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BILL ANALYSIS

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Senate Bill 897 (Substitute S-1)
Sponsor: Senator Mike Shirkey
Committee: Michigan Competitiveness

Date Completed: 3-21-18

CONTENT

The bill would amend the Social Welfare Act to add work requirements to the Medical Assistance Program. Specifically, the bill would enact Section 107b to do the following:

- **Require the Department of Health and Human Services (DHHS), by July 1, 2018, to apply for a Federal waiver to establish work requirements as a condition of receiving medical assistance under the Act.**
- **Require the DHHS, after the waiver was approved, to include in its implementation of the work requirements a requirement of 29 hours average per week of work, job training, or education.**
- **Provide for an exemption from the work requirements for an individual who was the sole caretaker of a family member under six years old, pregnant, receiving long-term disability benefits, a full-time student, undergoing substance use disorder treatment, or the sole caretaker of a dependent with a disability.**
- **Include a requirement that able-bodied medical assistance recipients verify family income monthly and report a change in income within 10 days.**
- **Prohibit a recipient from receiving public assistance for one year for failing to meet the income reporting requirement or knowingly making a false statement.**
- **Require the DHHS, beginning in July 2019, to contract with a third party for a survey to obtain information needed to determine how many recipients had left the Medical Assistance Program and the Healthy Michigan Plan as a result of obtaining full-time employment with medical benefits.**
- **Require the DHHS to contract with a third party for a survey to obtain the information needed to report to the Legislature annually, beginning in July 2019, the number of exemptions from work requirements granted to individuals receiving medical assistance or Healthy Michigan Plan medical assistance.**
- **Allow the DHHS to enforce the work requirements through random audits of medical assistance recipients, and provide that a recipient found noncompliant more than once could not receive any public assistance for one year.**
- **Require the DHHS to implement Section 107b within six months after a waiver was granted, and to notify individuals to whom the work requirements likely would apply.**
- **Require nonexempt applicants for medical assistance and nonexempt recipients to be in compliance within a specified time frame.**
- **Provide that a deviation by the DHHS from the proposed requirements or the Department's failure to meet the implementation and notification requirement would result in a 5.0% reduction in funding of Medicaid positions.**

The bill also would enact Section 107a to state the purpose of adding work requirements, and to define terms used in Section 107b.

The bill would take effect 90 days after being enacted.

Waiver Request

The bill would require the DHHS to apply for a waiver under Section 1115 of the Social Security Act by July 1, 2018, and then annually as required, to require work requirements as a condition of receiving medical assistance under the Social Welfare Act, including Sections 105 and 105d.

(Section 1115 of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services to waive specific provisions of health and welfare programs, including Medicaid, for certain experimental, pilot, or demonstration programs in a state. Section 105 of the Social Welfare Act requires the Michigan DHHS to administer the Medical Assistance Program for the medically indigent under the Medicaid program. Section 105d provides for the Healthy Michigan Plan, which is Michigan's Medicaid-expansion plan that provides health care benefits to low-income individuals who do not qualify for Medicaid.)

The waiver would have to be a request to allow for all of the following:

-- Administration of the work requirements in Section 107b aligned with administration of the work requirements in place for recipients of the Federal Supplemental Nutrition Assistance Program, to the extent possible.
-- Modification in the work requirements for an individual who had an acute medical condition or disability that resulted in a work limitation according to a physician's order.
-- Modification for an individual who had been recently released from imprisonment for a felony.
-- A requirement of 29 hours average per week of work, job training in an industry with proven demand, or education in an industry with proven demand, or a combination of any of the three, to count toward the work requirement.
-- A requirement that able-bodied medical assistance recipients verify family income monthly through MiBridges (an online site where recipients can make changes, apply for benefits, etc.).
-- A requirement that medical assistance recipients report a change in family income within 10 days.
-- Allowing an individual to meet the work requirements by actively seeking employment, if unemployment reached 8.5% regionally.

(The bill states that "modification" would not mean an exemption.)

