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BILL ANALYSIS

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Senate Bill 422 (Substitute S-1 as reported)
Sponsor: Senator Bruce Caswell
Committee: Government Operations

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CONTENT

The bill would enact the "Michigan Low-Income Health Plan Act" in order to provide for health care coverage, with limits, to individuals under 100% of the Federal Poverty Level (FPL).

(The plan would be in lieu of expanding the State's Medicaid program to those under 133% of the FPL. Those between 100% and 133% of the FPL would be eligible for tax credits and thus could purchase insurance on the health exchange established under the Affordable Care Act (ACA), so that population would not be covered by the Michigan Low-Income Health Plan. Those under 100% of the FPL could purchase insurance on the exchange, but would not be eligible for tax credits to support the cost of insurance, so likely would not be able to afford the insurance products available on the exchanges.)

Specifically, the bill would create the Michigan Low-Income Health Plan and provide coverage to Michigan residents who are citizens or legally present and also have lived in Michigan at least six months and who met all of the following criteria: 1) not eligible for Medicaid, Medicare, or MIChild; 2) household income under 100% of the FPL as defined using the Federal modified adjusted gross income standard; 3) under the age of 65; 4) not eligible for veterans' health benefits; and 5) no other health insurance coverage.

The bill would create the "Michigan Low-Income Plan Trust Fund" to help support the program, with the Department of Community Health (DCH) Director serving as the administrator. Money in the Fund could be spent to administer the aid and to provide additional benefits, including increasing the limit on inpatient hospitalization coverage.

The Michigan Low-Income Health Plan would have to be implemented by January 1, 2014. The DCH Director would be required to implement the Plan so eligible individuals would enroll through the State's health exchange established under the ACA. Individuals would be enrolled with a Medicaid contracted health plan, which would be required to comply with performance objectives established under the bill.

The enrollment process would identify whether an applicant was eligible for any other public or private health coverage and require that the applicant be directed to enroll in any other plan for which he or she was eligible rather than the Michigan Low-Income Health Plan.

Enrollees would have to pay a premium. For those with incomes between 0% and 25% of the FPL, the premium would be $5 per month per household. The premium would increase to $10 per month per household for those between 26% and 50% of the FPL, $15 per month for those between 51% and 79% of the FPL, and $20 per month for those between 80% and 100% of the FPL.

Federally Qualified Health Centers, which provide coverage to low-income individuals and uninsured, would have to accept Michigan Low-Income Health Plan payments, set at the fiscal year 2011-12 Medicaid payment level, as payment in full for primary care services.

The legislation would establish the Michigan Low-Income Health Plan as payer of last resort and would implement cost-sharing requirements identical to those for Medicaid.

With exceptions, the services covered would be the essential health benefits package as outlined in the ACA. This would be a general health coverage package including ambulatory care, hospital coverage, pharmaceutical, mental health and substance abuse, and other typical health care coverage. Primary care and preventive services would have to be covered as thoroughly as in the State's Medicaid program. Pharmaceuticals would be covered, with generics being used when available except as recommended by the provider and in the case of psychotropic and psychotic medications. Coverage would be provided for "certain specified outpatient hospital procedures" (without specifics on any potential limitations). Inpatient hospital coverage would be subject to $35,000 annual limit.

Enrollees would be required to comply with financial participation requirements (such as payment of premiums) and would be disenrolled for three months if they were in violation of those requirements.

The bill also would require annual reports to the Legislature beginning on April 1, 2015.

The bill includes a sunset date of January 1, 2017.

FISCAL IMPACT

Assumptions

The fiscal impact of Senate Bill 422 is difficult to estimate. There are numerous assumptions that must be made and these assumptions can cause the fiscal impact estimate to vary significantly.

Caseload Assumptions

This analysis, based on information from the DCH and the State Budget Office (SBO), assumes a maximum caseload in FY 2013-14 of 250,000 and a maximum caseload in FY 2014-15 of 300,000. These are rough estimates of the number of potential Medicaid expansion clients who are under 100% of the FPL. The former number, 250,000 in FY 2013-14, reflects a slow enrollment process for the program outlined in Senate Bill 422, a slow enrollment estimate that is also reflected in the Snyder Administration's projections on Medicaid expansion.

