Legislative Analysis

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MEDICAID EXPANSION & FEDERAL WAIVERS

House Bill 4714 (Substitute H-3, as amended)
Sponsor: Rep. Matt Lori
Committee: Michigan Competitiveness

Complete to 6-17-13

A SUMMARY OF HOUSE BILL 4714 AS PASSED BY THE HOUSE

The bill proposes to incorporate the Medicaid expansion included under the federal Affordable Care Act, effective on January 1, 2014, into Michigan's Medicaid Program. The bill would amend the Social Welfare Act to allow adults less than 65 years of age with an annual income level up to 133% of federal poverty guidelines to enroll in the medical assistance program (Medicaid) unless:

(1) The state Department of Community Health (DCH) is unable to obtain a waiver from the US Department of Health and Human Services meeting certain criteria established in the bill; and

(2) The federal government matching funds for the program are reduced below 100% and annual state savings and other savings associated with the implementation of the program are not sufficient to cover the reduced federal match. (The DCH would have to determine how state and other savings will be calculated by June 1, 2014.)

The bill is understood to require several waivers to be sought. The first would be the Medicaid expansion request described on Page 2 under which an expanded program could begin as early as January 1, 2014. Another waiver, for which approval would be required by December 31, 2015, would have to allow the newly eligible individuals who had received medical assistance coverage for 48 months under the expanded program and who were between 100% and 133% of the federal poverty guidelines to choose to do one of the following: (1) purchase private insurance coverage through an exchange operated in the state and be considered eligible for federal subsidies by the federal government; or (2) remain in the Medicaid program but with increased cost-sharing requirements. The maximum cost-sharing would increase from 5% to 7% of income for all out-of-pocket costs. (However, such cost-sharing could be reduced in certain circumstances, as described later. Copays could not be reduced to less than 3% of income.)

The bill specifies that in order to continue with the reform and expansion program, the DCH must receive full waiver approval before December 30, 2015. If the DCH has not received full waiver approval by December 31, 2013, the department must request written documentation from the US Department of Health and Human Services by December 31, 2013, that if the waivers were rejected causing the Medicaid program to revert back to eligibility requirements in effect on the effective date of the bill, there would be no financial federal funding penalty.

[The bill specifies that the provisions of the waivers -- and the choices above -- would not apply to individuals cited under 42CFR 440.315 of federal law. That section describes certain exempt individuals (e.g., pregnant women, the blind or disabled, individuals entitled to benefits under Medicare, the terminally ill in hospice care, parent or caretaker relatives, and the medically frail, among others). See: http://www.law.cornell.edu/cfr/text/42/440.315]

If Waivers not Approved

If a waiver was not approved by December 31, 2015, then by January 31, 2016, the DCH would have to notify enrollees that the expanded program would be terminated on April 30, 2016.

The Expansion Waiver

The DCH would be required to seek a waiver to:

- Enroll adults who meet federal citizenship requirements into a contracted health plan that provides for an account into which money can be deposited to pay for incurred health expenses. The money could come from any source, including the enrollee, the enrollee's employer, and private and public entities on the enrollee's behalf. Contributions would be returned if the enrolled individual became ineligible in the form of a voucher to purchase private insurance.

- Give such enrollees a choice in choosing a contracted health plan. (A "contracted health plan" is defined in the bill as a managed care organization that the state contracts with to provide or arrange for the delivery of comprehensive health care services.)

- Ensure all enrollees have access to a primary health care physician and to preventive services.

- Require enrollees with annual incomes between 100% and 133% of the federal poverty guidelines to contribute not more than 5% of income for cost-sharing requirements. (Such contributions would not apply for the first six months of enrollment.) If approved, the DCH would have to require contracted health plans to have procedures and compliance metrics for contribution payments to ensure the requirements were being met.

- Allow the out-of-pocket contributions required above to be reduced to zero if healthy behaviors are met. Copays could not be reduced to less than 2% of income. Contributions could be reduced by the contracted health plan based on the enrollee's attaining specific goals to improve or maintain healthy behaviors that include completing a DCH-approved health risk assessment to identify unhealthy characteristics, including alcohol and tobacco use, obesity, and immunization status.

- During the enrollment process, inform newly eligible enrollees about advance directives and require the enrollees to either complete an advance directive or to decline.

