

HEALTHY MICHIGAN PLAN WORK REQUIREMENTS AND PREMIUM PAYMENT REQUIREMENTS

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Senate Bill 897 (H-2) as passed by the House
Sponsor: Sen. Mike Shirkey
House Committee: Appropriations
Senate Committee: Michigan Competitiveness
Complete to 6-7-18

Analysis available at
<http://www.legislature.mi.gov>

(Enacted as Public Act 208 of 2018)

SUMMARY:

Senate Bill 897 would amend the Social Welfare Act to add workforce engagement requirements for able-bodied adults enrolled in the Healthy Michigan Plan. The bill prescribes which recipients would have to meet workforce engagement requirements, activities that would count toward workforce engagement, and penalties for noncompliance.

The bill would also replace the current Healthy Michigan Plan “Marketplace Option” with the requirement that HMP enrollees with income between 100% and 133% of federal poverty and who have been enrolled for 48 months to complete a health risk assessment and pay a premium of 5% of income as a condition on remaining enrolled in the Healthy Michigan Plan.

Finally, the bill would create a set of triggers to terminate the Healthy Michigan Plan if a revised second waiver is not approved by the federal Centers for Medicare & Medicaid Services (CMS). The bill is described in more detail below.

DETAILED SUMMARY:

Workforce Engagement Requirements

By October 1, 2018, the bill would require the Department of Health and Human Services (DHHS) to submit a Medicaid demonstration waiver application to CMS under Section 1115 of the federal Social Security Act that would do all of the following:

- Require an average of 80 hours per month of qualifying work activities.
- Require able-bodied adults to verify qualifying work activities by the tenth of each month through the online MiBridges information system.
- Require exemptions from the workforce engagement requirements for the following Healthy Michigan Plan¹ recipients:
 - Individuals age 20 and under who have previously been placed in foster care.
 - Individuals age 63 and 64.

¹ Individuals have to be between the ages of 19 and 64 to qualify for Healthy Michigan Plan, so exemptions are not required for individuals younger than 19 and older than 64.

- Pregnant women.
- Individuals who have a disability that makes him or her eligible for Medicaid (i.e. individuals commonly referred to as Disabled, Aged, Blind (DAB) Medicaid recipients).
- Caretakers of a family member under the age of 6, with only 1 parent allowed to claim this exemption.
- Caretakers of a disabled dependent, with only 1 individual per household allowed to claim this exemption.
- Caretakers of an incapacitated individual.
- Individuals receiving temporary or permanent disability benefits from a private insurer or the government.
- Full-time students, who are not dependents of a parent or guardian or whose parent or guardian qualifies for Medicaid.
- Individuals who are designated as medically frail.
- Individuals who have a medical condition that results in a work limitation according to a licensed medical professional.
- Individuals who have proven to meet the good cause temporary exemption.
- Individuals who have been incarcerated within the last 6 months.
- Recipients of state unemployment benefits.
- Allow court-ordered, prescribed, or Medicaid-funded substance use disorder treatment to count toward the workforce engagement requirements if the treatment impedes an individual's ability to meet the requirements.
- Require community service to be completed with a nonprofit organization and for community service to only count as a qualifying activity for up to 3 months in a 12-month period.
- Require a recipient who is also a recipient of the Supplemental Nutrition Assistance Program (known in Michigan is the Food Assistance Program) or the Temporary Assistance for Needy Families program (known in Michigan as the Family Independence Program) who is either compliant or exempt from that program's workforce engagement requirements to be considered compliant with or exempt from the Healthy Michigan Plan workforce engagement requirements.
- Allow a recipient to have 3 months of noncompliance in a 12-month period. After that, the recipient would lose coverage for at least 1 month and would not be allowed to reenroll until he or she becomes compliant.

The bill defines qualifying work activities as any of the following:

- Employment or self-employment, or having income consistent with being employed or self-employed, which would mean making at least minimum wage for an average of 80 hours per month.
- Education, including high school equivalency test preparation and postsecondary education.
- Job training.
- Vocational training.
- Unpaid workforce engagement, including internships.
- Tribal employment programs.

