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BILL ANALYSIS



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House Bill 4714 (Substitute S-7)
Sponsor: Representative Matt Lori
House Committee: Michigan Competitiveness
Senate Committee: Government Operations

CONTENT

House Bill 4714 (S-7) would amend the Social Welfare Act to provide for the expansion of the Medicaid program pursuant to the 2010 Patient Protection and Affordable Care Act (referred to below as the ACA). The bill also contains a significant number of provisions that go well beyond the basic issue of expansion of the Medicaid program. The provisions of the bill are not arranged by topic, so to provide a better understanding of the legislation, this analysis groups the provisions by category.

Expansion of Medicaid

Section 105d(1) would direct the Department of Community Health (DCH) to seek a waiver to expand Medicaid coverage to the ACA expansion population. The Senate Fiscal Agency (SFA) estimates that the expansion would provide Medicaid coverage to 325,000 people in fiscal year (FY) 2013-14 and over 400,000 in FY 2014-15 and beyond. Sections 105d(1)(a), (c), and (d) provide that eligible individuals would be placed in a contracted health plan, that enrollees would have a choice in health plans, and that all enrollees would have to have access to a primary care physician and preventive services.

Section 105d(20) includes provisions governing coverage for able-bodied individuals eligible for Medicaid expansion between 100% and 133% of the Federal Poverty Level (FPL) who have reached their 49th month of coverage. The definition of "able-bodied" incorporates 42 CFR 440.315, which exempts not only disabled individuals under Federal definitions, but also state-defined disabled individuals and pregnant women. Such individuals would have to choose to either purchase private insurance coverage through a health exchange (assuming that under a Federal waiver they would receive the tax credits necessary to cover most of the insurance costs from the Federal government) or be subject to greater cost-sharing requirements (7% maximum as opposed to 5%) while remaining in Medicaid.

Section 105d(21) would require the DCH to inform enrollees at least 60 days before the end of their 48th month of coverage that they would have to choose whether to purchase private insurance through a health exchange or be subject to greater cost-sharing requirements while remaining in Medicaid.

Section 105d(22) would require the DCH to implement a system for individuals who failed to make a choice under Section 105d(20) to continue their Medicaid coverage in the 49th month with greater cost-sharing requirements.

Health Savings Accounts, Cost-Sharing, and Healthy Behavior Incentives

Section 105d(1)(a) would create the equivalent of a health savings account for enrollees, into which an unspecified amount of funding from an enrollee, the enrollee's employer, and private and public entities could be deposited to pay for health expenses.

Section 105d(1)(b) would require the contracted health plans to track all enrollee co-pays for the first six months of enrollment and calculate the average monthly co-pay. The enrollee would then be required to remit the average co-pay each month into his or her account, with periodic adjustments and quarterly statements to the enrollee. The section also would require the DCH to pursue a range of consequences for enrollees who did not meet their cost-sharing requirements and would require the DCH to report to the Legislature on this issue by June 1, 2014.

Section 105d(1)(e) would limit cost-sharing contributions for those between 100% and 133% of the FPL to 5% of income. Cost-sharing would not apply for the first six months of eligibility. Contracted health plans could reduce required contributions for those who met the requirements for healthy behaviors. The section lists ways enrollees could meet healthy behavior goals, including an annual health risk assessment to identify unhealthy characteristics including alcohol and tobacco use, substance use disorders, obesity, and immunization status.

If a person left the Medicaid program, the contribution made on his or her behalf to the health savings account would be returned to the enrollee as a voucher to purchase private insurance.

Section 105d(1)(j) would require the DCH to coordinate with the Department of Treasury on a procedure for offsetting State tax refunds of enrollees who owed a liability to the State due to uncollected cost-sharing. Nonpayment of cost-sharing would be considered a liability to the State.

Section 105d(1)(k) would require The Bureau of State Lottery, before payment of a lottery prize of \$1,000 or more, to determine whether the prize winner had a current liability to the State. Nonpayment of cost-sharing would be considered a liability to the State.

Section 105d(7) would direct the DCH to limit any reduction in an enrollee's required contribution if the enrollee failed to pay co-pays or made inappropriate use of emergency departments.

Section 105d(12)(c) would direct the DCH, in cooperation with the contracted health plans, to create financial incentives to reward enrollees who improved their health outcomes or maintained healthy behaviors.