- Develop incentives for eligible enrollees who assist the DCH in detecting fraud and abuse in the Medicaid program.

- Allow for services provided through telemedicine.

Copy of Approved Waiver to Legislature

Not more than seven calendar days after receiving a waiver from the US Department of Health and Human Services, the DCH would have to submit a written copy of the approved waiver provisions to the Senate Majority Leader, the Speaker of the House of Representatives, and the Senate and House standing committees on matters of health for review.

Enrollment in Contracted Health Plans

The DCH would have to develop and implement a plan to enroll all fee-for-service enrollees into contracted health plans if allowable by law and if the Medicaid program is the primary payer. This includes all newly eligible enrollees. Under the bill, the DCH is directed to include contracted health plans as the mandatory delivery system in its waiver request. The department would also have to pursue any and all necessary waivers to enroll persons eligible for both Medicaid and Medicare into managed care beginning July 1, 2014. By September 2015, the DCH would have to identify all remaining populations eligible for managed care and develop plans for their integration into managed care.

Pharmaceutical Benefit

The department would have to implement a pharmaceutical benefit that utilizes copays at appropriate levels allowable by the Centers for Medicare and Medicaid Services to encourage the use of high-value, low-cost prescriptions, such as generic prescriptions and 90-day prescription supplies, as recommended by the enrollee's physician.

Uncollected CoPays and Deductibles

The DCH would have to work with providers, contracted health plans, and other departments to create a process to reduce the amount of uncollected copays and deductibles for the new program and to reduce the administrative cost of collecting those copays and deductibles.

Health Status of Enrollees & Assisting Individuals into Workforce

The new program described in the bill (1) would have to include information about the impact on the health status of the covered population of new enrollees, including a targeted assessment related to employability and (2) would have to promote employment-related services and job training available to lower the Medicaid caseloads by assisting able-bodied adult Medicaid recipients who are unemployed into the workforce. (Able-bodied adults would refer to adults aged 21 to under 65 who are not included in the provisions of 42 CFR 440.315.)

Uncompensated Care

The bill specifies that the new program is being created to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift of uncompensated care. To that end, the DCH must examine the financial reports of hospitals and evaluate the impact that

providing medical coverage to the expanded population of enrollees has had on uncompensated care.

By December 31, 2014, the DCH would have to make an initial baseline report to the Legislature about uncompensated care, and each December 31 following would have to make a report on evidence of the reduction in uncompensated care borne by hospitals compared to the 2014 baseline report. Based on the evidence of such a reduction, beginning April 1, 2015, the department would proportionately reduce the disproportionate share payments to hospitals for the purpose of producing state General Fund savings. The department would have to recognize savings from this reduction by September 30, 2016.

Impact on Insurance Rates

The Department of Insurance and Financial Services (DIFS) would be required to examine the financial reports of insurance companies and evaluate the impact that providing medical coverage to the expanded population had on rates, and would have to take the evaluation into account in the annual approval of rates. By December 31, 2014, DIFS would have to make a baseline report to the Legislature on rates, and each December 31 following would have to make a report on evidence of the reduction in rates compared to the baseline report.

Improving Medicaid's Effectiveness and Performance

The DCH would have to explore and develop a range of innovations and initiatives to improve the effectiveness and performance of the Medicaid program and to lower overall health care costs in the state. The department would have to report the results of these efforts to the chairs of the House and Senate Appropriations subcommittees on DCH matters and to the House and Senate Fiscal Agencies by September 30, 2015.

The department would have to pursue a broad range of innovations and initiatives as time and resources will allow, including:

- The value and cost-effectiveness of optional Medicaid benefits as described in federal statute.
- The identification of private sector (primarily small business) benefit differences compared to the Medicaid program optional services and justifications for the differences.
- The minimum measures and data sets required to effectively measure the Medicaid program's return on investment for taxpayers.
- A review and evaluation of the effectiveness of current incentives for contracted health plans, providers, and beneficiaries, with recommendations for expanding and refining incentives to accelerate improvement in health outcomes, healthy behaviors, and cost-effectiveness.
- A review and evaluation of the current design principles that serve as the foundation for the state's Medicaid program.

Reports

The various reports required in the bill would have to be made available to the Legislature and be available and easily accessible on the DCH and Legislative websites.

