]preadsheet coming in from ESI[30] did have leading zeros on it."[31] "[T]hey had a number that the first set of numbers were consistently the same and it would be comparable going to Meijer's or Walgreen's and you would have a set of numbers on your prescription bottle that might say like 00012 – and then a bunch of other numbers. The first numbers then would be consistent for that pharmacy."[32] Ms. Avery testified that by removing the leading zeros or in a few

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[25] Tr. Vol 1 at 116.
[26] Magellan acquired ICORE in 2006 and CDMI in 2014. See P-X1 at paragraph 4. See Tr. Vol 2 at 13.
[27] See PX-3, PX-6, PX-7, PX-8, Tr. at 128-129, 133, 135-136.
[28] Tr. Vol 1 at 134.
[29] *Id.*
[30] ESI is Express Scripts.
[31] Tr. Vol 1 at 134.
[32] *Id.*

instances, other leading numbers, she was able to match additional rebate numbers with Priority's claim numbers. She testified that removing the leading numbers did not affect her analysis because the other three fields, matched.[33] By removing the leading zeros and in a few instances, the first few numbers, the fourth column matched. She answered in the affirmative, that when matching all four fields with corresponding PH and PHIC data, there were no duplicates, and the database never returned more than one claim.[34] Ms. Avery testified that she is confident the information received from the PBMs is accurate, because the data fields matched. Further, she testified she had no reason to doubt the accuracy of the affidavit filed by the records custodian for Magellan[35]

During cross-examination, Ms. Avery was questioned if she ever saw "a receipt or invoice relating to a particular prescription or claim that shows the transaction ID, the paid amount, et cetera?"[36] She replied, "[n]o I haven't but Priority is not in the business for keeping that documentation. That would be up to our PBM."[37] She testified that it was appropriate to remove leading zeros due to her knowledge regarding prescriptions. She testified, "prescriptions in general knowing that front zeros can be removed because of how data comes into the system and knowing that prescription numbers can have a dash on them like 00012- and then the prescription number I knew that it's the front end of it that needs to be taken off and nothing from the back end would have to be taken off."[38] With regard to the leading numbers, she replied, "it was one particular

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[33] Tr. Vol 1 at 134.
[34] Tr. Vol 1 at 136.
[35] See PX-1, Tr. Vol 1 at 120.
[36] Tr. Vol 1 at 153.
[37] *Id.*
[38] Tr. Vol 1 at 164.

pharmacy that those first digits were all the same for every one of their prescription IDs, and so again [,] like I said [,] it could be there was a dash in there but it gets removed when our system brings them in. And knowing that just from personal experience that those dashes can be in there."[39] She confirmed that after her analysis, approximately 850 claims failed to match, but she could find them if she considered each, individually.[40] She testified, however, PH's databases have "millions and millions of records of claims in there."[41] As a result, she didn't manually look at individual text files.

Cindy Brink

Ms. Brink is the Director of Financial Reporting and Analysis at PH. She has worked for PH and PHIC for fourteen years. Before coming to PH, she completed audits for Ernst and Young, and earned her CPA certification. She is the leader of two teams, one, accounting and financial reporting, and the second, financing operation. Financing operation handles all cash coming in and going out of the organization. In her roles, Ms. Brink is extremely familiar with PH and PHIC's accounting records and methods.

With regard to PH and PHIC's rebate PBMs, it is Ms. Brink's understanding that rebates are based on claim by claim transactions because "the PBMs provided us schedules with claim level information for the rebates. If they were not based on claim by claim transactions, they would not be able to give us that information."[42] Ms. Brink testified she reviewed the spreadsheets sent from Magellan and Express Scripts, relative to rebate information, and compared them to cash receipts that PH and PHIC

[39] Tr. Vol 1 at 165.
[40] See R-49 at 17. See Tr. Vol 1 at 168.
[41] Tr. Vol 1 at 146.
[42] Tr. Vol 2 at 12-13.

received related to 2012. She determined the rebate information and cash receipts were very close to matching. After additional filtering using Ms. Avery's methods approximately, $1,417 in Express Scripts claims were unmatched,[43] approximately $5,064 ICORE claims were unmatched,[44] and no claims were unmatched for CDMI.[45] Ultimately, Ms. Brink testified that it was an inefficient use of employee time to conduct any additional research to match the remaining 850 unmatched rebates/claims, as the amount of tax due (1% of paid claims), was so minimal that PH and PHIC determined it would pay the tax related to these amounts.[46] Ms. Avery communicated to Ms. Brink that she could find the 850 unmatched claims if she looked at each individually, but in terms of tax due, it would not make much of a difference.[47] For example, 1% of $1,417 unmatched Express Scripts claims equals $14 in tax due. As such, PH and PHIC's final estimate of tax due, was conservative.

