

Issue Paper

PAPERS EXAMINING CRITICAL ISSUES
FACING THE MICHIGAN LEGISLATURE



FISCAL ANALYSIS OF THE FEDERAL HEALTH REFORM LEGISLATION

by

Steve Angelotti, Fiscal Analyst
David Fosdick, Fiscal Analyst

April 2010



Gary S. Olson, Director – Lansing, Michigan – (517) 373-2768 – TDD (517) 373-0543
www.senate.michigan.gov/sfa

Senate Fiscal Agency

THE SENATE FISCAL AGENCY

The Senate Fiscal Agency is governed by a board of five members, including the majority and minority leaders of the Senate, the Chairperson of the Appropriations Committee of the Senate, and two other members of the Appropriations Committee of the Senate appointed by the Chairperson of the Appropriations Committee with the concurrence of the Majority Leader of the Senate, one from the minority party.

The purpose of the Agency, as defined by statute, is to be of service to the Senate Appropriations Committee and other members of the Senate. In accordance with this charge the Agency strives to achieve the following objectives:

1. To provide technical, analytical, and preparatory support for all appropriations bills.
2. To provide written analyses of all Senate bills, House bills and Administrative Rules considered by the Senate.
3. To review and evaluate proposed and existing State programs and services.
4. To provide economic and revenue analysis and forecasting.
5. To review and evaluate the impact of Federal budget decisions on the State.
6. To review and evaluate State issuance of long-term and short-term debt.
7. To review and evaluate the State's compliance with constitutional and statutory fiscal requirements.
8. To prepare special reports on fiscal issues as they arise and at the request of members of the Senate.

The Agency is located on the 8th floor of the Victor Office Center. The Agency is an equal opportunity employer.



Gary S. Olson, Director
Senate Fiscal Agency
P.O. Box 30036
Lansing, Michigan 48909-7536
Telephone (517) 373-2768
TDD (517) 373-0543

Internet Home Page <http://www.senate.michigan.gov/sfa>

ACKNOWLEDGMENTS

The authors wish to thank Matt Grabowski, SFA Fiscal Analyst, for his input on this paper. Thanks are also extended to Wendy Muncey of the Senate Fiscal Agency for her assistance in finalizing this report.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
Caveats	3
Overview	3
SUMMARY OF FISCAL IMPACT	4
MEDICAID AND RELATED PROVISIONS	
Expansion of Medicaid.....	5
Medicaid Primary Care Rate Increase.....	7
MI-Child Changes	7
Medicaid Pharmaceutical Changes	7
Medicaid Long-Term Care Provisions	8
Maintenance of Effort.....	8
Other Medicaid Provisions	9
Impact on Public Hospitals of the DSH and Other Adjustments	10
GROUP INSURANCE CHANGES	
Effects of Group Insurance Changes on State and Local Government.....	10
CONCLUSION	12

INTRODUCTION

In March 2010, the United States Congress passed and President Barack Obama signed two acts, the Patient Protection and Affordability Care Act and the Health Care and Education Responsibility Act of 2010. For purposes of this document, these acts will be referred to as "Federal health reform".

The Federal health reform legislation seeks to expand access to health services through the creation of new Federal mandates upon individuals and businesses and modifications in the structure of publicly provided health benefits as well as the individual and group health insurance markets.

The Federal health reform legislation requires all U.S. citizens and legal aliens in the United States to have a qualifying health care plan. Individuals who do not have a qualifying health care plan are subject to a Federal tax penalty. The reform legislation provides subsidies and tax credits to individuals with incomes up to 400% of the Federal poverty level (FPL).

The legislation further assesses a fee upon businesses with 50 or more employees that do not provide health care coverage. Small businesses, defined as those with 25 or fewer employees, are eligible for tax credits to assist with the purchase of health coverage.

The Federal health reform plan funds an expansion of the Medicaid program to include all adults under 133.0% of the FPL. This expansion would begin in 2014 with no state financial participation until 2017. States would be required to provide 10.0% match funding for this expansion population by 2020. The expansion in Medicaid coverage is coupled with requirements that states refrain from eliminating Medicaid coverage for currently covered optional eligibility groups before 2014.