Financial Incentives

By January 1, 2014, the DCH and the contracted health plans would have to create financial incentives for all of the following: (1) contracted health plans that meet specified population improvement goals; (2) providers who meet specified quality and cost targets; and (3) enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in an initial risk assessment by their primary care practitioner.

Administrative Costs

The DCH would have to maintain administrative costs at a level of not more than 1% of the department's portion of the Medicaid program. The administrative costs would be capped at the total administrative costs for the fiscal year ending September 30, 2016, except for inflation and project-related costs required to achieve medical assistance savings.

Substance Abuse

The DCH would be required to measure contracted health plan performance on application of standards of care related to the appropriate treatment of substance abuse.

Hospital Charges

Any hospital that participated in Medicaid could not charge uninsured individuals with an annual income under 133% of the federal poverty guidelines more than 115% of rates paid by Medicare.

Determining Income Level

The DCH would have to apply a modified adjusted gross income methodology in determining if an individual's annual income level was below 133% of federal poverty guidelines.

Medicaid Eligibility Process

The DCH would have to provide a process by which individuals could apply for or renew Medicaid eligibility through in-person assistance, by telephone, a website from which the department would enroll individuals in the appropriate health care program without regard to the specific program for which the individual applied.

Vendors: Cost Saving & Health Improvement

The DCH would have to make available at least three years of state Medicaid program data, without charge, to any vendor considered qualified by the department who indicated an interest in submitting proposals to contracted health plans in order to implement cost savings and population health improvement opportunities through the use of innovative information and data management technologies. Any program or proposal would have to be consistent with the state's goals of improving health; increasing the quality, reliability, availability, and continuity of care; and reducing the cost of care of the newly eligible population of enrollees. The use of the data for the purpose of assessing the potential opportunity and subsequent development and submission of formal proposals to contracted health plans would not be considered a cost or contractual obligation to the DCH or the state.

FISCAL IMPACT:

Background Information

The FY 2013-14 Executive Budget proposed to incorporate the Medicaid expansion included under the federal Affordable Care Act into Michigan's Medicaid Program and state budget, thereby expanding program eligibility to 133% of the federal poverty level, which could be as many as 400,000 enrollees initially. Concurring with the proposed budget action would result in an estimated $1.5 billion in federal funds being received by the state in FY 2013-14 and an estimated $206.0 million in GF/GP savings due to 100% federal payment of certain costs currently being financed with state funds. Those amounts are 3/4-year amounts and would increase in FY 2014-15.

The initial state budget approved by the Legislature for FY 2013-14 does not incorporate the proposed expansion. Funding adjustments could, however, be enacted through a supplemental appropriations bill.

Additional information on the projected fiscal impact of the Executive's proposed Medicaid expansion is available in this HFA memorandum:

http://www.house.mi.gov/hfa/PDFs/Medicaid%20Expansion%20Memo%20Mar4.pdf

Summary

HB 4714 would apply certain conditions to the Medicaid expansion proposed under the Executive Budget and includes other Medicaid program modifications. Several changes to the Medicaid program delineated in the bill are premised on the approval of two federal waivers, which contain several requirements that may or may not be agreed to by the federal Centers for Medicaid and Medicare.

The bill requires that the waiver conditions be that if federal financing falls below 100%, annual state savings and other savings associated with the expansion must completely provide for the State match. The Affordable Care Act stipulates that 100% federal funding will no longer be available beginning January 1, 2017. (Beginning in 2017, federal financing would drop to 95% and then drop to 90% beginning in 2021.) State savings will continue, however, due to federal match being applied toward certain mental health-related and other costs currently funded solely by the state. Current projects indicate the savings will exceed the match costs through FY 2019-20. However, the precise year in which the match costs will begin to exceed the state savings is subject to a number of uncertainties.

The proposed Medicaid expansion and conditions proposed under this bill are generally expected to have a positive fiscal impact on state-level health care costs, subject to a number of uncertainties and complexities described below.

The 1st Waiver

The first waiver indicated in HB 4714 requires the DCH to submit to the federal government a Medicaid expansion request which would cover the same population as outlined in the Governor's plan which could begin as soon as January 1, 2014. The bill requires that the following conditions be included in the waiver request.