There is another factor in the caseload estimate – the take-up rate. Some eligible individuals would choose not to enroll. This could be due to lack of interest, an aversion to enrollment, lack of knowledge of the program, or the premium cost. For the purposes of this analysis, the take-up rate is assumed to be 75% of eligible individuals.

Cost and Savings Assumptions

The program would provide coverage for both physical health and behavioral health services. At present, behavioral health services are provided through the Community Mental Health (CMH) non-Medicaid services line item (as well as substance abuse services from the Community Substance Abuse line item) in the DCH budget.

For the purposes of this analysis, it is easier to estimate the physical health per member per month cost, with the understanding that mental health and substance abuse costs will be effectively paid for from the CMH non-Medicaid and Community Substance Abuse line items. In other words, every dollar of mental health services paid for under the Michigan Low-Income Health Plan would result in roughly a dollar of savings in the CMH non-Medicaid line item, so the costs effectively would net out. On the physical health side, there would be a cost increase as

the benefits would be more generous than those provided under the Medicaid Adult Benefits Waiver (ABW) and various other limited coverage programs offered by the State and counties.

The physical health costs actually reflect the basic benefit under the ABW plus the cost of a limited inpatient hospital benefit. This analysis assumes $150 per member per month for the physical health ABW benefits, based on the physical health side of the ABW reflected in appropriations and caseload, adjusted upward for inflation. (ABW costs are $142 per member per month in FY 2012-13, so a $150 per member per month amount appears reasonable.)

A limited inpatient hospital benefit is difficult to price. A study of Genesee County's health plan indicates that, in 2007, unpaid costs for hospital services to indigent care recipients averaged about $60 per member per month. As the Genesee programs do cover some outpatient services, and inability to pay would limit the ability of recipients to use the full range of inpatient services, $60 per member per month seems to be a reasonable number for a capped inpatient benefit.

The total cost, on the physical health side, is $210 per member per month and that number is used in this analysis.

Adult Benefits Waiver Coverage

The Federal waiver for the ABW program lasts through September 30, 2014. This is a capped enrollment program, not an entitlement, and the State attempts to manage opening and closing of enrollment to maintain an average caseload of around 62,000. There is little likelihood that the waiver will be extended – the Federal government would note that states have the option to cover these individuals through Medicaid expansion. However, in the first year of the program described under Senate Bill 422, the ABW program could remain in place. Thus, the expenditures for the ABW physical health program, a total of about $84.0 million over the final nine months of FY 2013-14, would serve as an offset to the FY 2013-14 cost estimate.

Furthermore, with the ABW program expiring on September 30, 2014, the full-year GF/GP costs of the ABW, $37.0 million, would serve as an offset to FY 2014-15 costs.

Premium Revenue

This analysis assumes average premium revenue of $15 per member per month, multiplied by the number of cases.

Veterans' Services

The legislation specifically states that those eligible for veterans' services would not be eligible for the program, under the assumption that they would be served by Federal veterans' health care programs. Data from the DCH indicate that about 3% of the ABW population are veterans, so the caseload assumption is reduced by about 10,000 cases.

Conversion of Cases to Supplemental Security Income (SSI) and Social Security Disability Income (SSDI)

Potentially, a number of individuals in the eligible population could be determined by the Federal government to be disabled and thus eligible for SSI or SSDI. Individuals eligible for SSI and SSDI are eligible for "regular" Medicaid, and SSDI individuals become eligible for Medicare after two years. Thus, to the extent that people are eligible for SSI or SSDI, the caseload would be reduced.

There would be other effects from such a shift, though. While the population eligible for the Michigan Low-Income Health Plan would be reduced, resulting in a lesser cost for that program, there would be an increase in the number of people in the regular Medicaid program, with the State covering 34% of the costs.

Another effect would be on the Community Mental Health non-Medicaid line item. There is a strong likelihood that many if not most of those deemed disabled would be disabled due to

behavioral health issues. The treatment costs these individuals incur would make up a significant portion of the CMH non-Medicaid line item, so there could be considerable savings in the CMH non-Medicaid line item, savings that would be 100% GF/GP.