- Participation in substance use disorder treatment.
- Community service.
- Job search directly related to job training.

The bill defines good cause temporary exemptions as any of the following:

- The recipient is an individual with a disability as described under the federal Americans with Disabilities Act of 1990, The Rehabilitation Act of 1973, or the Patient Protection and Affordable Care Act who is unable to meet the workforce engagement requirements related to that disability.
- The recipient has an immediate family member in the home with a disability and is unable to meet the workforce engagement requirements for reasons related to the disability of the family member.
- The recipient, or a family member who resides in the home, experiences hospitalization or serious illness.

DHHS would have to implement the Healthy Michigan Plan workforce engagement requirements as outlined in the waiver requirements listed above and to notify able-bodied adults 90 days in advance of the implementation date of January 1, 2020. The bill would also prohibit DHHS from withdrawing, terminating, or amending the waiver, or any subsequent waivers needed to prevent the waiver from lapsing, without the express approval of the legislature through a change in state statute.

DHHS would have to enforce the Healthy Michigan workforce engagement requirements through a compliance review process. The compliance review process would identify who, through self-attestation in MiBridges, misrepresented his or her compliance. A recipient who is found to have misrepresented his or her compliance would be excluded from the Healthy Michigan Plan for 1 year.

The bill would require the initial implementation costs of the workforce engagement requirements and up to \$5.0 million in ongoing administrative costs of the workforce engagement requirements to not be considered when determining the cost-benefit analysis required in Section 105d for the purposes determining whether state and other nonfederal net savings are sufficient to cover the cost of the reduced federal match for the Healthy Michigan Plan. By January 1, 2020 the federal match for the Healthy Michigan Plan will be 90%.

The bill would permit DHHS to first direct recipients to existing job training resources, child care, transportation, and other supports and would allow DHHS to develop strategies for assisting able-bodied adults meet the Healthy Michigan Plan workforce engagement requirements.

The bill would require DHHS to notify the Governor and the legislature when the waiver is submitted. DHHS would have to conduct surveys to determine the number of individuals no longer receiving Healthy Michigan Plan benefits as a result of obtaining both employment and medical benefits and the number and type of exemptions granted.

Healthy Michigan Plan Second Waiver

Current statute required DHHS to submit a second Healthy Michigan Plan waiver on September 1, 2015 and for that waiver to be approved by CMS by December 31, 2015. As written, state statute requires Healthy Michigan Plan recipients with income between 100% and 133% of federal poverty who have received Healthy Michigan Plan coverage for 48 months to choose 1 of 2 options:

1. Change their Healthy Michigan Plan eligibility status so that he or she is considered eligible for the federal advance premium tax credit and cost-sharing subsidies through the federal health care exchange (i.e. “Marketplace Option”).
2. Remain covered through the Healthy Michigan Plan, but at increased cost sharing of up to 7% of income.

The approved second Healthy Michigan Plan waiver became effective on April 1, 2018 and requires Healthy Michigan Plan enrollees, who are not medically frail and who have been enrolled for at least 12 months to either complete a health risk assessment or to migrate to a qualified health plan offered through the Marketplace (i.e. the “Marketplace Option”). The state-federal fund sourcing remain the same whether the Healthy Michigan Plan enrollee retains traditional coverage or receives coverage through the “Marketplace Option”.²

The two significant differences between how the second waiver was agreed to by DHHS and CMS and how statute is written are:

1. The approved second waiver continues to require state matching funds, rather than federal advance premium tax credit and cost-sharing subsidies, if an individual receives coverage through the federal exchange.
2. The approved second waiver does not permit increased cost sharing for traditional coverage of up to 7% of income. Instead cost sharing remains at up to 5% of income through the requirement that an individual complete health risk assessment, with its corresponding cost sharing reductions, in order to retain traditional coverage.