The Federal health reform legislation mandates the creation of health insurance exchanges. These entities, administered at the state level by a public or nonprofit organization, would offer health coverage to individuals and small businesses. The exchanges would offer five plans, with varying levels of benefits, largely described in the legislation, in the individual and small group insurance market.

The legislation imposes a number of new regulations upon insurers. It requires that insurers issue and renew coverage to all individuals seeking insurance and limits the size and reason for variation in rates imposed upon individuals. The legislation prohibits health insurance plans from imposing annual or lifetime dollar limits on provided coverage and from excluding health coverage to an individual because of a pre-existing condition.

The Federal health reform legislation includes a number of policy and tax changes intended to offset anticipated cost increases. Major savings or revenue-generating items included in the legislation are associated with reductions in provider reimbursement through Medicare, significant cuts in disproportionate share hospital (DSH) payments to hospitals in Medicare and Medicaid, new fees for health insurers and pharmaceutical manufacturers, and an excise tax on high-cost insurance. The Congressional Budget Office has assumed that the legislation will provide health coverage for an additional 32.0 million individuals by 2019 with a 10-year cost of \$938.0 billion. [Table 1](#) lists key provisions in the legislation and a timeline for implementation.

Table 1
Summary of Health Care Reform Provisions with Implementation Time Line

	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>
<u>Medicaid Provisions</u>											
Medicaid to 133% FPL					X	X	X	X	X	X	X
Federal match rate					100%	100%	100%	95%	94%	93%	90%
Maintenance of Effort	X	X	X	X	X	X	X	X	X	X	X
Increase Physician Rates				X	X						
Increase SCHIP Match						X	X	X	X	X	X
Reduce Medicaid DSH					X	X	X	X	X	X	X
More Pharm. Rebates	X	X	X	X	X	X	X	X	X	X	X
Medical Home Option		X	X	X	X	X	X	X	X	X	X
LTC Community Services		X	X	X	X	X	X	X	X	X	X
HCBS Enhanced Match			X	X	X	X					
<u>Insurance Market Changes</u>											
Cover Dependents to 26	X	X	X	X	X	X	X	X	X	X	X
Eliminate lifetime limits	X	X	X	X	X	X	X	X	X	X	X
Eliminate annual limits					X	X	X	X	X	X	X
Pre-existing conditions, kids	X	X	X	X	X	X	X	X	X	X	X
Pre-existing conditions, all					X	X	X	X	X	X	X
3-1 maximum ratio for age					X	X	X	X	X	X	X
Reduce wait periods to 90 days					X	X	X	X	X	X	X
Justify rate increases	X	X	X	X	X	X	X	X	X	X	X
<u>Coverage Expansion Provisions</u>											
Individual Mandate					X	X	X	X	X	X	X
Minimum fine					\$95	\$325	\$695	COLA	COLA	COLA	COLA
Maximum fine					\$285	\$975	\$2,085	COLA	COLA	COLA	COLA
Employer Mandate (>50 workers)					X	X	X	X	X	X	X
Premium Credits/subsidies					X	X	X	X	X	X	X
Temporary Reinsurance	X	X	X	X							
Temp. High Risk Pool	X	X	X	X							
Temp. Individual Reinsurance					X	X	X				
State-based exchanges					X	X	X	X	X	X	X
<u>Medicare Provisions</u>											
Medicare Advantage changes		X	X	X	X	X	X	X	X	X	X
Threshold for Medicare Premiums		X	X	X	X	X	X	X	X	X	X
Medicare DSH reduction					X	X	X	X	X	X	X
Long term care insurance program		X	X	X	X	X	X	X	X	X	X
Phase out of Part D "donut hole"	X	X	X	X	X	X	X	X	X	X	X
<u>Revenue Provisions</u>											
Medical expense threshold, Part A tax for high incomes, employer Part D deduction				X	X	X	X	X	X	X	X
Pharmaceutical firm fees		X	X	X	X	X	X	X	X	X	X
Health insurer fees					X	X	X	X	X	X	X
Medical devices tax				X	X	X	X	X	X	X	X
Tax on high-cost policies								X	X	X	X
Tanning tax	X	X	X	X	X	X	X	X	X	X	X

Source: NCSL

The purpose of this analysis is to examine the fiscal impact of the Federal health reform legislation on State and local government in Michigan. The analysis will not delve into the merits of the legislation, nor will it examine the fiscal impact of the legislation on the Federal budget or nongovernmental entities.