Federal Waivers

To be implemented fully, the legislation would require a Federal waiver effectively split into two parts: the first to implement the health savings accounts, the cost-sharing, and the healthy behavior incentives, and the second to implement the provisions tied to the 49th month of eligibility.

Section 105d(3) would require transmittal of any approved waiver to the Legislature for review within seven days of receipt by the DCH.

Section 105d(23) would set in motion the termination of expansion Medicaid coverage if the second portal waiver were not approved by December 31, 2015. By January 31, 2016, the Department would have to notify enrollees that the program would be terminated on April 30, 2016.

Section 105d(26) states that, if the waivers were not approved by December 31, 2013, the DCH would have to request documentation from the U.S. Department of Health and Human Services (HHS) that if the waivers were rejected and Medicaid expansion thus were not implemented, the State would not incur a Federal financial penalty.

Expiration of Expansion Coverage

In addition to the above-noted "rejected waiver" scenario, Section 105d(27)(b) provides that expansion coverage would expire when annual State costs exceeded State and non-Federal net savings due to the shift of State-funded costs to expansion Medicaid. Section 105c(b) would direct the DCH to determine and the State Budget Office (SBO) to approve by June 1, 2014, how State and non-Federal savings would be estimated.

Provisions Affecting Providers

The legislation contains a number of provisions affecting providers, including several that are not directly related to Medicaid expansion.

Section 105d(1)(i) would require that individuals eligible for expansion be covered for telemedicine services, with the term telemedicine being defined as it is in the Insurance Code.

Section 105d(2) would require hospitals participating in Medicaid to discount charges to uninsured individuals with income under 300% of the FPL to 115% of the rates paid by Medicare. (This provision would address an issue often mentioned in the press, where uninsured individuals can sometimes be asked to pay full hospital charges, which are generally well in excess of actual hospital costs.) This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(5) would direct that the expansion population have a pharmaceutical benefit with copays at levels allowable by the Centers for Medicare and Medicaid Services to encourage the use of generic drugs and 90-day prescriptions. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(8) would require a report on the impact of expansion of Medicaid on uncompensated care. By each December 31, starting in 2014, the DCH would have to report information on the reduction in uncompensated care, compared to FY 2012-13 as a baseline. By April 1, 2015, the DCH would have to proportionally reduce disproportionate share hospital (DSH) payments to produce GF/GP savings and recognize savings by September 30, 2016. At present, there is a \$45.0 million DSH pool funded with GF/GP dollars and Federal Medicaid match.

Section 105d(12) would require the DCH to create financial incentives to reward health plans that met specified population improvement goals and to reward providers that met specified quality, cost, and utilization targets.

Section 105d(14) would require the DCH to ensure that payments made to contracted health plans were actuarially sound. (This echoes a Federal requirement that already applies to all current health plans providing Medicaid services.) This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(19) would require the DCH to measure contracted health plans on their performance relative to appropriate treatment of substance use disorders. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Administrative Issues

Section 105c would require the DCH to implement an automated eligibility determination and enrollment process by which individuals could apply for Medicaid (both regular Medicaid and expansion). (At present, the Department of Human Services handles Medicaid eligibility, so this would be a major change in administrative function.) The DCH Director would submit a recommendation to Legislative leadership and to the SBO on how to most effectively handle eligibility and enrollment. The DCH could handle these functions directly, delegate the functions to another State agency, or contract with a private or nonprofit provider. Section 105c is separate from Section 105d and thus the provisions of Section 105c are not tied to whether Medicaid expansion was implemented or terminated.

Section 105d(15) would cap administrative costs for Medicaid at 1.0% of the DCH appropriation for Medicaid. After FY 2015-16, the administrative costs would be capped at the actual administrative expenses in FY 2015-16, with inflationary adjustments. Projects designed to achieve GF/GP savings in Medicaid would be exempt from the administrative cost cap. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Studies

Section 105d(9) would direct the Department of Insurance and Financial Services (DIFS) to examine financial reports from health insurers to determine the impact of Medicaid expansion on insurance rates and whether the expansion had reduced cost-shifting from uncompensated care to insurance rates. The DIFS would be directed to consider the information in the annual approval of insurance rates. The DIFS would have to report on each December 31, with a boilerplate report due by December 31, 2014, on the impact of Medicaid expansion on private insurance rates.