- Enroll this population into contracted health plans, of their choice, which provide for health savings account (HSA)-like accounts
- Ensure that enrollees have access to a primary care physician and to preventive services
- Require enrollees with incomes between 100-133% of the FPL to contribute not more than 5% of their adjusted gross income for medical care expenses (does not apply to the first 6 months of enrollment). Contributions may be reduced if enrollees meet certain health goals.
- Enrollees must be given the opportunity to complete an advanced directive
- Incentivize enrollees to assist the DCH in detecting Medicaid fraud and abuse
- Allow for services provided through telemedicine.

One of the largest impacts of this initial waiver would be the 100% federal funding for health care services of an additional 400,000 Medicaid enrollees. Assuming that the Medicaid qualifying FPL is increased to 133% on January 1, 2014, the State is estimated to receive $1.5 billion of federal dollars in FY 2013-14 and $2.0 billion in FY 2014-15, assuming 100% funding by the federal government. These additional revenues in the health care economy will likely spill over into Michigan's other economic sectors, but the overall economic impact cannot be quantified.

Related to the potential influx of $1.5 to $2.0 billion is the effect on the amount collected by the Department of Treasury of Health Insurance Claims Assessment revenue. The Governor's Executive Budget Recommendation included an estimated increase of $10.7 million in FY 2013-14 and $11.9 million in FY 2014-15 resulting from additional taxable claims which are expansion based.

Existing state GF/GP support for physical and mental health programs have been identified that would be reduced due to this legislation:

- Non-Medicaid Mental Health
- Out-prison healthcare for incarcerated individuals (Corrections budget)
- The Adult Benefits Waiver
- PlanFirst! Family Planning Waiver
- Transitional Medical Assistance-Plus
- Various Public Health programs

The non-Medicaid Mental Health program would experience the largest amount of savings. Approximately $153.0 million GF/GP would no longer be necessary to support the program as more individuals would qualify for Medicaid under the expanded FPL and would be 100% federally covered beginning in 2014. Including savings from the other programs listed, total estimated indirect GF/GP savings would be $205.2 million GF/GP in FY 2013-14.

An additional impact of the expanded Medicaid population would be the amount of uncompensated health care borne by providers. It is assumed that the additional federal health care funding will lower provider's uncompensated care, with some portion of these costs/losses typically being shifted to private health insurance purchasers. The

Department of Community Health has indicated that an insured family, or employer, could realize a $400 reduction in annual health care insurance cost through the reduction of uncompensated care costs brought about by extending insurance coverage to this new population.

The State of Michigan provides health insurance coverage to approximately 47,500 active state employees through state sponsored health insurance. If the State could save $400 in annual health insurance costs per employee, then the amount would be approximately $19.0 million annually. No estimate is provided on savings to local units of government.

Related to potential uncompensated care savings is a possible reduction in the State's support of the disproportionate share hospital (DSH) pool. Of the $428.0 million FY 2012-13 DSH pool, $9.0 million GF/GP is used as partial match for $45.0 million sub-pool. These payments are made to hospitals that serve a high percentage of low-income patients that are either uninsured or are covered by Medicaid, State Medical Programs or Children's Special Health care Services.

It may be decided at some point that the $45.0 million DSH pool be reduced given lower uncompensated care costs resulting from the expansion. The ACA includes a planned reduction in the gross pool size and anticipated the federal savings to help fund the ACA. When and if the State changes the level of the $45.0 million pool is indeterminate.

The proposed bill also requires that enrollees with annual incomes between 100% and 133% of the FPL make contributions of up to 5% for their cost sharing requirements. Assuming that the average annual income is $13,000, a 5% contribution is $650. Multiplied by 150,000, the estimated number of affected individuals, the amount is $97.5 million annually. As long as the federal government is financing the program entirely, savings would not accrue to the State. The 5% may be a combination of copays and premiums or other cost sharing concepts. It is generally understood that copays may be cost savings to the State or federal government by lowering provider rates, but that a large share of those savings end up being a cost shift to providers that cannot collect all of the copay amounts. Required contributions to an account used to pay for health expenses can be reduced to 0% if healthy behaviors are met. Copays cannot be reduced to less than 2% of income.

Improving the health of an additional 400,000 Michigan residents would be expected to result in short and long-term savings in health care costs by investing in preventive care and minimizing expensive emergency room care. A healthier working population has positive business economic impacts such as greater worker productivity, lower absenteeism both resulting in a better business climate. The magnitude of those impacts, however, cannot be quantified.

