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BILL ANALYSIS

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Senate Bill 459 (Substitute S-1 as reported by the Committee of the Whole)
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Sponsor: Senator Patrick J. Colbeck
Committee: Government Operations

CONTENT

Senate Bills 459 (S-1) and 460 (S-1) would create the "Patient-Centered Care Act" and amend the Social Welfare Act, respectively, to direct the State to license private health care exchanges; create the "Low-Income Trust Fund"; "migrate" Medicaid recipients, effective January 1, 2015, to individual health savings accounts from which they could purchase a qualified health plan; define qualified health plans for the purposes of the proposed Act; and delineate what such plans could cover.

The bills are tie-barred.

Senate Bill 459 (S-1)

The bill would direct the Department of Financial and Insurance Services (DIFS) to establish and administer a program to license private health exchanges that would not include ACA established exchanges. Those operating exchanges would have to meet already-established good moral character requirements in the Insurance Code. The Department would have to investigate the applicants to determine whether they were qualified to operate a private exchange. Exchanges would have to offer one or more qualified health plans, cooperate with data security requirements, include a process to determine whether those using the exchanges were eligible for government assistance programs, operate in a fiscally solvent manner, comply with State and Federal privacy laws, cover abortion services only through an optional provider, and provide discounts to those eligible for government programs to enable them to realize the full value of the programs.

The Department would be required to certify benefit plans meeting certain criteria as "qualified health plans". The criteria for an acceptable benefit plan would include being offered by a health insurer as defined under Federal law and offering access to quality health care through a package of benefits equal to or greater than the essential health benefits package as defined under the Federal Affordable Care Act (ACA). In considering whether a benefit plan met the quality health care standard, DIFS would have to consider the availability in the package of benefits under a traditional insurance option, the availability of direct primary care services, and the availability of fee-for-service options if there were a sufficient balance in the benefit package to cover minimum essential benefits in combination with other coverage.

The bill also would require DIFS, if the Federal government did not allow enrollment in a government program through a private exchange, to issue a coupon to a resident eligible for a government program to be redeemed with a government exchange or other appropriate State or local agency.

In addition, DIFS would have to ensure that information necessary to determine eligibility for government programs would not be transmitted to anyone outside the exchanges, and to use a standardized data scheme to collect information to determine eligibility. It also would have to create a government assistance program portal for use by the exchanges.

The Department also would be required to seek a determination from the U.S. Department of Health and Human Services as to whether the private exchanges met the Federal qualifications for an exchange. If an exchange to be licensed did not meet the Federal qualifications, DFIS could issue a license only to nonprofit entities that met the qualifications.

The bill would create the Low-Income Trust Fund in the Department of Treasury. Money from the Fund could be spent only for purposes of implementing and administering the program described in the bill. If Senate Bill 460 (S-1) were enacted and Medicaid and MIChild recipients were "migrated" into qualified health plans as defined in Senate Bill 459 (S-1), and savings from migration were deposited in the Fund, then the DIFS Director would spend the money in the Fund for former Medicaid and MIChild recipients to cover deductibles under high-deductible health insurance. These deductibles would be covered until the former Medicaid or MIChild recipients' health savings account balances were actuarially sufficient to cover their deductibles.

Senate Bill 460 (S-1)

Effective January 1, 2015, the bill would "migrate" Medicaid recipients to an individual health savings account from which they could purchase a qualified health plan as defined in Senate Bill 459 featuring the same scope of benefits as under current law. The qualified health plan would be purchased with the balance of funds provided by eligible government assistance (that is, a portion of the State's Medicaid funding). The amount would be determined by establishing the average cost of a qualified health plan composed of direct primary care services and a high-deductible plan based on commercial market rates.

Senate Bill 460 (S-1) would define "migration savings" as the difference between total Medicaid costs and the total eligible government assistance amount. An amount not to exceed the amount necessary to cover gap insurance or the average deductible would be used to cover former Medicaid recipients' uncovered costs until the individuals' health savings accounts were actuarially sufficient to cover the deductible of the high-deductible plan.

The bill also would require the Department of Community Health (DCH) to seek a waiver from the U.S. Department of Health and Human Services to implement the migration of Medicaid recipients.

If the waiver were not approved, the program would not be implemented and the current Medicaid program would remain in effect. Also, if the waiver were not approved, the Department would have to provide the Legislature with a report that would determine the amount of money it would cost the State, without Federal match, to provide the same level of benefits using a qualified health plan composed of direct primary care services and a high-deductible insurance plan as provided for in Senate Bill 459 (S-1), and determine the savings if all State employees were provided the same level of benefits using direct primary care services and a high-deductible insurance plan as provided for in Senate Bill 459 (S-1). If the report estimated net savings from a State-only approach to these services, the Department would have to implement the provisions of the bill and cease administering the Medicaid program. The State also would be directed, notwithstanding any provision of law to the contrary, not to expand the Medicaid program.

Proposed MCL 400.105c (S.B. 460)

FISCAL IMPACT

The fiscal impact of the bills is indeterminate. Nevertheless, it is possible to make relevant observations, including an estimate of the maximum cost of the legislation if applicable Federal waivers were obtained.