Ms. Brink testified that she considered the PBM rebate data to be reliable, because "[w]e do reconciliations within Priority Health. For example, I reconcile to cash receipts. Ms. Avery compared them to the claims level detail in our databases, but we also receive these reports that give opinions from public accounting firms that the controls at these service providers are sufficient for providing accurate data."[48]

During cross examination, Ms. Brink testified that in 2012, the rebate checks came with a cover letter, and little else. She also testified, however, "[w]e received many

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[43] Tr. Vol 2 at 20.
[44] Tr. Vol 2 at 29.
[45] Tr. Vol 2 at 33.
[46] Tr. Vol 2 at 45.
[47] Tr. Vol 2 at 46. See R-49 at 17.
[48] Tr. Vol 2 at 37. These are industry standard reports, referred to as SOC1 (Service Organization Control 1 report,) and SSAE16 (Statement of Standards for Attestation Engagements). See PX-10.

communications from the rebate PBM, so throughout the course of business we received this information from them on a regular basis. It may not all have been in the same mailing."[49] Ms. Brink testified that PH and PHIC's regulators require that pharmacy rebates be tracked separately from pharmacy claims, and as such, the matching of claims to rebates was an outside exercise[50]. She testified, however, that PH and PHIC now request a full data set from their PBMs, but in 2012, they were not provided with rebate detail.[51]

Ms. Brink was questioned extensively about the PBM data matching analysis, and the possibility of a false match. She expressed that she was satisfied with the data because, "we used four independent fields from one another and Ms. Avery testified to that yesterday."[52] When questioned about the accuracy of PH and PHIC data, she testified that the "information that came from Priority Health databases that Ms. Avery brought in is validated by others within the organization on a regular basis as part of ongoing business operations. . . ."[53]

RESPONDENT'S CONTENTIONS

Respondent contends that the legal issue in this case is whether Petitioners properly reduced their HICAA tax bases with pharmacy rebates received from their PBMs, as allowable recoveries. Respondent claims the Tribunal interpreted "net of recoveries," when defining "paid claims" to mean that the recovery must have a direct relationship to a specific claim paid by a carrier to a medical services provider.

[49] Tr. Vol 2 at 64. PBMs initially provided only cash receipts, rebates by drug class and insurance product. See Pet's Brief at 4.
[50] Tr. Vol 2 at 69, 74.
[51] Tr. Vol 2 at 77-78.
[52] Tr. Vol 2 at 91.
[53] Tr. Vol 2 at 151.

Respondent contends the COA did not reverse the Tribunal's interpretation of the statute.

Respondent contends that in order for Petitioners to prevail in this matter, they must show that the rebate amounts that they deducted from their tax bases, actually reduce individual claims they previously paid to pharmacies. Respondent alleges that Petitioners failed to meet their burdens and the assessments should be affirmed.

RESPONDENT'S ADMITTED EXHIBITS

R-01: Priority Health 2012 Annual Return for Health Insurance Claims Assessment

R-02: Priority Health Insurance Company 2012 Annual Return for Health Insurance Claims Assessment

R-03: Priority Health Audit Pre-Confirmation Letter

R-04: Priority Health Insurance Company Audit Pre-Confirmation Letter

R-05: Priority Health Audit Confirmation Letter

R-06: Priority Health Insurance Company Audit Confirmation Letter

R-07: Priority Health Audit Records Request

R-08: : Priority Health Insurance Company Audit Records Request

R-09: Priority Health, Health Insurance Claims Assessment Questionnaire

R-10: Priority Health Insurance Company Health Insurance Claims Assessment Questionnaire