<u>The 2nd Waiver</u>

A second waiver, to be approved by December 31, 2015, would require that after 48 months of cumulative Medicaid eligibility the expansion population with annual incomes between 100% to 133% of the FPL would have to make the choice either to purchase private insurance coverage through the health care exchange and be considered eligible for federal subsidies, or, remain in the Medicaid program but pay up to 7% of their

annual income in cost sharing. The contributions to an account used to pay for incurred health expenses can be reduced to 0%. Copays cannot be reduced to less than 3% of income.

The population expected to be within the 100% to 133% FPL threshold is estimated to be 150,000. It is difficult to anticipate the federal subsidies available and the cost of insurance of the yet-to-be-developed exchange. Assuming that the average annual income is $13,000 for this population, a 7% contribution is $910. Multiplied by 150,000, the estimated number of affected individuals, the amount is $136.5 million annually, assuming all affected individuals are able to and choose to pay the contribution in order to have health insurance coverage. If this waiver is not approved by December 15, 2015, then the expansion population is no longer covered and the DCH shall notify enrollees by January 1, 2016, that the program shall be terminated on April 30, 2016.

Other Program Modifications

The bill requires that, contingent upon the approved expansion waiver and identified annual state savings exceeding state match costs, then the DCH will provide for a process that individuals may apply for or renew Medicaid and MIChild eligibility in-person, by telephone or through a website. The Department of Human Services would continue to determine Medicaid eligibility. The savings from this modification is indeterminate.

The bill requires that any hospital that participates in the Medicaid program shall not discount charges to uninsured individuals with annual incomes under 133% of the FPL no more than 115% of rates paid to Medicare. This action may give financial relief to poor individuals but may be a disincentive for some hospitals to provide services by Medicaid enrollees.

By September 30, 2016, the DCH is required to have developed and implemented a plan to enroll all fee-for-service enrollees into contracted health plans if allowable by law and if the medical assistance program is the primary payer. Currently, the majority of Medicaid enrollees not included in a managed care plan are those receiving long-term care services and the "spend-down" population. The DCH is currently working with the federal government to manage the care of the dual eligible population, those individuals who are have health care coverage but both Medicaid and Medicare. Whether this population would be assumed in the contracted health plan expansion is not clear. It is generally assumed that savings would be derived by enrolling more Medicaid eligibles into a managed care system.

The bill requires the DCH to work with providers, contracted health plans, and other departments to create a process to reduce the amount of uncollected copays and deductibles. There may be a financial cost to the State if the DCH assumes the responsibility of copay and premium collections.

The DCH is required to provide information regarding the health status of the expansion population, including a targeted assessment related to employability. The Department shall promote employment related services and job training. The fiscal impact of this requirement is indeterminate.

The DCH and the Department of Insurance and Financial Services (DIFS) are to prepare reports related to the effects of the Medicaid expansion on uncompensated care costs and health insurance rates, respectively. There will be administrative expenses related to the preparation of these reports.

The bill also requires the DCH to provide a report that will assess the value and cost effectiveness of the current Medicaid program, incentives for Medicaid HMOs and beneficiaries, measures used to calculate return on investment and a comparison of the differences between primarily small business and Medicaid health care benefits. There will be some cost to the Department to construct this report, but may result in savings depending on the outcome of the analysis.

By January 1, 2014, the DCH, contracted health plans and providers shall create financial incentives for contracted health plans that meet specified population improvement goals, for providers who meet specified quality and cost targets, and for enrollees who demonstrate improved health outcomes and maintain healthy behaviors. Although there would be costs to the State for these incentives, the aforementioned improvements should come with heath care expenditure savings to the State.

The bill requires the DCH to ensure that all capitated payments made to contracted health plans are actuarially sound. The federal government requires actuarial soundness of Medicaid contracted health plans and there is a cost to the State for this assurance.

The DCH is required to maintain administrative costs at a level of not more than 1% of the DCH's state medical assistance program. The total administrative costs are capped at the level of year-end FY 2015-2016 expenditures. Exceptions are made for increases that generate Medicaid savings or for inflation. This cap of administrative expenses may hold down State costs but implementation and interpretation of the intent may be difficult.

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