Section 105d(10) would direct the DCH to develop innovations and initiatives to improve the effectiveness of the Medicaid program, with a report due by September 30, 2015. As part of this process, the Department would have to study the value and cost-effectiveness of optional Medicaid services, compare private sector (especially small business) employee health care benefits to Medicaid, measure Medicaid's return on investment for taxpayers, evaluate the effectiveness of current incentives for Medicaid providers and beneficiaries, review and evaluate current Medicaid design principles, and identify private sector initiatives used to encourage compliance with medical advice.

State Savings and the Michigan Health Savings Fund

Section 105d(29)(b) defines "state savings" as net savings for any State fund and names programs from which State savings could occur (including the Adult Benefits Waiver, Community Mental Health non-Medicaid Services, and prisoner health care). Any savings from other State fund accounts would have to be proposed to the House and Senate Appropriations Committees for approval. The section would require that not less than 50% of the State savings be deposited in the Michigan Health Savings Fund established in the Department of Treasury to be used for Medicaid State matching requirements. The Michigan Health Savings Fund would have to be established through separate legislation.

FY 2013-14 Appropriation

Section 105e would make FY 2013-14 appropriations related to Medicaid expansion. These proposed appropriations include Federal funding for the expansion services, a mix of Federal and State funding for administrative costs, and GF/GP savings in the DCH and the Department of Corrections for various programs whose costs would be partially shifted to the Medicaid expansion line items.

Other Provisions

Section 105d(1)(g) would require that Medicaid expansion enrollees be informed about advance directives and be required to complete a DCH-approved advance directive on a form that would include an option to decline such a directive. Any directives received would be placed in the Peace of Mind registry established in Public Act 179 of 2012.

Section 105d(1)(h) would require that incentives be developed for enrollees who assisted the DCH in detecting Medicaid fraud and abuse, with a report to the Legislature.

Section 105d(4) would require the DCH to develop and implement a plan by the end of FY 2015-16 to enroll all Medicaid fee-for-service enrollees into contracted health plans if allowed by law and if Medicaid were an enrollee's primary payer. This section also would direct the DCH to pursue waivers necessary to implement the first phase of the dual-eligible waiver, which would provide for coordinated care for those dually eligible for Medicaid and Medicare, by July 1, 2014. In addition, Section 105d(4) would create long-term care performance bonus incentive plans of up to 3.0% of the capitation payments paid under the waiver. These provisions would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(6) would direct the DCH to work with health plans, providers, and other departments to create processes that would reduce the amount of uncollected co-pays and deductibles and reduce the administrative cost of collecting co-pays and deductibles. At least 0.25% of capitation payments would be withheld to create a cost-sharing compliance bonus pool starting in fiscal year 2015-16. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(13) would continue the contracted health plan performance bonus incentive pool for health plans providing physical health services established in boilerplate in the DCH budget. The section would take effect October 1, 2015, and provide more specifics on issues to be included in the measures, such as inappropriate use of emergency departments, ambulatory care, 30-day readmission rates, and generic drug use. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(16) would direct the DCH to require the contracted health plans to have procedures and metrics in place to ensure that contribution requirements were being met. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(17) would increase the withholding for the contracted health plans providing physical health services from the 0.19% defined in the DCH boilerplate to at least 0.75%. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(18) would establish, by October 1, 2015, a performance bonus incentive pool for the special prepaid health plans, that is, the Medicaid mental health managed care organizations. Among the criteria would be partnering with other contracted health plans to reduce nonemergency use of emergency department services, increased participation in patient-centered medical homes, increased use of electronic health records, and identification of enrollees who may be eligible for services through the Veterans Administration. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 105d(25) would make at least three years of Medicaid program data available to any qualified vendor interested in submitting proposals to contracted health plans to achieve health savings or improved outcomes through use of information and data management

technologies. Provision of data would not be considered a cost or contractual obligation to the DCH or to the State.

Section 105f would establish a Michigan Health Care Cost and Quality Advisory Committee consisting of eight members including Administration officials and the chairs and minority vice chairs of the Senate and House Health Policy Committees. By December 31, 2014, the Committee would have to issue a report with recommendations on the creation of a health care costs and quality database and consider legislation in other states as well as the impact of uncompensated care on insurance rates. This provision would take effect whether or not the waivers necessary to implement Medicaid expansion received Federal approval.