Caveats

There are many risks to providing a fiscal analysis of legislation as complex as the Federal health reform. Many of the changes will result in secondary rather than primary effects; this applies in particular to the changes to insurance markets. Even after full implementation, attempts to ascertain the specific effects of such policy changes will face a "signal-to-noise" ratio problem. (Technically, a signal-to-noise ratio measures how signal has been corrupted by noise.) For example, if group health insurance costs increase by 5.0% from 2014 to 2015, does that mean the legislation reduced costs because group insurance costs otherwise would have increased by 6.0%? Or does it mean that the legislation increased costs because group insurance costs otherwise would have increased by 4.0%? Estimating what the cost increase would have been without the legislation will be difficult, if not impossible.

Even the estimates of the direct fiscal impact on State and local government will be of varying reliability. While one can probably eventually provide a solid estimate of the cost of the expanded Medicaid coverage, as well as the savings from shifting individuals from State-funded programs to the Medicaid expansion population, the cost of other provisions will be more difficult to estimate.

This difficulty is for two reasons beyond that of developing a direct estimate: first, some of the changes will depend on interpretation of rules. For instance, it is not clear whether the DSH funded "county care" programs are subject to the maintenance of effort provisions, even though the people who would receive coverage are not an eligibility group per se. The second problem is that states will likely make choices based on the incentives in the legislation, in particular the incentives for the expansion of community-based care and the increase in Medicaid physician rates. It is not in the purview of this analysis to forecast what are, at root, political decisions made by state governments.

Therefore, this analysis will focus on the general fiscal impact of the Federal health reform legislation, with the caveat that many of these numbers are imprecise and impossible to estimate with a high level of certainty.

Overview

There are several ways in which the Federal health reform legislation would affect State and local government. Most obviously, the State government is a major provider of medical coverage to low-income individuals through the State's Medicaid program, the State's MI-Child program, and various programs that provide medical services to low-income individuals who are not eligible for Medicaid. Furthermore, local governments provide funding to support various services for low-income individuals not eligible for Medicaid through county-based medical programs.

Second, there are hospitals that are owned by local units of government whose finances would be affected by the provisions of the Federal legislation.

Finally, both the State and local governments are employers and provide health insurance coverage to their employees. The changes to group health insurance included in the Federal legislation will have an impact on the cost of employer-provided group health insurance.

For the purposes of this analysis, the base Medicaid match rate for years after fiscal year (FY) 2010-11 is assumed to be 66.67%. The base Medicaid match rate for FY 2010-11 is 65.79% and it is expected to increase because Michigan's economy has underperformed the rest of the nation's economy. This match rate means that for every \$1 the State spends, it gets \$2 in Federal match funding.

This is a very preliminary analysis based on information from other sources that also are trying to sort through the details. It draws heavily on information from the National Conference of State Legislatures (NCSL), the Congressional Budget Office (CBO), the United States Census, the Kaiser Family Foundation, and Federal Funds Information for States. As discussions proceed with Federal agencies, public policy entities, and others in Michigan's government, there likely will emerge a more accurate and useful consensus on the impact of the legislation on State and local government in Michigan.

SUMMARY OF FISCAL IMPACT

The impact of the Federal health reform legislation on State and local government is a highly complex question. It is impossible to provide a specific estimate of the impact, as there would be considerable secondary effects tied to behavioral changes by individuals and governmental and private entities.

Even with full implementation of the legislation, separating the specific costs and savings would be nearly impossible. Many of the cost changes would be part of the expenditure trend and the signal-to-noise ratio would make it impossible to separate the impact of the legislation from the overall trend line.

What can be stated is that the Medicaid provisions, for the most part, would have limited impact on State expenditures before the expansion of Medicaid coverage to all people under 133.0% of the Federal poverty level in 2014. The Federal government would cover 100.0% of the costs for the expansion population in 2014, with that match rate decreasing to 90.0% by 2020.