R-11: Priority Health Audit Report of Findings

R-12: Priority Health Insurance Company Audit Report of Findings

R-13: Priority Health Audit Workpapers

R-14: Priority Health Insurance Company Audit Workpapers

R-22: Priority Health Notice of Preliminary Audit Determination

R-23: Priority Health Insurance Company Notice of Preliminary Audit Determination

R-24: Priority Health Final Audit Determination Letter

R-25: Priority Health Insurance Company Final Audit Determination Letter

R-26: Priority Health Application of Audit Payment

R-27: Priority Health Insurance Company Application of Audit Payment

R-28: Priority Health Notice of Intent to Assessment No. UJ62218

R-29: Priority Health Insurance Company Notice of Intent to Assessment No. UJ62404

R-34: Priority Health Informal Conference Recommendation

R-35: Priority Health Reasons and Authority for the Decision of the Dep't of Treasury

R-36: Priority Health Insurance Company Informal Conference Recommendation

P-37: Priority Health Insurance Company Reasons and Authority for the Decision of the Dep't of Treasury

R-38 Priority Health Final Assessment No. UJ62218

R-39: Priority Health Insurance Company Final Assessment No. UJ62404

R-41: CDMI, LLC Pharmaceutical Product Rebate Services Agreement

R-42: Express Scripts, Inc. Formulary and Rebate Administration Agreement

R-43: ICORE Healthcare, LLC Injectable Pharmaceutical Products Rebate Agreement

R-45: Nicholas Gate Deposition Transcript

R-46: Cindy Brink Deposition Transcript

R-47 Deb Avery Deposition Transcript

R-49: Rebate Detail Emails

RESPONDENT'S WITNESS

Christopher Potts

Mr. Potts is employed by Respondent and audited PH's and PHIC's 2012 HICA tax liability. During the course of his audit he disagreed with Petitioners' reduction of gross paid claims attributed to pharmacy rebates, which he contends are not recoveries.[54] As a result, Respondent levied the final assessments in question.

When questioned by the Tribunal, why Mr. Potts disallowed the pharmacy rebates, he replied, "it was strictly based on the FAQ and discussing with our policy."[55] He testified, rebates have, "to flow down and affect the gross paid amount."[56] He further testified, "if they had paid $100 and they were saved, you know, they paid the claim as $100 and let's say they got a $20 rebate that should reduce the claim amount. Nowhere did I say - - or it was under our opinion after talking with our lawyer from policy that that did not reduce the claim amount."[57] On redirect, Mr. Potts answered in the negative, if he saw an instance where an individual claim was reduced by a specific rebate amount? He was questioned if he would allow it as a recovery if the claim were reduced by a specific rebate amount? He answered, "possibly."[58]

The Tribunal also questioned Mr. Potts how he determined gross paid claims and exclusions? He testified in order to determine which claims were subject to HICA, he

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[54] The auditor did allow recoveries relative to coordination of benefits payments received (reimbursement for a claim previously paid, from another insurance company responsible for the claim – see Tr. Vol 1 at 57-58, 60) and subrogation payments received (reimbursement from the legal collection of a claim previously paid – see Tr. Vol 1 at 58), but not reimbursement in the form of rebates for pharmacy claims previously paid. See Respondent's post-hearing brief at 7, 9.
[55] Tr. Vol 2 at 188.
[56] *Id.*
[57] *Id.*
[58] Tr. Vol 2 at 193, 194.

sampled the data provided by PH and PHIC. He testified, “we’re looking at like a 90 percent competence relative like within at 10 percent error.”[59]

FINDINGS OF FACT

The Tribunal’s Findings of Fact concern only evidence and inferences found to be significantly relevant to the legal issues involved; the Tribunal has not addressed every piece of evidence or every inference that might lead to conflicting conclusion and has rejected evidence contrary to those findings.

1. Petitioner, Priority Health is a nonprofit Michigan health maintenance organization and Petitioner, Priority Health Insurance Company (PHIC) is its wholly owned subsidiary.
2. Petitioners provide insurance coverage for prescription drugs.
3. Petitioners contracted with third-party pharmacy benefit managers (PBMs) to administer and coordinate their prescription drug benefit program. Petitioners utilized Argus Health Systems, Inc. to manage pharmacy claims payments, and also contracted with Express Scripts, ICORE and CDMI to administer rebates on prescription drugs.
4. Petitioners provided their rebate PBMs with the details of their paid claims and the PBMs would determine if they qualified for rebates. If the claim qualified, the drug manufacturer paid the rebate to the PBM, which in turn paid the rebate to Petitioners.