For the purposes of this analysis, it is assumed that 40,000 individuals, through an aggressive effort, would be converted to SSI or SSDI, with an average starting date of July 1, 2014. This would result in a lowering of the covered caseload. It also would result in an increased cost in Medicaid, with an assumed capitation rate for physical health and mental health services of $9,000 per person per year. Finally, this analysis assumes $120.0 million full-year GF/GP savings in the CMH non-Medicaid line item.

It is certainly possible if not likely that the number of cases converted to SSI or SSDI would be much lower or that the average conversion of cases would be delayed well past July 1, 2014. In either case, program costs would increase.

Results

Table 1 at the end of this analysis shows the results of the fiscal analysis. The projection for FY 2014-15 is more straightforward so it will be described first. The 2013-14 fiscal year covers only three quarters of the year and includes a continuation of the ABW program, and the conversion of 40,000 cases to SSI/SSDI is assumed to take place during the year, so the offsets are not as straightforward to present.

As noted earlier, the assumed cost for physical health coverage, per member per month, is $210, composed of $150 for the basic ABW benefit and $60 for the limited inpatient coverage.

The base caseload for FY 2014-15 would be 300,000. It is a straightforward calculation, 300,000 times $210 per month for total cost before offsets of $756.0 million.

The ABW program would no longer be in existence in FY 2014-15 and various other small costs cited in the SBO's Medicaid expansion analysis also would be offset, for savings of $37.0 million GF/GP.

The next items tie to the conversion of 40,000 cases to SSI and SSDI. There would be three changes related to this. First, there would be the reduction of costs for the Michigan Low-Income Health Plan. Due to greater health needs for a disabled population, it is assumed that these individuals would cost $300 per member per month if they were served in the Michigan Low-Income Health Plan. Thus, the savings would be $300 per member per month times 12 months times 40,000 individuals, or $144.0 million.

These savings would be almost completely offset by the State share of the costs in the regular Medicaid program for these individuals, as SSI and SSDI cases (for the first two years in the latter case) would be Medicaid-eligible. As noted above, the assumed capitation cost per case is $9,000, so $9,000 times 40,000 individuals times a roughly 34% State share equals a cost increase of $122.4 million GF/GP.

In addition, there is the earlier-noted assumed savings in the CMH non-Medicaid line of $120.0 million, as these people would appear to represent a large portion of non-Medicaid mental health costs.

As those eligible for veterans benefits would be excluded, 10,000 more cases would be removed from the rolls, for savings of $25.2 million.

Finally, there would be the collection of premium revenue as an offset. The assumption is that the remaining 250,000 people (300,000 less 40,000 converted to SSI/SSDI plus 10,000 veterans) would pay an average of $15 per month, for total revenue of $45.0 million.

After these offsets are applied, the total cost of the program would be $507.2 million GF/GP.

The next step is to look at the take-up rate. The assumption here is a 75% take-up rate; thus, the estimated FY 2014-15 cost of the program would be 75% of $507.2 million or $380.4 million.

The estimate for FY 2013-14 is a bit more complicated. In effect, the full cost of the ABW program would be backed out, as that program would continue during FY 2013-14. The other numbers are adjusted downward because the program would be in effect for nine months rather than 12 months and because the conversion of cases to SSI/SSDI would occur on an average date of July 1, 2014, and thus only lead to changes for one-fourth of the year.

The net cost of the program in FY 2013-14 before offsets would be $472.5 million, based on a nine month calculation and a 250,000 base caseload. The adjustments for the SSI/SSDI conversion would be one-fourth the amounts for FY 2014-15 due to the average July 1, 2014, conversion date. The veterans benefit and premium amounts would be adjusted downward due to the three-fourths year implementation and the lower base caseload.

The net result would be a net GF/GP cost in FY 2013-14 of $359.4 million. Once the 75% take-up rate is applied, that would be reduced to $269.6 million. Backing out the Federal portion of the ABW, as that program could remain in place in FY 2013-14, would reduce net costs for FY 2013-14 to $213.6 million GF/GP.