Section 107(2) would require the DCH to use a new measure, modified adjusted gross income (MAGI), to determine income eligibility. (This is one of the provisions specified in the ACA that is a mandate on the states.)

Also, as a general rule, the bill includes language requiring that all reports be made available on the executive branch's and legislative branch's internet websites.

MCL 400.105 et al.

BACKGROUND

Introduction

One of the key components of the ACA is expansion of the Medicaid program to cover individuals up to 133% of the FPL effective January 1, 2014.

While Medicaid provides health insurance to low-income individuals, there are many low-income individuals who are not eligible for the program. Both Medicaid and Medicare were designed as health insurance for individuals receiving payments under the Federal Social Security Act. Medicare was created to provide health insurance to people receiving Social Security payments. Medicaid was created to provide health insurance to people receiving Aid to Families with Dependent Children (AFDC or cash welfare) and Supplemental Security Income (SSI) disability payments.

While Medicaid, by providing health insurance to AFDC and SSI recipients, provided significant coverage to low-income individuals, the program did not provide coverage to all such individuals. Many low-income individuals are not eligible for AFDC or SSI.

Various expansions of Medicaid over the years, particularly targeted to families, especially children, provided more extensive coverage. Nevertheless, there is still a large cohort of low-income individuals who are not eligible: in particular, single non-SSI disabled adults and non-SSI disabled couples without children. Furthermore, the income eligibility level for many adults with children was very low, well under 50% of the FPL, so many who fit into a categorical eligibility category were excluded due to income.

The ACA was designed to greatly reduce the number of uninsured individuals. For uninsured individuals with greater incomes, a mandate to purchase insurance is included, along with tax credits and health insurance exchanges, to make it easier for individuals to afford and purchase insurance. The tax credits will be available to those between 100% and 400% of the FPL. For individuals with lower incomes, the ACA includes a provision to expand Medicaid to cover all those under 133% of the FPL. (In 2014, 133% of the FPL will be about \$15,500 for a single adult and about \$26,500 for a family of three.) Various estimates indicate that most of the uninsured individuals who will become insured due to the ACA will do so because of the Medicaid expansion, not as a result of the tax credits and health exchanges. The Congressional Budget Office has estimated a reduction of 30.0

million in the number of uninsured individuals due to the ACA, and projected that 17.0 million of that 30.0 million reduction would be due to the Medicaid expansion.

To avoid significant initial state costs, the Medicaid expansion will be 100% federally funded over the first three years, with the match rate dropping to 90% Federal by calendar year 2020 and thereafter. This effectively eliminates state costs for the program, other than potential administrative costs, over the first three years and limits state costs even after the Federal match rate begins to drop.

The ACA made states' funding for their regular Medicaid programs contingent on the states agreeing to the expansion. In other words, if a state chose not to expand Medicaid, that state would lose the Federal match for its "regular" Medicaid program. As this would mean the loss of billions of Federal support (about \$9.0 billion in Federal Medicaid match in Michigan alone), states would have had little option but to expand.

The U.S. Supreme Court in June 2012 largely upheld the ACA. There was one key provision that was struck down – the financial penalty to states that refused to expand Medicaid. Past Supreme Court decisions allowed for Federal financial incentives that served as "nudges" (such as a 5% reduction in Federal transportation funding to states that did not raise their drinking ages to 21). The Supreme Court ruled that the threatened loss of 100% of Medicaid match revenue went beyond a "nudge" and constituted "economic dragooning".

Therefore, states have the option to decide whether to expand Medicaid. States are still in the process of making decisions. The Kaiser Family Foundation, as of July 29, 2013, estimated that Medicaid expansion was "moving forward" in 24 states (including Washington D.C.), and that it was "not moving forward" in 21 states, with six states, including Michigan, having ongoing debate. <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

The Situation in Michigan

Governor Rick Snyder proposed expanding Medicaid in his FY 2013-14 budget proposal, which was released on February 7, 2013. The Governor included assumed GF/GP savings of \$205.9 million due to implementation. The savings would result from the shifting of GF/GP-funded indigent health care services, in particular Community Mental Health (CMH) non-Medicaid services, to the expanded Medicaid program. The Senate Fiscal Agency, in a paper published in March 2013 (cited below), agreed with the estimated savings over the first few years, though the SFA projected lower savings and greater costs several years down the road.