In addition, the waiver would have to include a request to allow an exemption for an individual who was one or more of the following:

-- The sole caretaker of a family member under the age of six years.
-- A current recipient of temporary or permanent long-term disability benefits from a private insurer or from the government.
-- A full-time student who was emancipated or whose parents qualified for Medicaid, and who was carrying 12 hours of more per semester or term, including a student in a postsecondary institution.
-- An individual undergoing treatment for substance use disorder (as defined in the Mental Health Code).
-- A pregnant woman.
-- The sole caretaker of a dependent with a disability.

The exemption for a sole caretaker of a dependent with a disability could be used only one time per household or, in a household with more than one child, one time per child.

("Caretaker" would mean a parent or an individual who is taking care of a child in the absence of a parent. A caretaker would not be subject to the proposed work requirements if he or she were not a medical assistance recipient under Section 105 or 105d. "Child" would mean an individual who is not emancipated, who lives with a parent or caretaker, and who is either 1) under the age of 18, or 2) age 18 and a full-time high school student.)

Beginning July 1, 2018, and by July 1 each subsequent year, the Medicaid Director would have to submit to the Governor, the Senate Majority Leader, and the Speaker of the House of Representatives a letter confirming the submission of the waiver request.

Implementation of Work Requirements

After the requested waiver was approved, the DHHS would have to include the following in its implementation of the work requirements:

-- A requirement of 29 hours average per week of work, job training in an industry with proven demand, or education in a field with proven demand, or a combination of any of the three, to count toward the work requirement.
-- A requirement that able-bodied medical assistance recipients verify family income on the first day of each month through MiBridges, and a requirement that a medical assistance recipient report a change in family income within 10 days after learning of the change.
-- A provision allowing an individual to meet the work requirement by actively seeking employment if unemployment reached 8.5% regionally.
-- An exemption for an individual who met one or more of the conditions listed in the requirements for the waiver request.

If a medical assistance recipient failed to report a change in family income or knowingly made a false statement in complying with the income reporting requirements, he or she would be prohibited from receiving public assistance for one year.

("Able-bodied adult" would mean an individual 19 to 64 years of age who is not pregnant and who does not have a medical disability that makes him or her eligible for medical assistance under the Social Welfare Act.)

The Department first would have to direct medical assistance recipients to existing resources for job training or other employment services, child care assistance, transportation, or other supports. The DHHS could develop strategies for assisting medical assistance recipients to meet work requirements under Section 107b.

Evaluation & Reports

Beginning July 1, 2019, the DHHS would have to contract with a third party to conduct a survey to obtain the information needed to complete an evaluation of the Medical Assistance Program under Sections 105 and 105d to determine how many recipients had left the Medical Assistance Program and the Healthy Michigan Plan as a result of obtaining full-time employment with medical benefits.

The Department also would have to contract with a third party to conduct a survey to obtain the information needed to submit a report to the Legislature beginning July 1, 2019, and every July after that, that showed separately, for medical assistance under Section 105 and medical assistance under Section 105d, the number of exemptions from work requirements granted to individuals in that year and the reason the exemptions were granted.

Enforcement

The DHHS would be permitted to enforce Section 107b by conducting random audits of medical assistance recipients under Sections 105 and 105d who were required to meet the work requirements. The first time a random audit found a recipient noncompliant with Section 107b, he or she would have one chance to become compliant. If a recipient were found noncompliant a second or subsequent time, he or she would be prohibited from receiving all public assistance for one year.

Implementation of Section 107b

The DHHS would be required to implement the requirements of Section 107b within six months after the date a waiver was granted, and to give notice of the work requirements to the individuals to whom the requirements would likely apply. The Department's failure to do so would have to result in a 5.0% reduction in funding of the number of Medicaid FTE (full-time equated) positions.

A deviation by the DHHS from the work requirements or requirements described in Section 107b also would have to result in a 5.0% reduction in funding of the number of Medicaid FTE positions.

Compliance

Beginning 45 days after the six-month period described above (six months after the waiver was granted), medical assistance applicants who were not exempt from the work requirements would have to be in compliance with the requirements within 45 days after the eligibility determination.