The bill would replace those 2 options with the requirement that Healthy Michigan Plan recipients, with income between 100% and 133% of federal poverty who have received Healthy Michigan Plan coverage for 48 months, complete a health behavior assessment with intentional effort to make the healthy behaviors incrementally more challenging and pay a premium of 5% of income. If an individual does not comply with these two conditions, his or her Healthy Michigan Plan coverage would be suspended.

Additionally, the bill would replace the current trigger to terminate the Healthy Michigan Plan if the second waiver was not approved by CMS before December 31, 2015 with new termination triggers related to the revised second waiver. The bill would require the Healthy Michigan Plan to terminate coverage under any of the following 4 scenarios: if the waiver is not approved by CMS within 12 months of submission; if the waiver is denied by CMS and a new or amended waiver after denial is not approved by CMS within 12 months of submission; if the waiver is subsequently canceled or invalidated by CMS and

² More information on the second waiver can be found here: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797-355639--00.html

a new or amended waiver after cancelation or invalidation is not approved by CMS within 12 months of submission; and if the waiver is approved by CMS but does not comply with state statute related to the Healthy Michigan Plan. Under each of these 4 scenarios, Healthy Michigan Plan recipients would be given a 4 months' notice that Healthy Michigan Plan coverage would be terminated.

The bill would require the annual state and other nonfederal net savings calculation be published by the State Budget Office annually on January 15. The bill would also require the Healthy Michigan Plan to end at the end of the fiscal year if this calculation is not sufficient to cover the reduced federal match. Current law already requires Healthy Michigan Plan to end under such a scenario, but does not include a specific end date.

The bill would also make various technical edits to reflect the federal approval of the first 2 Healthy Michigan Plan waivers and actions already undertaken by DHHS.

The bill would take effect 90 days after enactment.

MCL 400.105d, Proposed MCL 400.107a, and Proposed MCL 400.107b

BACKGROUND:

A March 14, 2017 letter³ and a January 11, 2018 policy guidance⁴ from CMS indicated their openness in allowing states to test, through a Section 1115 demonstration waiver, the hypothesis that work and community engagement activities can improve a Medicaid recipient's health and well-being and can promote independence and self-care.

Since that time, 4 states (Arkansas, Indiana, Kentucky, and New Hampshire) have had Section 1115 Medicaid work requirement demonstration waivers approved, and there are a number of other states either with pending waiver applications or debating submitting a waiver application.

FISCAL IMPACT:

Taken all together, Senate Bill 897 would lead to an estimated net state savings of between \$7 million and \$22 million annually. The fiscal impact for the workforce engagement requirements and second waiver requirements are discussed separately below.

Workforce Engagement Requirements

Senate Bill 897 would likely lead to a nominal amount of upfront, one-time administrative costs, but once the Healthy Michigan Plan workforce engagement requirements are fully implemented, would lead to an estimated net state savings of between \$5 million and \$20 million annually. Without actual experience from other states (and with other state fiscal impacts varying significantly), there is not data with which to provide a more precise state fiscal impact.

³ Found here: <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>

⁴ Found here: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>

The most significant fiscal impact would be the forecasted decline in Healthy Michigan Plan caseloads. There are approximately 670,000 able-bodied adult Healthy Michigan plan recipients, with an estimated 130,000 (or 20%) adults qualifying for an exemption and 540,000 non-exempt, able-bodied adult Healthy Michigan Plan recipients. House Fiscal Agency estimates a decline of 5% to 10% in the number of non-exempt, able-bodied adult Healthy Michigan Plan recipients.⁵ This estimate is based on the following:

- Other state forecasted caseload reductions ranging from 5% to 15%.
- This bill requiring the same amount of work per month as in the states with an approved demonstration waiver.
- This bill having similar noncompliance penalties as used in the states with an approved demonstration waiver.
- The reliance of self-attestations to determine compliance should lessen any caseload decline.