The Governor's proposal for Medicaid expansion was not included in the House and Senate versions of the FY 2013-14 DCH budget, nor was it included in the Conference Report signed recently by the Governor. Various members of the Legislature who opposed expansion expressed concern about the reliability of Federal funding, the addition of hundreds of thousands of new clients to Medicaid, and the long-term sustainability of the Medicaid program.

Failure to include the expansion in the budget bill does not preclude a statute to implement some form of Medicaid expansion nor does it preclude a supplemental appropriations bill to make appropriations adjustments reflecting the fiscal impact of Medicaid expansion. A statute is not necessary to implement expansion; the Governor's budget included funding and boilerplate language but no statute. The advantage of a statute, according to proponents, is that it would remove the debate over whether to expand Medicaid from the budgetary process. The disadvantage is that a statute could reduce the ability of the State to make adjustments to the program.

Federal Flexibility

Due to the Supreme Court decision, the Federal government, through the Department of Health and Human Services (HHS) and its subsidiary agency, the Centers for Medicare and Medicaid Services, has had to shift from implementing Medicaid expansion in all states to finding ways to encourage states to choose to expand Medicaid.

As an example, Arkansas passed legislation expanding Medicaid, but only after discussions with the HHS about a waiver to allow "expansion Medicaid eligibles" to use the expansion Medicaid dollars to purchase private insurance from the health exchanges. While the terms of such a waiver have not yet been agreed to, it does appear that the HHS will not insist on a traditional fee-for-service or managed care Medicaid model in Arkansas. There are recent reports that the Commonwealth of Pennsylvania will seek a waiver similar to the Arkansas proposal.

Alternative Approaches in Michigan

The discussions in Arkansas and other states have led some policymakers in Michigan to discuss seeking a nontraditional approach in Michigan, one that would require a waiver from the HHS.

During May 2013, there were discussions among Michigan legislators about an approach for the expansion population that would differ from traditional Medicaid. Two of the key elements were incentives for recipients who took actions correlated with better health outcomes and a transition to a health savings account (HSA) approach to coverage. An HSA approach would involve the deposit of premium revenue from the client as well as State money into an account that the client could use to cover initial health expenses, with full Medicaid coverage kicking in after the HSA funding was exhausted. Such provisions would require Federal waivers, though it did appear, based on discussions with the HHS, that the HHS would give the waiver requests serious consideration.

On May 9, 2013, Representative Matt Lori introduced House Bill 4714. The bill included the incentives and HSA approach, but added two new provisions: a 48-month time limit for nondisabled adults and extension of the incentives, health savings account approach, and time limit to nondisabled adults in the traditional Medicaid population.

There were concerns that the HHS would not support any waiver with a tight time limit, so discussions continued between House members and the Snyder Administration.

After weeks of discussion and hearings, the House of Representatives adopted a revised version of House Bill 4714 on the evening of June 13, 2013. A Senate workgroup chaired by Senator Roger Kahn recommended a newly revised version of House Bill 4714 on July 24, 2013.

FISCAL IMPACT

In March 2013, the SFA published an extensive paper on the fiscal impact of Medicaid expansion in Michigan: <http://www.senate.michigan.gov/sfa/Publications/Issues/MedicaidExpansion/MedicaidExpansionProposal.pdf> The SFA believes that the estimates in that paper also generally apply to HB 4714 (S-7) as written.

To summarize the SFA findings, the SFA concurred with the Executive estimate that Medicaid expansion would result in over \$200.0 million in GF/GP savings in FY 2013-14 and over \$270.0 million in GF/GP savings in FY 2014-15. The major factor in this savings would be a significant reduction in CMH non-Medicaid costs as most of the CMH non-Medicaid clients would be eligible for expansion Medicaid. Due to revisions in the administrative

start-up costs, the savings in FY 2013-14 would more likely be in the range of \$190.0 million GF/GP.

As the Federal match rate declines from 100.0% to 90.0%, State costs would begin to increase. The SFA estimates that State costs would exceed State savings for the first time in FY 2019-20. By FY 2027-28 the SFA estimates that State costs would exceed State savings by over \$200.0 million GF/GP. It should be noted, though, that FY 2027-28 would be the first year in which cumulative State costs, going back to FY 2013-14, would exceed cumulative State savings. Therefore, it is the SFA's belief that cumulative State costs would not exceed cumulative State savings for the first 15 years of Medicaid expansion.

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