Beginning on the bill's effective date, nonexempt individuals who were medical assistance recipients on that date would have to be in compliance with the work requirements within 45 days after the six-month period.

Purpose

The bill states that the purpose of adding work requirements to the Medical Assistance Program "is to utilize workforce demand to prepare an able-bodied adult for a life of self-sufficiency and independence from government interference".

Proposed MCL 400.107a & 400.107b

BACKGROUND

In a letter to State Medicaid Directors dated January 11, 2018, the Centers for Medicare and Medicaid Services (CMS) announced "a new policy designed to assist states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability".

According to the letter, CMS will support state demonstration projects under Section 1115 of the Social Security Act that require eligible adult beneficiaries to engage in work or community engagement activities (e.g., skills training, education, job search, caregiving, or volunteer service) in order to determine whether those requirements assist beneficiaries in obtaining sustainable employment or other community engagement, and whether sustained employment or other productive community engagement leads to improved health outcomes.

According to a report by the Kaiser Family Foundation, as of mid-January CMS had approved a work requirement waiver in Kentucky, and eight other states had pending waiver requests at CMS that would require work as a condition of eligibility for Medicaid-expansion adults and/or traditional Medicaid populations (*Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues*, January 2018). These proposals generally would require beneficiaries to verify their participation in approved activities, such as employment, job search, or job training programs, for a certain number of hours per week in order to receive health coverage, and typically would exempt certain populations.

Legislative Analyst: Suzanne Lowe

FISCAL IMPACT

If the bill were enacted and if the necessary Federal waivers were approved, the legislation would likely lead to an indeterminate but likely net marginal reduction in State expenditures. There are numerous elements in this estimate: 1) administrative costs, both one-time and ongoing, to implement the work requirement; 2) reduced Medicaid expenditures due to individuals, subject to the work requirement, who either did not meet the requirement and were rendered ineligible or increased their hours of work enough so their income exceeded the Medicaid eligibility threshold; 3) potential supportive services costs, in particular job training, child care, and transportation; 4) indirect revenue effects, including reduced Health Insurance Claims Assessment (HICA) revenue and, to the extent employment increased, increased income tax and sales and use tax revenue; and 5) potential secondary effects tied to changed incentives and increased income.

The magnitude of the nonadministrative costs and savings would depend on how many Medicaid-eligible individuals subject to the work requirement would increase their working hours to comply, how many such individuals would fail to comply and would be cut off from Medicaid eligibility, the number of the newly employed who would need supportive services, and the potential secondary behavior effects.

While various states have discussed implementation of Medicaid work requirements, there is no experience in other states with such requirements, so it is not possible to provide anything approaching a precise estimate of costs and savings. As a result, this fiscal analysis is vague. The key factors in any more precise estimate would include: the percentage of those subject to the requirements who failed to comply and were cut off from Medicaid, the percentage of those subject to the requirements who increased their income sufficiently to leave Medicaid, the potential increased tax revenue from those who increased their income (whether or not they left Medicaid), the percentage of the work requirement population who would require and seek child care and other supportive services, and administrative costs to implement and administer the work requirement.

Administrative Costs

The State has implemented work requirements for the Food Assistance Program (FAP) population, so one may expect that the administration of a Medicaid work requirement could be "grafted" onto administrative and systemic changes that were used to create a FAP work requirement. However, the populations, while they overlap, are handled differently in terms of eligibility and information technology. Eligibility for FAP is a group eligibility process handled by the Department of Health and Human Services BRIDGES system, while Medicaid eligibility is determined on an individual basis and is handled by the Community Health Automated Medicaid Processing System.

While there has not yet been any direct experience with a Medicaid work requirement, a

number of states and cities have estimated the administrative costs of implementing work requirements for human services programs. These estimates include $37.5 million in state funding for systems changes in Wisconsin, $70.0 million Gross (no state amount specified) for Medicaid work requirements in Tennessee, $17.5 million in state funding for Medicaid work requirements in Kentucky, and up to $23.1 million in state funding for Medicaid work requirements in the first full year in Virginia.