- The 2014 Medicaid expansion would not have any initial State costs. By 2020, the State would be paying roughly \$200.0 million General Fund/General Purpose (GF/GP) yearly to support the costs of the expansion.
- The State would see major savings, beginning in 2014, in the Community Mental Health (CMH) non-Medicaid line, as many people served by this line would become covered by Medicaid. The yearly savings from that change would be in the range of \$150.0 million or more GF/GP.
- The initial 100.0% match rate, combined with the CMH non-Medicaid savings, would mean the expansion would lead to net GF/GP savings to the State beginning in 2014 and over the first few years.
- The legislation would mandate an increase in Medicaid primary care physician payment rates to Medicare levels. While this provision, which would be in effect in 2013 and 2014, would be 100.0% Federally funded, there is the possibility that the State would choose to continue funding the rate increase in 2015 and beyond, with an annual GF/GP cost of roughly \$40.0 million.
- The MI-Child match rate, beginning in FY 2015-16, would increase by 23.0%, which would reduce annual State costs by roughly \$12.0 million GF/GP.

- The legislation's various long-term care (LTC) provisions would provide incentives, via enhanced match rates, for states to expand the use of community-based care. If Michigan opts to expand these services, there would be a net GF/GP cost increase in spite of the enhanced match rate.
- The legislation's maintenance of effort requirements would bar the State from eliminating coverage for optional Medicaid eligibility groups such as Group 2 caretaker relatives and Group 2 19- and 20-year-olds. While this would not affect the status quo in Michigan, it would bar coverage eliminations such as the \$9.8 million GF/GP savings assumed from coverage eliminations in the Senate-passed FY 2010-11 Department of Community Health budget bill. Furthermore, the Governor's proposed FY 2010-11 enrollment freeze for the Adult Benefits Waiver may not be permitted either.
- The legislation offers incentives to states to promote healthy lifestyles, to set up health care homes for those with chronic conditions, and to expand preventive services. Each of these could have a relatively minor impact on State expenditures.
- The legislation's reductions in Medicaid and Medicare disproportionate share hospital (DSH) payments would have an impact on public hospitals, in particular University Hospital in Ann Arbor and Hurley Hospital in Flint. While their uncompensated costs, which are in the range of \$70.0 million combined, would decrease significantly with the expansion of coverage, their Medicaid and Medicare DSH payments also would decrease significantly.
- The changes to group insurance, in particular the requirement in 2010 for employers to cover dependent children up to age 26 on parents' insurance policies, could increase State and local government costs up to \$20.0 million, with some offsetting savings to the extent that some dependent children up to age 26 who are currently on Medicaid obtain private coverage.

MEDICAID AND RELATED PROVISIONS

Expansion of Medicaid

The most notable Medicaid change in the Federal legislation is an expansion of Medicaid coverage to all individuals with incomes less than 133.0% of the Federal poverty level, which is just over \$14,000 for an individual and just over \$19,000 for a two-person household.

The group that would benefit from this expansion is nondisabled childless adults. The Granholm Administration has estimated that this expansion would add 375,000 individuals to the Medicaid program, and this appears to be a reasonable estimate. At present, the only nondisabled childless adults eligible for Medicaid are those well under 50.0% of the FPL. The main eligibility categories for Medicaid and MI-Child are children and pregnant women up to 200.0% of the FPL, low-income elderly and disabled individuals, and cash welfare recipients. Single adults and couples without children represent the largest uncovered low-income population, and the Federal legislation would provide coverage for them.

This expansion would take effect in 2014 and be 100.0% Federally funded for the first three years. After that, the states would begin to pay a portion of the cost, with the state share climbing to 10.0% by 2020.

Federal Funds Information for States (FFIS) has estimated the Gross cost of the Medicaid expansion in Michigan to be \$1.8 billion by 2017 and \$2.0 billion by 2019. One may assume an initial Gross cost, when the coverage takes effect in 2014, of about \$1.5 billion. As noted, the

expansion would be 100.0% Federally funded from 2014 to 2016; therefore, there would be no State match cost. The Federal Match rate for this population would decline from 100.0% in 2016 to 95.0% in 2017, 94.0% in 2018, 93.0% in 2019, and 90.0% in 2020 and beyond. By 2020 and in subsequent years, the State would have to cover 10.0% of the cost, or somewhere in the range of \$200.0 million GF/GP per year.