Proponents of the legislation have made the legitimate point that there could be beneficial secondary effects if the legislation resulted in reduced costs for Medicaid, for the State as an employer, or for businesses that wished to provide health care coverage. It also could be the case that a new approach to health care could lead to fewer businesses dropping health care coverage and shifting some of their employees to Medicaid for health coverage. It is not the practice of the Senate Fiscal Agency (SFA) to use dynamic scoring approaches with proposed

legislation, so those potential impacts are not addressed in this analysis. (Proponents of Medicaid expansion have made similar arguments about the economic impact of additional health care spending in the State, and the SFA did not address those claims in its analysis of that proposal.)

Assuming Federal waivers to transfer both the expansion and the regular Medicaid population into the system outlined in the bills were granted, the one key factor for the fiscal analysis is the amount of money to be placed in the Low-Income Trust Fund to be used to cover the cost of deductibles and gap insurance. Senate Bill 460 (S-1) states, "Migration savings is the difference between the current Medicaid cost for all enrollees minus the average eligible government assistance amount for all enrollees times the number of enrollees." Migration savings plus government assistance, therefore, would equal current Medicaid cost. Senate Bill 460 (S-1) also would require "a portion" of migration savings to be placed in the Low-Income Trust Fund to help cover gap insurance or the average deductible under a high-deductible plan. The maximum amount that could potentially be spent would be the entire migration savings amount, so total spending, at a maximum, would equal current Medicaid spending.

Therefore, the upper bound for spending would be the current level of Medicaid spending. It should be noted that, if the Federal government granted waivers to enact the program, there would be savings for what is generally called the Medicaid expansion population, an amount similar to what would be saved under Medicaid expansion. In other words, Community Mental Health non-Medicaid costs would be reduced and the Adult Benefits Waiver would no longer be needed. It is questionable whether the Corrections savings tied to expansion would occur; it is not clear what the policy would be on issuing insurance to those in the Corrections system, although parolees likely would be covered. As such, assuming the waivers were granted, there would be GF/GP savings of about $250.0 million full-year or about $170.0 million during FY 2014-15, the first fiscal year the program would be in effect.

There certainly could be greater savings. The proposal would affect the entire Medicaid program, which spends well over $12.0 billion Gross per year. To the extent that a new model increased efficiencies and provided incentives to reduce expenditures, the portion of migration savings placed in the Low-Income Health Fund could be reduced, leading to significant GF/GP savings.

Advocates also cite evidence that a direct primary care model results in reduced overhead for primary care, and state that an equivalent or greater amount of services could be available for a lesser price.

A separate concern is not directly tied to the fiscal impact, but involves the role of the Federal government. While there is authorization in the Affordable Care Act for direct primary care services to be part of a qualified health plan, this does not mean that a qualified health plan model using private or high-deductible insurance can be used for Medicaid without a waiver.

The indeterminate nature of the new approach would likely raise concerns at the Federal level. It is possible that services to Medicaid clients involving direct primary care services, a high-deductible insurance plan, and gap insurance or deductible support would cost less than the current amount spent on Medicaid. However, it is also possible that the migration savings would not be sufficient to cover the deductibles faced by Medicaid clients, many of whom have significant pre-existing conditions and would go through even a high deductible on an annual basis.

If the migration savings, which would be capped, were not sufficient to cover the deductible costs, then Medicaid clients would face much greater out-of-pocket costs. Given the track record of the Department of Health and Human Services on nominal changes in Medicaid co-pays, there may be significant concerns about the possibility of far larger yet indeterminate out-of-pocket expenses for clients who would otherwise be served by Medicaid. Thus, while the design of the legislation would create an upper limit on costs, that limit also could make it much more difficult to obtain the necessary Medicaid waivers to implement the program.

It also should be noted that the Medicaid population, even the so-called expansion population, does differ from the general population. Even the expansion population, which does not include Supplemental Security Income disabled (as those individuals are categorically eligible for

Medicaid), includes people with significant disabilities, in particular many with mental illness. While these people would seek high-deductible coverage off the private exchanges, the expected cost of their coverage would be greater than that for an average person with similar demographics who is not in the expansion population.

There are a number of other more minor fiscal considerations in the bills, such as the administrative cost for DIFS and the DCH to authorize exchanges and create the program, but those are insignificant compared to the potential yet indeterminate fiscal impact of the migration of Medicaid recipients to the new program. The provision requiring a study of the potential savings from converting to a State-run program could have costs of up to $100,000.

The basic conclusion is that, assuming Federal approval of waivers, there would be an upper limit on costs, with potential GF/GP savings similar to those from the Medicaid expansion proposals. The fiscal impact itself, of a model that has not yet been tried on a large scale, is indeterminate. There is the potential for savings. However, there is also the potential for a nontrivial amount of costs to be passed along to former Medicaid clients, and the uncertainty as to whether that would occur could raise concerns with the Federal government and make the waiver approval process difficult.

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