Changes in Assumptions

There are numerous assumptions that could be adjusted. It is probably most useful just to change a handful to show how wide the variance in this analysis could be. As noted before, the net GF/GP costs for FY 2013-14 and FY 2014-15, respectively, would be $213.6 million and $380.4 million.

Changing the Take-Up Rate

If the take-up rate were 60% rather than 75%, then the net GF/GP costs for FY 2013-14 and FY 2014-15, respectively, would be reduced to $159.6 million and $304.3 million.

If the take-up rate were 90% rather than 75%, then the net GF/GP costs for FY 2013-14 and FY 2014-15, respectively, would increase to $267.5 million and $456.5 million.

Changing the Cost Per Case

If the cost per case were $250 per month rather than $210 per month, the net GF/GP costs for FY 2013-14 and FY 2014-15, respectively, would increase to $281.1 million and $488.4 million.

If the cost per case were $180 per month, the net GF/GP costs for FY 2013-14 and FY 2014-15, respectively, would decrease to $162.9 million and $299.4 million.

Assuming Fewer SSI/SSDI Cases Converted

If far fewer cases were converted to SSI/SSDI, then net costs would increase. If only 10,000 cases could be converted, then the net GF/GP costs for FY 2013-14 and FY 2014-15, respectively, would increase to $233.5 million and $460.1 million.

Conclusion

Senate Bill 422 would establish a limited benefit health care program for those under 100% of the FPL. The services provided would exceed those provided under the ABW but would not be a complete set of benefits due to the limitation on inpatient hospitalization coverage.

The fiscal impact, under any scenario, would reflect an increase in GF/GP expenditures in both the partial first year (FY 2013-14) and the full year in FY 2014-15. It should be noted that the actual estimate is strongly dependent on the assumptions noted above, so there is no definitive analysis of the fiscal impact.

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TABLE 1: ESTIMATED COSTS AND SAVINGS ASSOCIATED WITH SENATE BILL 422
based on assumptions outlined in analysis

Components of cost (per member per month)	(Jan 1 - Sept 30) FY 2013-14	(Full Year) FY 2014-15
Cost without mental health or inpatient, based on ABW	$150	$150
Cost of limited inpatient coverage	$60	$60
Total cost per member per month without mental health	$210	$210
Maximum number of people covered, 0%-100% FPL	250,000	300,000
Total Cost of Program before Offsets	$472,500,000	$756,000,000
Offsets to Costs		
Remove ABW, Plan First, Public Health GF costs (per DCH/SBO)	(27,750,000)	(37,000,000)
Assume conversion of 40,000 cases to SSI/SSDI *	(36,000,000)	(144,000,000)
Increased Medicaid GF costs from 40,000 new SSI cases **	30,600,000	122,400,000
Reduced CMH costs due to conversion of cases ***	(30,000,000)	(120,000,000)
Assume 3% of caseload is eligible for Vets benefits (10,000)	(18,900,000)	(25,200,000)
Premium revenue from remaining cases at $15/month ****	(31,050,000)	(45,000,000)
Net GF/GP cost	$359,400,000	$507,200,000
CASELOAD ASSUMPTION		
Percent of eligible population partaking in program	75%	75%
Net GF/GP cost if 75% of eligible individuals partake	$269,550,000	$380,400,000
FY 2013-14 ABW coverage as offset to new costs *****	(56,000,000)	
Net GF/GP cost	$213,550,000	$380,400,000

* - assume average cost for these individuals is $300/month, also assume 7/1/14 average conversion in FY 14, 1/4 SSDI cases are Medicaid eligible for first two years

** - assume average capitation payment of $9,000, 34% State cost, average 7/1/14 conversion in FY 14

*** - assume roughly 60% of costs could be ascribed to new SSI cases, average 7/1/14 conversion in FY 14

**** - applies to lower caseload, with SSI/SSDI cases included partial year in FY 14

***** - assumes all current ABW cases convert, full take-up of ABW cases, GF savings accounted above so only Federal dollars are saved; ABW waiver expires 9/30/2014.

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