Based on these estimates and the fact that Michigan has a larger population than most of these states, the Senate Fiscal Agency (SFA) estimates costs in Michigan of $20.0 million to $30.0 million GF/GP per year for administration of a Medicaid work requirement.

The bill also includes a provision that would penalize the Medical Services Administration by 5.0% of funding for FTE positions if there were a deviation by the DHHS from the requirements of the legislation. If this provision were triggered, the savings would be about $1.0 million GF/GP.

Estimating the Base Population

The legislation would apply to nonelderly, nondisabled adult Medicaid recipients with exemptions built in for full-time students, pregnant women, individuals being treated for substance use disorders, sole caretakers of children under six years old, and sole caretakers of a dependent with a disability, and modifications for individuals with work limitations according to a physician's order and individuals recently released from imprisonment for a felony. There also would be limitations on the work requirement if regional unemployment were at or greater than 8.5%.

When attempting to estimate the nonelderly, nondisabled adult Medicaid caseload, one finds about 690,000 individuals who are enrolled in the Medicaid expansion program, the Healthy Michigan Plan (HMP), and about 300,000 individuals who are generally referred to as "TANF" (Temporary Assistance to Needy Families). That leads to a maximum population of just under 1.0 million who could be subject to the work requirements.

Due to the exemptions, especially those for full-time students, caretakers, and pregnant women, the 1.0 million figure should be considered to be a maximum well in excess of the actual number of people who would be subject to the work requirement.

Medicaid Costs for the Base Population

An examination of Michigan's Medicaid physical health and behavioral health capitation rates for nonelderly adults in the HMP and TANF populations, weighted for caseload, indicates that costs to cover these people average about $4,300 Gross per person per year. Services to the TANF population are reimbursed at a roughly 65.0% Federal match rate. Healthy Michigan Plan services are reimbursed at a match rate that is currently 94.0% but will drop to 90.0% on January 1, 2020. Because this population is so heavily weighted to HMP, the average GF/GP cost would be far less than the 35.0% or so GF/GP cost of the regular Medicaid population; in fact, the GF/GP cost for the population potentially subject to the work requirement, on average, would be about $600 per person per year.

Caseload Reduction: How Many Would Leave Assistance under the Work Requirement?

This question is by far the most difficult to address, although it is key in doing a fiscal analysis of the legislation. There have not been any long-term studies on work requirements for Medicaid as no such work requirements have yet been implemented on any significant scale.

States have implemented work requirements for FAP benefits. In January 2017, Michigan implemented FAP work requirements in four counties. During a time that the FAP caseload in non-work-requirement counties dropped by almost 5.5% in Michigan, the caseload in those four counties dropped by 12.0%. One could assume that the 6.5% difference was due to the work requirement, with some recipients increasing their working hours and no longer being eligible due to income and others not meeting the work requirement and no longer being eligible due to violating the work requirement.

However, there are numerous factors that make that 6.5% figure an approximation with a potentially wide variance. First, the portion of the FAP caseload subject to the work requirement was a subset of the entire FAP caseload in those counties. Second, those counties may have seen better or worse economic growth than other counties, leading to an impact on the caseload for reasons aside from the work requirement. On the other hand, studies in other states on FAP work requirements have shown an impact of similar magnitude.

Caseload Reduction Savings

For the purposes of this analysis, the SFA has not attempted to estimate the impact of a work requirement that has not been implemented, especially on a population that overlaps but is still significantly distinct from the FAP population. Instead, the SFA analysis examines the impact of each 1.0% change in the affected caseload. If one starts with the maximum caseload of almost 1.0 million, each 1.0% reduction in the caseload due to the work requirement would reduce State Medicaid expenditures by an average of $43.0 million Gross and $6.0 million GF/GP. If there were a 6.5% reduction in State Medicaid expenditures, the average estimated savings would be $277.8 million Gross and $38.5 million GF/GP. This would be the case whether the individuals were no longer eligible for Medicaid due to violating the work requirement or due to having increased income.

HICA Offset

The State has a 1.0% tax on paid medical claims known as HICA. For each 1.0% reduction in caseload, the State would see a reduction in HICA revenue of $430,000, which would increase GF/GP costs by the Federal share of this amount (due to actuarial soundness requirements) or about $370,000. As HICA is slated to expire on July 1, 2020, this would not be a long-term reduction in revenue.