[59] Tr. Vol 2 at 190.

5. The HICAA imposes a 1% tax on all paid claims made by health insurance companies in Michigan.
6. MCL 550.1732(s) defines the tax base for HICAA paid claims, as "actual payments, net of recoveries made to a health and medical services provider . . . by a carrier, third party administrator, or excess loss or stop loss carrier."
7. The Tribunal determined "recoveries" included pharmaceutical rebates which should be subtracted from paid claims. The Tribunal determined that rebates must be traced to specific paid claims.
8. Petitioners provided the Tribunal with documentation matching their pharmaceutical rebates (obtained from PBMs) to their paid claims.
9. There were 850 rebates that were not matched to paid claims.
10. Matching the 850 rebates to paid claims was possible if the 850 claims were analyzed individually. Petitioners determined this additional research was not an effective use of employee resources and chose to pay the increased amount of HICA tax due.
11. Respondent contends pharmacy rebates are not recoveries based on its FAQ.
12. Respondent levied assessments UJ62218 and UJ62404, against Petitioners, covering the 2012 tax year, based on the denial of pharmacy rebates as recoveries.

CONCLUSIONS OF LAW

In its order denying summary disposition to both parties in this case, entered September 22, 2017, the Tribunal rejected Respondent's determination that pharmacy rebates do not constitute recoveries pursuant to the HICAA. In its Frequently Asked

Questions, (FAQ) 42, Respondent states, 'Recoveries' includes any amounts received by the payer that are applied against a claim (and that affects the amount of the actual payment made to the provider)." In its FAQ 126, Respondent replies to the question,

> Can rebates received by a Pharmacy Benefit Manager from drug companies be netted as 'recoveries' against the PBMs 'paid claims' for purposes of the Health Insurance Claims Assessment (HICA)?
>
> A: In most cases, no. 'Recoveries' includes any amounts received by the payer that are applied against a claim, as long as the recovered amount affects the amount of the actual payment made to the provider. Rebates received by PBMs from drug companies do not typically affect the amount of the payment made to the medical services provider, which in this case is the pharmacy dispensing the drug.[60]

Respondent's auditor, Mr. Potts, testified that he relied on the FAQ and Respondent's policy person, an attorney, when rejecting Petitioners' attempts to reduce its paid claims by the amount of its pharmaceutical recoveries.[61] In its order denying summary disposition to both parties, the Tribunal found, that while Respondent's FAQs may provide beneficial guidance, they are not binding on the Tribunal. "[A]gency interpretations are entitled to respectful consideration, but they are not binding on courts and cannot conflict with the plain meaning of the statute."[62]

The Tribunal found that Respondent's interpretation of MCL 550.1732(s) reads an additional requirement into the statute that is simply not supported. MCL 550.1732(s) states, "'[p]aid claims' means actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier." The Tribunal found "[t]he receipt of a

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[60]Health Insurance Claims Assessment (HICA) Act Frequently Asked Questions, https://www.michigan.gov/taxes/0,4676,7-238-43519_43542-389419--,00.html (viewed December 23, 2020).
[61] Tr. Vol 2 at 188. See PX -11 at 4, 8, 14, 19.
[62] *In re Rovas Complaint*, 482 Mich 90, 117-118; 754 NW2d 259 (2008).

rebate from the pharmaceutical company, is the regaining of a portion of the actual payment,"[63] but Respondent "adds a requirement not present in the statute, requiring any recovery to be tied to a reduction in the claim payment made to the provider, not the regaining of a portion of the claim already paid."[64] The Tribunal found that if Petitioners' specific paid pharmacy claims can be linked to specific pharmaceutical rebates, the amount of the rebate recoveries can be subtracted from paid claims relative to HICA liability. The COA found that Mr. Gates' testimony that claim by claim detail could be obtained, suggested "petitioners were capable of tracing rebates to specific claims as required by the statute. . . . "[65] At the hearing on remand, Petitioners alleged they received rebate detail from their PBMs and successfully matched individual rebates with individual paid claims. Respondent alleged that Petitioners' methods were flawed and they were unable to effectively trace rebates to paid claims.