This match cost does not cover the entire picture, however. While FFIS estimates that Michigan's share of the expansion costs would increase from \$0 to \$89.0 million GF/GP in 2017, the State spends a considerable amount of GF/GP funding, without a Federal match, on services to people who would become eligible for Medicaid under the legislation. In particular, in FY 2009-10, the State appropriated \$287.5 million GF/GP for Community Mental Health (CMH) non-Medicaid services.

While it is difficult to estimate precisely the amount of funding for these services that would go to the new Medicaid population, 2008 demographic data reported by the CMH boards indicate that it would be considerable. About three-fourths of those served by CMH for whom income was reported had incomes under \$10,000 and over 90% had incomes below \$20,000. Most of those individuals, of course, were already Medicaid-eligible. Given the skewing of the clientele toward those with lower incomes, it is safe to assume that at least half of the CMH non-Medicaid funding is going toward services for those who would become eligible for coverage under the Medicaid expansion.

If one assumes that almost \$144.0 million of the GF funding for CMH non-Medicaid services is going toward those who would be covered under the Medicaid expansion, then the State may see potential savings.

If the State chooses to maintain the present level of mental health services to people who remain ineligible for Medicaid, one may assume GF/GP savings of \$144.0 million in 2014. If the State chooses to use some of these savings to increase mental health funding for the remaining non-Medicaid population, the savings would be less. These savings come with one caveat – the CMH non-Medicaid services are provided through what amounts to a form of triage; there is no entitlement. These individuals, once they are covered by Medicaid, would be entitled to the full array of mental health services under Medicaid. That would result in an increase in Gross costs (and an eventual increase in State GF/GP costs once the Federal match rate drops below 100.0%). Those increased costs, however, appear to be reflected in the FFIS estimates referred to above.

Given these adjustments, the State would actually see initial savings from the Medicaid expansion of well over \$100.0 million GF/GP in 2014. By 2019 and 2020, as the Federal match rate would drop from 100% to 93% and 90%, respectively, the State's increased GF/GP costs for the expansion would begin to match or exceed the GF/GP savings on CMH non-Medicaid.

There also would be a secondary effect on existing programs that provide limited medical benefits to low-income individuals not presently eligible for Medicaid. In particular, the State's Medicaid Adult Benefits Waiver (ABW) and the so-called "County Care" programs would be superseded by the Medicaid expansion. It appears that the State would have to continue providing the GF/GP funding used to support the ABW program, due to maintenance of effort requirements (which are discussed later in this analysis).

It is not clear whether local governments would have to continue providing the funding used to earn Medicaid match to support the County Care programs. This is because the Special Indigent Care Payments line is actually a DSH program and not a specific Medicaid expansion population. It is possible that the Federal government will impose, through rule or interpretation, a maintenance of effort requirement on this particular issue. The legislation states that "voluntary contributions" by

local governments would not be considered to be required contributions, but it is not clear how that will be defined.

It should also be noted that the health reform legislation gives states the option to expand immediately eligibility to all individuals under 133.0% of the FPL, at the regular Medicaid match rate. If Michigan opts to do this, the cost increase would be over \$500.0 million GF/GP. Even with the CMH non-Medicaid offset, the cost would still be well over \$300.0 million GF/GP.

Medicaid Primary Care Rate Increase

The Federal health reform legislation requires states to increase their Medicaid physician rates for primary care services performed by primary care doctors up to Medicare levels in 2013 and 2014. The legislation also provides 100.0% Federal funding for these rate increases.

According to the Kaiser Family Foundation, Michigan's Medicaid reimbursement rate for primary care physicians was 59.0% of Medicare in 2008. Given the 8.0% payment reduction that was implemented fully in FY 2009-10, that rate is now about 54.0% of Medicare rates. Nationally, Kaiser found that, in 2008, the average payment rate for Medicaid primary care physician services was 66.0% of Medicare rates. The Congressional Budget Office estimates that the primary care rate increase will cost the Federal government about \$3.0 billion per year in 2014.

Based on those figures, and given that Michigan has about 3.0% of the nation's Medicaid enrollment, it appears that the annual cost of this provision would be roughly \$120.0 million, all Federal.

It is important to note, however, that once the mandated increase and the 100.0% Federal funding for the increase expire, the State may opt to continue funding the rate increase. The alternative would be to reduce Medicaid primary care physician rates back to 54.0% of Medicare levels. If the State opted to maintain the increase, the increased annual cost would be approximately \$40.0 million GF/GP.