Once fully implemented, at an average annual cost per case for a Healthy Michigan Plan recipient of \$5,500, Healthy Michigan Plan costs would decline by an estimated \$147.4 million to \$294.8 million Gross (\$14.7 million to \$29.5 million GF/GP). The state share of any Healthy Michigan Plan caseload decline, beginning January 1, 2020, would be 10%. The state match requirement for the Healthy Michigan Plan remains at 10% thereafter and does not change annually like the traditional Medicaid federal medical assistance percentage (FMAP) does.

The other significant fiscal impact would be the added administrative casework and information technology updates required to verify hours worked, qualifying exemptions, and other casework each month for the approximately 670,000 Healthy Michigan Plan recipients. Other state fiscal estimates for added administrative costs have ranged from as low as \$17.5 million to as high as \$70.0 million. This range varies significantly because of the different ways in which this added casework can be verified (e.g. automated reporting and self-attestations require less administrative casework than other ways to verify information).

This bill would rely on self-attestations through the online MiBridges information system, so most of the administrative costs would be related to increased call center demand for individuals who do not have access to the internet. The customer services representative at the call center would then be responsible for entering the qualifying work activities into MiBridges. The other significant administrative cost would be the requirement to use a compliance review process to identify Healthy Michigan Plan recipients who misrepresented their workforce engagement compliance in MiBridges. Since this bill would rely on compliance methods that do not require significant administrative casework and with DHHS's recent experience with adding monthly work requirements for able-bodied adults without dependents on the Food Assistance Program without receiving additional state appropriations for casework or information technology updates. House Fiscal Agency estimates the state administrative costs of this bill to be on the lower end of

⁵ A 27,000 to 54,000 caseload decline would reduce total Healthy Michigan Plan caseloads by 4% to 8%.

the range listed above at approximately \$20.0 million Gross (\$10.0 million GF/GP) in ongoing administrative costs.

The one-time information technology costs would most likely not exceed \$10 million Gross (\$1.0 million GF/GP) as this bill closely mirrors other forms of public assistance work requirements.

With a reduction in Medicaid expenditures, state health insurance assessment revenues would have a corresponding reduction to the extent that Healthy Michigan Plan expenditures are not offset by additional health insurance claims from Healthy Michigan Plan recipients who would now receive or purchase other health insurance. With the likelihood that the Health Insurance Claims Assessment (HICA) will be replaced with a new Insurance Provider Assessment (IPA) that would have a variable assessment on Healthy Michigan Plan member months, it is unknown at this time what the reduction in state health insurance assessment revenues would be but would likely be nominal.

There also are a number of support service programs, such as child care and workforce development, that could see an increase in the demand for those support services. These programs are predominately federally funded, so this increased demand should not have a significant state fiscal impact.

Healthy Michigan Plan Second Waiver

A mandatory 5% premium payment for Healthy Michigan Plan recipients, with income between 100% and 133% of federal poverty who have received Healthy Michigan Plan coverage for 48 months, would increase net premium collections by nearly \$20 million Gross, of which \$2.0 million would constitute state GF/GP savings.

House Fiscal Agency assumes between 35,000 and 25,000 of the approximately 125,000 Healthy Michigan Plan recipients with income between 100% and 133% of federal poverty have received Healthy Michigan Plan coverage for 48 months or more, as approximately 40% of the recipients are new to the program annually.

Presently, Healthy Michigan Plan recipients, with income between 100% and 133% of federal poverty, are required to contribute 2% of income (in addition to co-pay requirements) and can receive a 50% reduction if they complete a health risk assessment. The most recent 12-month total of owed contributions was \$16.4 million. Additionally, DHHS only collects 30% (or \$5.1 million annually) of the required contributions,⁶ as the approved federal waiver expressly prohibits Healthy Michigan Plan coverage from being suspended for nonpayment.

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.

⁶ The March 2018 MI Health Account summary is found here:
https://www.michigan.gov/documents/mdhhs/MIHA_Monthly_Exec_Summary_Report_506215_7.pdf