Ms. Avery, Petitioners' lead financial analyst testified that she was tasked with matching the PBMs' rebate data, with Petitioners' claims data. In doing so, she matched four columns of data: fill date, national drug category, pharmacy ID and prescription ID.[66] When matching all four fields with corresponding PH and PHIC data, there were no duplicates, and the database never returned more than one claim.[67] By comparing these fields, Ms. Avery was able to determine the transaction ID for each claim from PH and PHIC's claims data. Each transaction ID identified an individual

[63] *Priority Health and Priority Health Insurance Company*, Docket Nos. 16-000784 and 16-000785 (September 22, 2017)
[64] *Priority Health and Priority Health Insurance Company*, Docket Nos. 16-000784 and 16-000785 (September 22, 2017)
[65] *Priority Health, supra* at 7.
[66] Tr. Vol 1 at 119.
[67] Tr. Vol 1 at 136.

pharmacy claim so Petitioners could isolate each rebate matched to an individual pharmacy claim.[68] Using this method, Ms. Avery was able to match all but 850 rebates to claims.[69] By not including 850 potential rebates, Petitioners increased their HICA liability and as a result, their rebate estimate was conservative.

Respondent contends that Ms. Avery inappropriately removed leading zeros and certain leading numbers to create more matches relative to the Express Scripts data. However, the Tribunal finds Ms. Avery convincingly testified, that these actions were taken, for example, to simply match the PBM data, which included leading zeros, to Petitioners' data for the same item, which was stored without leading zeros. Ms. Avery has twenty-one years of daily experience managing PH and PHIC data, and the Tribunal finds her testimony and data analysis persuasive. She further testified, she could find the missing 850 matches, however she would have to consider each claim individually, line by line, and Ms. Brink agreed that the amount of tax saved would be so minimal that the extra hours of research were an inefficient use of employee time.[70]

Respondent contends the rebate data from the PBMs might be inaccurate, but Ms. Brink persuasively testified that the PBM operations are regulated by public accounting firms.[71] Further, affidavits from the records custodians of Magellan and Express Scripts, confirming the accuracy of the records, were provided as exhibits.[72] Respondent contends PH and PHIC's claims data might be inaccurate, however, Ms.

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[68] Tr. Vol 1 at 214.
[69] For Express Scripts, alone, there were 654,017 prescription claims and associated pharmaceutical rebates from 1/1/12 to 12/31/12. See Petitioner's Brief at 8, PX-5, PX-6.
[70] Tr. Vol 2 at 45-46.
[71] Tr. Vol 2 at 36.
[72] See PX1 and PX5. Respondent alleges the records custodians should be present to testify. (Tr. Vol 1 at 120). The Tribunal, however, does not make its conclusions based only on the affidavits, but considers them as one component relative to the reliability of the data.

Brink persuasively testified she is confident Petitioners' records are accurate, and that the information from Petitioners' databases are validated by others in the organization on a regular basis.[73] Respondent appears to be grasping at straws, trying to find a way to invalidate Petitioners' data, when its own auditor, in his audit reports of findings wrote, the "[t]axpayer has written specific queries to access their claims database for the exclusions allowed under the HICA Act and to accrue for claims that are subject to HICA. After a review of their procedures the auditor was satisfied that the taxpayer has established proper procedures to account for the HICA fee."[74] Yet, even after including the aforementioned sentences in the audit reports, the auditor denied pharmaceutical rebates as recoveries based on Respondent's FAQ, which, as noted above, the Tribunal finds inappropriately adds an additional requirement not found in the statute.[75]

Respondent implies that Petitioners misled the COA by suggesting in their brief on appeal that they had the necessary rebate information from the PBMs when they didn't receive it until 2019. However, Ms. Brink persuasively testified that she contacted the PBMs in 2017.[76] In any event, the COA ordered the Tribunal, and not itself, to "determine whether the documents obtained by petitioners are sufficient to support their calculations of recoveries or paid claims."[77] The Tribunal finds the documents to be sufficient.