MI-Child Changes

The Federal legislation would bar any changes to eligibility for the State Children's Health Insurance Program (SCHIP), known in Michigan as MI-Child. This program currently provides health coverage through Blue Cross/Blue Shield of Michigan to non-Medicaid eligible children between 150-200% of the FPL. At present the State receives roughly a 75.0% match rate for the program. The Federal legislation would increase that match rate by 23.0% (capped at 100.0%) for all states beginning in fiscal year 2015-16. Michigan's annual cost for the MI-Child program would decrease by roughly \$12.0 million GF/GP in FY 2015-16 and in subsequent years.

Medicaid Pharmaceutical Changes

The Federal legislation increases Medicaid pharmaceutical rebates for brand name and generic drugs, effective January 1, 2010. The legislation also allows states to collect rebates on Medicaid pharmaceuticals prescribed by Medicaid managed care organizations. The passage of the latter provision was assumed in building the FY 2009-10 Department of Community Health (DCH) budget, with an effective date of October 1, 2009, and projected GF/GP savings of \$32.0 million.

The CBO estimate assumes Federal savings of \$2.5 billion in FY 2010-11 from the various pharmaceutical rebate provisions. This would translate into total savings in Michigan for all

provisions of roughly \$25.0 million GF/GP, which is smaller than the \$32.0 million GF/GP already assumed for the managed care provision. Therefore, it is difficult to provide any meaningful estimate of the possible savings to the State.

Medicaid Long-Term Care Provisions

The Federal health reform legislation includes a number of provisions designed to increase the use of community-based long-term care for the Medicaid population, intended to reduce the use of more costly nursing homes. The fiscal impact on Michigan would depend on the degree to which the State avails itself of the opportunities provided and the extent to which diversions from nursing homes offset increased utilization of intermediate care services.

The legislation includes a new optional Medicaid benefit for community-based attendant services and supports for disabled Medicaid clients, with an enhanced match rate, 6.0% greater than the regular match rate, effective October 1, 2011. The legislation also loosens regulations regarding home and community-based services. These changes include allowing more services to be provided via a state plan amendment rather than by a waiver and allowing expansion of services in regions rather than statewide.

The Federal legislation would also require state Medicaid programs to apply the same spousal impoverishment rules to home and community-based services as are applied to nursing home residents, effective January 1, 2014. Based on the CBO estimates, this provision would lead to an increase in State GF/GP costs of \$2.0 million to \$3.0 million.

The most significant provision would allow an enhanced match rate of 5.0% above the Medicaid match rate for home and community-based services provided by states meeting certain requirements. The first is that the state spend less than 25.0% of its long-term care dollars in FY 2008-09 on home and community-based services. No matter how one defines these services (even if one includes Adult Home Help and Personal Care Services), Michigan spends less than 25.0% and thus meets this requirement. The second is that the state expand its spending on such services to 25.0% of its total long-term care expenditures by October 1, 2015. The final requirement is that the state demonstrate to the Federal government how it will achieve this goal. This enhanced match rate for these services would be available to qualifying states beginning in 2011.

If the State of Michigan chooses to participate in this program and undertakes an aggressive expansion of home and community-based services (HCBS), there would be a net increase in GF/GP costs. While some of the costs would be offset by nursing home diversions, it is apparent from past experience that there is an underserved at-home population that also would benefit from expansion of these services.

Maintenance of Effort

One of the most significant Medicaid provisions is the maintenance of effort requirement. As the Federal government would be picking up 100.0% of the cost of the Medicaid expansion population, the Federal legislation generally bars states from eliminating any optional Medicaid eligibility groups before 2014. Without this provision, states could eliminate Medicaid coverage for optional eligibility groups, save GF/GP funding, and then have the Federal government pick up 100.0% of the cost of covering these groups in 2014.

The one limited exception to this maintenance of effort requirement is for a state that certifies that it is facing a budget deficit. In that case, the state may ask permission to eliminate coverage for

nonpregnant nondisabled adults with incomes over 133.0% of poverty. As there are very few individuals in Michigan in optional eligibility groups with such incomes, there is very little opportunity for savings from optional eligibility group reductions.