Supportive Services Costs

The most significant supportive services cost would be child care for those covered by the legislation who have children and who increased working hours. It is important to note that the vast majority of those covered by the legislation either would not have child care needs because they do not have children under 18 requiring child care, are already subject to work requirements, or have access to alternative child care arrangements. The average State cost of full-time child care is about $5,000 per year. This amount would be far less for children who are enrolled in school and, again, would apply only to a limited subset of the covered population.

The legislation would allow individuals to fulfill their work requirement through job training "in an industry with proven demand", so there could be cost pressures on training programs funded by the State.

Other Secondary Effects

It is possible that some recipients would choose to apply for Social Security Income (SSI) benefits to avoid the work requirement. To the extent that these people are already eligible

as TANF cases, the fiscal impact would be on the SSI State Supplementation line - each newly eligible SSI recipient would receive a Federal SSI check along with an average $225 per year State Supplementation payment. That increased cost would be more than offset by ending a GF equivalent TANF payment of about $5,000 per year, for net GF/GP savings on grants of almost $4,800. The cost of Medicaid for these now Aged, Blind, and Disabled-eligible individuals would increase by about $3,000 GF/GP per year, for net savings of $1,800 GF/GP per case per year.

If a person currently eligible under HMP applied for and received SSI, then the increased capitation rate and lower Federal match rate would lead to an average GF/GP cost increase of $4,000.

It should be noted that the magnitude of the SSI payment itself, which is over $9,000 per year (almost all Federal) for those in the independent living category, already provides a strong incentive to individuals to apply for SSI benefits even without a work requirement. The work requirement itself would likely have only a marginal impact on individual decisions to apply for SSI.

To the extent that people increased their working hours due to the work requirement, State income and sales and use tax revenue would increase. If a person increased his or her income by $10,000 per year, the State would gain about $250 in income tax revenue (after adjusting for the personal exemption) and an indeterminate but likely similar amount of sales and use tax revenue. Furthermore, for those receiving Family Independence Program (FIP) payments, increased income would lead to a reduction in their FIP grant.

People who were sanctioned and forced to leave Medicaid would likely not be able to afford health insurance, which could lead to an increase in uncompensated care, especially at hospitals. This would lead to a negative State or local fiscal impact for public hospitals.

<u>Summary</u>

The potential net costs or savings of the legislation, if fully implemented, are tied to the degree to which people would leave Medicaid as a result of the work requirement, whether due to increased income or due to failure to meet the work requirement. There is a highly complex set of factors to analyze because no state has yet implemented such a work requirement.

To the extent that individuals would begin to work or increase their hours, there would be cost reductions as some would migrate off of Medicaid, there would be marginal increases in tax revenue, and there would be supportive services costs, especially for child care. To the extent that individuals were removed from Medicaid due to failure to comply with the work requirements, there would be reduced Medicaid costs but potential increases in uncompensated care for hospitals, with a State and local fiscal impact on publicly owned hospitals. The savings for those leaving the Medicaid caseload for whatever reason would average just over $6,000 GF/GP per case. The costs, in particular child care costs, would be focused on a much narrower subset of the population. Increased income for those in the FIP population would reduce FIP grants and State spending on the FIP. Finally, there would be administrative costs that the SFA estimates would be in the range of $20.0 million to $30.0 million GF/GP per year. Overall, the SFA believes that the net fiscal impact would be an indeterminate reduction in State costs.

While it is not certain that the overall impact would be a slight reduction in State expenditures, past experience with various work requirements for non-Medicaid programs does indicate a nontrivial reduction in caseload would occur, which would lead to savings on Medicaid. It is not certain that these savings would exceed the various possible costs, but that does appear

likely, unless the Medicaid work requirement experience proved to be significantly different from the experience with other work requirements.

This is a very basic and, as noted, an indeterminate analysis. As more information becomes available, particularly from other states, the SFA will update its estimates to provide a more complete picture.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.