Medical Care Advisory Council

Advisory Council to the Medicaid Director

May 28, 2013

The Honorable Mike Shirkey
Michigan Competitiveness Committee
Michigan House of Representatives
P.O. Box 30014
Lansing, MI 48909

Dear Chairman Shirkey:

I am writing on behalf of the Medical Care Advisory Council, a federally mandated advisory body to the state Medicaid director, to express our strong support for the expansion of Medicaid eligibility to 133% of the federal poverty level (FPL) as included in the Affordable Care Act. We strongly support the governor's proposal for both the expansion of eligibility and full Medicaid benefits for this population (letters attached).

We believe that accepting the available federal funds and providing comprehensive healthcare coverage to this low-income **working** population will help the state be more competitive as its workforce becomes healthier and worker absence due to illness is reduced. The result will be a win for those who gain coverage (mostly low-wage workers); employers who will benefit from both a healthier workforce and reduced cost shifting of uncompensated care costs; and the state budget which will benefit from lower state-funded healthcare costs and billions of increased federal funds. Expanding Medicaid will ensure that Michigan receives its allocation of federal funds and does not become a "Medicaid expansion donor state."

We are pleased that a bill has been introduced to allow a full discussion on this critical issue. We do, however, have concerns and questions about the bill as it is currently drafted. As this discussion continues, it is important to recognize that the majority of low-income uninsured individuals are in working households. Final decisions will have major impacts on both the employees and their employers.

Our concerns with the bill will focus on five key areas: time limits, the requirement of 100% federal financing, the coverage chasm that will be created, incentives, and waiver development.

<u>48-Month Time Limits:</u>

- We are very concerned about imposing 48-month time limits on Medicaid recipients. Unlike unemployment benefits available to a worker between jobs, healthcare is not a transitional need. Chronic conditions are not cured at the end of 48 months, and new healthcare crises do not spare workers because their healthcare coverage has ended. Moreover, low-income working individuals will likely have great difficulty finding affordable coverage when their Medicaid coverage terminates. Michigan has the highest number of people who have lost employer-sponsored coverage—1.6 million over the last decade—and the highest decline in the number of workers with employer coverage. The number of workers ages 18-64 with employer coverage fell by 1.23 million over the last decade. Finding a job

with healthcare coverage may not be an option, particularly for low-wage workers. Because employers understand they are not able to provide healthcare coverage on their own and need partnerships, they support the expansion of Medicaid eligibility including the Small Business Association of Michigan, the Michigan Chamber of Commerce, several regional chambers of commerce, and the Michigan Business and Professional Association, to name a few.

- The opinion (shared with the Committee) of Charles Miller of Covington and Burling, a well-respected law firm in Washington, DC with extensive Medicaid experience, is that time limits on Medicaid coverage "would be found by CMS to violate the Social Security Act" and could risk all federal funding for those subject to the time limit.

- We are concerned that health status gains made during the 48 months could be undermined or lost when coverage ends. If primary care services become unaffordable, then people will simply be forced to abandon their efforts, experience acute episodes of illness and end up back in hospital emergency rooms for care.

- We are concerned about the outcomes for women, who become pregnant after exhausting their 48 months, and their babies. As you may know, Michigan currently ranks 37th nationally in infant mortality. We are concerned about those with chronic disease (diabetes or asthma, for example) who require ongoing care to manage their diseases, with 70% of healthcare dollars currently spent on chronic diseases.

- Will large, low-wage employers be forced to offer coverage to those between 100% and 133% FPL to avoid penalties for their workers who purchase coverage through the Exchange (the new healthcare marketplace created under the ACA)? If employers do not offer coverage to their employees or offer plans that are not affordable, and the employees purchase coverage through the Exchange, the employers are subject to penalties.

<u>100% Federal Financing:</u>

- We are concerned that 100% federal financing is not an option for this proposal. We believe it represents only a "partial expansion" because it does not cover all who would be eligible under the ACA. This legislation excludes those with disabilities who have incomes between 100% and133% FPL as well as 19 and 20-year-olds who must be included for full expansion. The federal government has reiterated on several occasions that "partial expansions" will not be supported.

- We are also concerned that a waiver may not be able to be crafted to meet the federal requirements for cost neutrality. With the requirement to include the current "nondisabled" adult populations who are currently financed at the Federal Medical Assistance Percentage (66.32% in federal funding in 2014) and all administrative costs (routinely matched at 50%), federal costs would increase from their current levels.

<u>Coverage Chasm:</u>

- We are very concerned that without state subsidies, if time limits are imposed, those with incomes below 100% FPL will be financially unable to purchase coverage on the Exchange because they are NOT eligible for federal subsidies. They would be left with no coverage option.

Incentives:

- We concur with the concept of incentives, but believe they must be designed and implemented to truly benefit the recipient, taking into account his/her work situation and other possible barriers such as transportation. Obstacles or impediments to obtaining needed care or following a health plan may prevent the recipient from improving his/her health status and getting to a better place.

Waiver Development and Approval Process:

- As indicated above, we are concerned about the state's ability to craft a waiver that could be approved by the Centers for Medicare and Medicaid Services. Waivers are very complex to develop and negotiate, and receiving final approval is an arduous process. Even if approvals in concept, such as Arkansas, are received, detailed plans must still be developed and approved. It normally takes 120 to 180 days to submit and receive approval for a waiver. The clock is ticking on our time to receive 100% federal funding under the Affordable Care Act since the law specifies that 100% federal funding will only be available in 2014, 2015 and 2016.

It is also worth noting that Michigan Medicaid moved to private managed care coverage 17 years ago, the concept Arkansas and others are just now exploring. We have already reaped the many benefits they are just anticipating.

Members of the Council would be pleased to provide any further information to assist you in understanding this complex issue and are ready to work with you to develop the best option for Michigan's low-wage workers and their employers.

If you have questions or concerns, please feel free to contact me at jhudson@mlpp.org, or at 517-487-5436.

Sincerely,

Jan Hudson

Jan Hudson
Chairperson

cc: Members of the Michigan Competitiveness Committee
Bill Rustem, Director of Strategy, Office of the Governor
James Haveman, Director, Michigan Department of Community Health
Steve Fitton, Michigan Medicaid Director

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