Respondent in its post-hearing brief contends that Petitioners' did not rely on "source data," when completing the rebate/claims matching, however, Ms. Avery

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[73] Tr. Vol 2 at 151.
[74] See PX-11 at 2, 11, See Tr. Vol 1 at 53.
[75] See R-11 at 4, 8.
[76] Tr. Vol 2 at 70.
[77] *Priority Health, supra* at fn 7.

testified, “Priority is not in the business for keeping that documentation. That would be up to our PBM.”[78] Further, Ms. Brink testified she did consult PH and PHIC’s 2012 tax returns including the support for completing the returns, in her analysis.[79] Respondent also contends that Petitioners’ calculation of recoveries is based on “a hodgepodge of ad hoc estimates and result-driven spreadsheet filtering,”[80] however, its own auditor “was satisfied that the taxpayer has established proper procedures to account for the HICA fee.”[81] Further, the auditor, when determining which claims were subject to HICA, testified he used sampling which included an acceptable error rate. He testified, “we’re looking at like a 90 percent competence relative like within at 10 percent error.”[82] This testimony suggests some error rate is tolerated in auditing.[83] The Tribunal finds paying additional tax based on 850 of 654,017[84] prescription claims and associated pharmaceutical rebates, to be reasonable.

Respondent did not have its auditor refute Petitioner’s methodology during his testimony, again doubling down on the exclusion of pharmacy rebates as recoveries, based on the FAQ.[85] The Tribunal finds, however, that Petitioners have sufficiently supported their calculations of pharmaceutical rebate recoveries and as a result, it finds Respondent’s assessments must be cancelled.

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[78] Tr. Vol 1 at 153.
[79] Tr. Vol 2 at 100.
[80] Respondent’s Response to Pet’s Brief at 8.
[81] See Tr. Vol 1 at 53. See PX-11 at 11.
[82] Tr. Vol 2 at 190.
[83] *Id.*
[84] 850 of 654,017 equals .13%. See Petitioner’s Brief at 8, PX-5, PX-6.
[85] Tr. Vol 2 at 188.

JUDGMENT

IT IS ORDERED that Final Assessments UJ62218 and UJ62404 are CANCELLED.

IT IS FURTHER ORDERED that Respondent shall cause its records to be corrected to reflect the taxes, interest, and penalties, as finally shown in the Final Opinion and Judgment within 20 days of entry of this Final Opinion and Judgment.

This Final Opinion and Judgment resolves the last pending claim and closes this case.

APPEAL RIGHTS

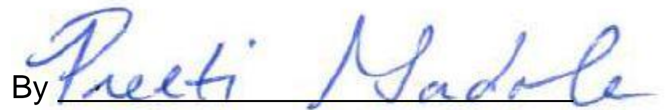
If you disagree with the final decision in this case, you may file a motion for reconsideration with the Tribunal or a claim of appeal with the Michigan Court of Appeals.

A Motion for reconsideration must be filed with the required filing fee within 21 days from the date of entry of the final decision.[86] Because the final decision closes the case, the motion cannot be filed through the Tribunal's web-based e-filing system; it must be filed by mail or personal service. The fee for the filing of such motions is $50.00 in the Entire Tribunal and $25.00 in the Small Claims Division, unless the Small Claims decision relates to the valuation of property and the property had a principal residence exemption of at least 50% at the time the petition was filed or the decision relates to the grant or denial of a poverty exemption and, if so, there is no filing fee.[87] A copy of the motion must be served on the opposing party by mail or personal service or by email if the opposing party agrees to electronic service, and proof demonstrating that

[86] See TTR 261 and 257.
[87] See TTR 217 and 267.

service must be submitted with the motion.[88] Responses to motions for reconsideration are prohibited and there are no oral arguments unless otherwise ordered by the Tribunal.[89]

A claim of appeal must be filed with the appropriate filing fee. If the claim is filed within 21 days of the entry of the final decision, it is an "appeal by right." If the claim is filed more than 21 days after the entry of the final decision, it is an "appeal by leave."[90] A copy of the claim must be filed with the Tribunal with the filing fee required for certification of the record on appeal.[91] The fee for certification is $100.00 in both the Entire Tribunal and the Small Claims Division, unless no Small Claims fee is required.[92]

By 

Entered: January 8, 2021

[88] See TTR 261 and 225.
[89] See TTR 261 and 257.
[90] See MCL 205.753 and MCR 7.204.
[91] See TTR 213.
[92] See TTR 217 and 267.