# Legislative Analysis

Mary Ann Cleary, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

**MEDICAID EXPANSION & FEDERAL WAIVER**

**House Bill 4714**
**Sponsor: Rep. Matt Lori**
**Committee: Michigan Competitiveness**

**Complete to 5-14-13**

**A SUMMARY OF HOUSE BILL 4714 AS INTRODUCED 5-9-13**

The bill would amend the Social Welfare Act to allow nondisabled adults with an annual income level up to 133% of federal poverty guidelines to enroll in the medical assistance program (Medicaid) for a maximum of 48 months if:

(1) The state Department of Community Health (DCH) is able 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 provides funding at a level of 100% for implementation and administration for the enrollees covered by the bill.

The Waiver
The DCH would be required to seek a waiver to:

- Enroll nondisabled adults (aged 21 through 64) into a contracted health plan that provides for an account into which money can be deposited to pay for incurred health expenses. However, they could decline enrollment into Medicaid and select private health insurance on or off the American health benefit exchange established or operating in the state.

- Give them a choice in choosing a contracted health plan.

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

- Develop incentives for healthy behavior and for progress made toward healthy behavior.

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

- Allow for services provided through telemedicine.

- Impose a 48-month limit on Medicaid services for nondisabled adults. The 48-month count would begin after the bill took effect and would not include months before that date. Those who received Medicaid for 48 months and were no longer eligible could select private health insurance on or off the American health benefit exchange established or operating in the state.

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 Legislature for review.

Contributions to Health Accounts

Nondisabled adults enrolled in Medicaid would have to make contributions of up to 5% of their annual income into their accounts based on the DCH's determination of their ability to pay. Contributions could include, but are not limited to, deductibles, copayments, premiums, or other applicable charges, as determined by DCH.

Hospital Charges

Any hospital that participated in Medicaid could not charge uninsured individuals with an annual income under 100% of the federal poverty guidelines more than 115% of rates charged to Medicare.

Each March 1, beginning in 2015, the DCH would have to provide a report to the Legislature that included information on the impact on the health status of the covered population, including a targeted assessment related to employability, the cost effectiveness of Medicaid, and an evaluation of the financial impact on the state's health care and health insurance systems.

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 Website

The DCH would have to provide a process by which individuals could apply for or renew Medicaid eligibility through 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.

**FISCAL IMPACT:**

Background Information

The FY 2013-14 Executive Budget proposes 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 450,000 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.

Additional information on the projected fiscal impact of the 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. The changes to the Medicaid program delineated in the bill are premised on the approval of a federal waiver, which contains several requirements that may or may not be agreed to by the federal Centers for Medicaid and Medicare, and requires that the waiver conditions be completely financed by the federal government. The Affordable Care Act stipulates that 100% federal funding will no longer be available beginning January 1, 2017, so the law will cease to be relevant beyond three years without further Legislative action. (Beginning in 2017, federal financing would drop to 95% and then drop to 90% beginning in 2021.)

If the waiver were approved, by requiring the federal government to not only finance the expanded Medicaid population but also a population where the cost is currently shared by the State and the federal government, there is an estimated GF/GP savings of $360.0 million each year over three years (above and beyond savings from the Medicaid expansion assumed in the Executive Budget). However, there is no existing precedent for federal approval of a number of the waiver requirements contained in the bill, and some requirements appear to be inconsistent with current federal law and CMS policy.

It should be noted that federal law regarding HHS waivers require that the waiver request be "cost neutral" to the federal agency. This means that the federal government would pay no more under the waiver conditions than what it currently pays.

The Waiver

If the waiver is approved, there are cost/savings implications to the State regarding the expanded population, cost shifting those eligible under the current program, administration expenses, incentivizing healthy behavior, Medicaid fraud and abuse detection, and program term limits.

Under an approved waiver all non-disabled qualifying individuals under 133% of the federal poverty level would be eligible for Medicaid, which would include those currently covered under "basic" Medicaid. This would include parents and caretaker relatives of children receiving Medicaid and childless adults—categories of eligibility at or below 50% of the federal poverty level. These currently covered populations are financed at the regular FMAP FY 2013 rate of 33.61% State and 66.39% federal. By making a waiver requirement that their costs be entirely paid by the federal government could save the State $360.0 million GF/GP each calendar year for 2014, 2015 and 2016.

The balance of the individuals covered by this waiver and similarly covered in the Executive's Medicaid expansion plan would be covered completely by federal funds and would have no GF/GP fiscal impact to the State within the three year period of this legislation beyond the GF/GP savings already assumed under the Executive expansion plan.

The waiver must require that qualifying nondisabled adults must have the option to decline Medicaid enrollment and be able to select private health insurance on or off the State's health care exchange. It is not clear whether it is assumed that Medicaid funding

would follow individuals that opt-out; therefore, the fiscal impact of this requirement is indeterminate.

The waiver is also to include the development of incentives to promote healthy behaviors for enrollees and incentives for enrollees to assist the Department of Community Health in detecting Medicaid fraud and abuse. No specifics are given on the method of incenting but it is possible that both short and long-term programmatic cost savings would be gained by healthier behaviors. These savings and the costs of incentives are indeterminate. It is also difficult to project what savings may be attributed to future Medicaid fraud and abuse discovery by enrollees.

The approved waiver must also require that nondisabled adults not receive Medicaid benefits for more than 48 months. Since the waiver is based on the requirement of 100% federal financing for the program, which will end on December 31st, 2016, the 48-month benefit time cap would not apply unless the federal financing percentage support were changed or the Legislature took future action to extend the provisions of the bill with amended provisions regarding federal funding levels. Further, it is unclear if such a time cap is consistent with federal law and policies.

Other Conditions

The proposed bill also requires that nondisabled adults enrolled in Medicaid make contributions of up to 5% of their annual income in the form of copays, premiums, or an account for health care expenses. The Department of Community Health is allowed some discretion in implementing enrollee cost sharing based on the enrollee's ability to pay. Assuming that the average annual income is $10,000, a 5% contribution is $500. Multiplied by the estimated number of 800,000 newly- and currently-eligible individuals, the amount of savings is $400.0 million annually. Since the federal government would be financing the program entirely, these savings would not accrue to the State. 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 the copay amounts. There is some question as to whether a copay requirement of pregnant women would be approved through a waiver request.

The bill also requires that costs for implementation and administration of the waiver be 100% federally financed, which is not consistent with current federal provisions for the Medicaid program. Typical cost sharing for these activities is 50/50. The Governor's expansion proposal estimated IT and administration costs of $20.0 million Gross per year, therefore a $10.0 million State cost. The $10.0 million State cost would be avoided if the federal government agreed to fully fund administration and IT costs related to the waiver population.

Legislative Analyst: Chris Couch
Fiscal Analyst: Steve Stauff