This maintenance of effort provision limits state flexibility in reducing Medicaid costs. In particular, the proposals in the Senate-passed FY 2010-11 DCH budget eliminating coverage for Group 2 caretaker relatives and Group 2 19- and 20-year-olds would not be permitted to take effect. The projected savings from those two proposals totaled \$9.8 million GF/GP over the final three months of FY 2010-11.

As noted above, the maintenance of effort requirement also appears to bar the State from changing eligibility for its Adult Benefits Waiver program. This provision, depending on how it is interpreted by Federal regulators, potentially could apply to the Governor's proposed FY 2010-11 freeze on enrollment in the ABW program. Failure to implement this freeze would increase State costs by about \$14.0 million GF/GP.

Finally, the way the law is interpreted through the regulatory process and the courts will influence whether counties will have to continue providing funding to support the Special Indigent Care payments. If this population is shifted to the new Medicaid expansion program without a maintenance of effort requirement, there could be savings for local governments. As mentioned, "voluntary contributions" by local governments would not be subject to maintenance of effort requirements.

Other Medicaid Provisions

Under current Federal law, services provided in institutes of mental disease (IMDs) to Medicaid eligible individuals between the ages of 18 and 64 are not eligible for a Federal match. The health reform legislation allows reimbursement for stabilization of a Medicaid-eligible individual in an emergency situation. The CBO scoring on this item implies a relatively minor cost increase for the Federal government of perhaps \$15.0 million to \$25.0 million per year; this suggests the savings to the State would be well under \$1.0 million GF/GP.

Several years ago, the State of Michigan implemented the "Family Planning Waiver". This program allowed the State to provide family planning services to individuals who were not Medicaid-eligible due to income but who would be Medicaid-eligible if there were a pregnancy. Because family planning services are reimbursed at a 90.0% match rate, the program produced estimated savings. The Federal health reform legislation changes this coverage from a waiver program to an optional eligibility group. This allows Michigan to continue the Family Planning Waiver program without having to go through the waiver process.

The legislation also prohibits Federal reimbursement for "health care acquired conditions", known more generically as conditions resulting from medical errors, effective July 1, 2011. This approach is also being implemented with the Medicare program. The net savings, according to CBO, would likely be minor.

The Federal legislation would provide Federal grants to states that offer incentives for Medicaid beneficiaries to lead healthy lifestyles. The grants would be 100.0% Federally funded and would be available in calendar year 2011. It appears that a state like Michigan would be eligible for several million dollars if it opts to participate.

The legislation allows states to set up health "homes" for individuals with two chronic conditions or those with one chronic condition who are at risk for another chronic condition. Such "medical homes" must provide a wide array of services including follow-up and family support. The program would have a 90.0% Federal match rate and would take effect January 1, 2011. Since the vast majority of Medicaid recipients in Michigan are in managed care, on one level at least, they have a medical "home", so the basic model has already been established. It is not clear to what degree pre-existing medical home models may be changed to allow the State to avail itself of the enhanced match dollars. If such an enhanced medical home proposal is acceptable to the Federal government, the enhanced match rate for those services would result in GF/GP savings to the State. These savings would be offset to some degree by increased costs from the requirement to provide expanded services.

The Federal health reform legislation provides an incentive to states that cover all of the services and immunizations recommended by the Federal Preventive Services Task Force and the Advisory Committee on Immunization Practices. The incentive is a 1.0% increase in the Federal match rate for these services. If the State brings itself into line with these recommendations, there would be an increase in cost, offset to some degree by the slightly higher match rate.

Impact on Public Hospitals of the DSH and Other Adjustments

Due to an increase in the number of people with insurance coverage under the Federal legislation, there would be a corresponding reduction in the amount of uncompensated care. The State provides significant funding to hospitals to help alleviate the costs of their uncompensated care via DSH payments. The Federal match dollars for these payments are capped. Under the health reform legislation, the Medicaid DSH cap would be reduced beginning in fiscal year 2013-14, at first by 4.4%, but eventually by roughly 50.0%. Furthermore, Medicare DSH payments, beginning in 2014, would be reduced by 75.0%.

While this cap reduction would reduce the need for matching DSH dollars from the State and other sources, it would not necessarily lead to GF/GP savings, as most of the match used to draw down DSH dollars comes from non-GF/GP sources. The amount of GF/GP savings, if any, would be determined by the Legislature and the Governor, acting through the budget process and deciding which DSH programs would continue to be funded.

The most significant DSH effects, from a State and local fiscal analysis perspective, would be on public hospitals, in particular University Hospital in Ann Arbor and Hurley Hospital in Flint. In 2007, University Hospital and Hurley Hospital had approximately \$85.0 million and \$50.0 million in net uncompensated charges, respectively. Hospital charges greatly exceed actual costs and the net losses due to uncompensated care are roughly half the net uncompensated charges figures. If the expansion of coverage significantly reduces uncompensated care faced by public hospitals, the net benefit to the units of government operating those hospitals would be in the tens of millions. These savings would be offset by an eventual 50.0% reduction in Medicaid DSH payments and the 75.0% reduction in Medicare DSH payments.

GROUP INSURANCE CHANGES

Effects of Group Insurance Changes on State and Local Government

In many respects, the most significant aspects of the health reform legislation are unrelated to government insurance programs such as Medicaid, SCHIP, and Medicare. The changes in the group and individual insurance markets are wide-ranging.

The group insurance provisions would not directly affect Medicaid and similar programs (while they may have an indirect impact), but they would affect employers. State government, local government, and school districts would all be affected by the provisions, many of which take effect during 2010.

The question of the effects of coverage expansions on employer costs is a difficult area in which to tread, as there are political arguments back and forth on the matter. This is especially true in terms of long-term net costs or net savings from an expansion of health care coverage. Advocates of group insurance changes like the ones found in Federal health reform generally argue that expansion of coverage would help abate health care cost-shifting from uncompensated care to private insurance. Entities opposed to these changes might argue that an expansion of coverage would lead to an increase in demand for services.

It is important, however, to keep any analysis fairly basic and immediate rather than long-term: If the number of employee dependents covered is increased, then one can assume that the cost of insurance for the employer will increase. In particular, the requirement that all children up to age 26 be covered under group policies, effective six months after enactment, will increase health insurance costs for employers, including state and local governmental entities. This would be somewhat offset to the extent that some people up to age 26 will no longer seek or retain coverage funded by Medicaid.

There are other provisions, in particular the elimination of lifetime (and, eventually, annual) cost caps for insurance. However, the one provision that explicitly will affect the cost of health insurance in the near term is the expansion to dependents up to age 26.

The data required to estimate the costs of this provision are difficult to obtain. This is because varying employers already cover dependent full-time college students up to a certain age. The State, for instance, covers dependent full-time students up through their 25th birthday. This is also because the majority of State and local employees work for local units of government, including school districts, which have individually negotiated employment contracts; thus, there is not one consistent standard.

There are 1.1 million people in Michigan between the ages of 19 and 26. Based on data from the Kaiser Family Foundation, it appears that fewer than 200,000 of these individuals are uninsured. Based on census data, about 10% of Michigan's employed individuals work for State or local governmental entities. This implies that there are up to 20,000 individuals between the ages of 19 and 26 who now may receive health insurance due to the employment of their parent or parents.

This, however, is almost certainly an overestimation of the population in question. First, governmental employees generally have health insurance coverage while many other employed individuals do not. Second, based on the example of the State, where full-time students up to age 25 are covered on their parents' policies, it is likely more of the children of State and local government employees are covered already. Finally, many of those in the 19 to 26 age range are not dependents. In the end, the 20,000 figure is likely excessive by a factor of two or more.

For the purposes of this analysis, it is assumed that an additional 10,000 individuals will now be covered by insurance. The typical capitation rate for people in this age range is \$2,500 to \$3,000 per year. Thus, a \$25.0 million to \$30.0 million Gross increase in insurance costs for State and local government combined is assumed, with the caveat that the benefits for some State employees are paid for, in part, with other fund sources. Therefore, the cost to the State and local governments themselves will more likely be in the range of \$20.0 million. As noted above, these costs will be

offset by the fact that there will be some 19- to 26-year-olds who, no matter where their parents work, will no longer need Medicaid coverage. So, the net cost to State and local government will be less than the \$20.0 million estimate.

CONCLUSION

Overall, Federal health reform will have a number of impacts on expenditures, in both directions, of State and local governmental entities. This is only a preliminary analysis and will almost certainly be updated over the next few months as discussions progress and more complete information becomes available.