

**NOTICE AND AGENDA FOR  
MEETING  
OF THE  
KALAMAZOO COUNTY BOARD OF COMMISSIONERS**

**Legislative Meeting**

**Friday, June 7, 2013  
7:30 a.m.**

- |             |  |
|-------------|--|
| 7:30 – 7:35 | Welcome and Call to Order  |
| 7:35 – 9:15 | Issues/Updates <ul style="list-style-type: none"><li>➤ State Budget/Revenue Sharing</li><li>➤ Transportation Infrastructure Funding</li><li>➤ Indigent Defense Statewide</li><li>➤ Mental Health<ul style="list-style-type: none"><li>• Funding/Medicaid Expansion</li><li>• Possible Mental Health Code Amendment</li></ul></li><li>➤ Additional Updates by Legislators</li></ul> |
| 9:15 – 9:20 | Citizens Time  |
| 9:20 – 9:30 | Any other items  |
| 9:30        | Adjournment  |



Kalamazoo County

# Health & Community Services

Linda S. Vail, MPA  
Director, Health Officer

## MEMORANDUM

Date: April 18, 2013

To: Peter Battani, County Administrator

Cc: John Faul, Deputy County Administrator

From: Linda Vail, Director/Health Officer, Health & Community Services Department

Subject: Medicaid Expansion in Michigan

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Local Health Departments across the state are strongly supportive of Medicaid Expansion because of the increase in access to a variety of health services for more individuals. I have attached two documents with this memo that provide significant detail about Medicaid Expansion, the reasons our local public health system within the state have gone on record in support of Medicaid Expansion, and the impact of Medicaid Expansion with regard to those who are currently uninsured.

Within Health and Community Services (HCS), we see Medicaid patients in our STD Clinic, Immunization Clinic and Dental Clinic. Medicaid Expansion will require fewer patients to self-pay. We will see some increase those served, but notably the increased coverage will also create a billable service to Medicaid for patients who previously may have had to pay for a service out of pocket. As a result, the more significant result will be a shift in funding source from self-pay to Medicaid reimbursement for many individuals that we already serve.

If Medicaid Expansion is not passed, we are unsure of the impact because the Governor's budget was built on the premise of Expansion.

Please find attached the following two documents:

Medicaid Expansion Talking Points

Medicaid Expansion Resolution by the Michigan Association for Local Public Health





**MICHIGAN  
ASSOCIATION  
FOR LOCAL  
PUBLIC HEALTH**



P.O. Box 13276 ♦ Lansing, Michigan 48901 ♦ (517) 485-0660 ♦ [www.malphp.org](http://www.malphp.org)  
426 S. Walnut, 2<sup>nd</sup> Floor ♦ Lansing, Michigan 48933 ♦ (517) 485-6412 Fax

## **Medicaid Expansion Resolution**

**Whereas**, pursuant to PA 368 of 1978, Section 333.2433, “A local health department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs...prevention and control of health problems of particularly vulnerable population groups...”

**Whereas**, on August 13, 2012, at the monthly meeting of the Board of Directors of the Michigan Association for Local Public Health, the following resolution was adopted:

**Whereas**, under the provisions of the Patient Protection Affordable Care Act, a State can expand its Medicaid program to cover individuals and families earning up to 133% of the Federal Poverty Line. It is estimated that an additional 500,000 citizens of Michigan will be covered under such expansion.

**Whereas**, under current law, citizens of Michigan will be mandated to either purchase healthcare insurance or pay a tax regardless of State participation in the expansion of the Medicaid Program. Further, any Federal money available for this expansion in Michigan would otherwise be forfeited to the benefit of citizens of other states; and

**Whereas**, opting out of the Medicaid Program expansion will continue to place an economic burden on hospitals and other health care providers who will not be reimbursed for services they may provide; and

**Whereas**, by reducing the number of uninsured, state and local costs for uncompensated care for the uninsured will decline;

**Therefore be it resolved**, that in order to protect the health of all its citizens, especially those most in need, the Michigan Association for Local Public Health Board of Directors strongly urges the State of Michigan to participate in the expansion of the Medicaid Program under the Patient Protection and Affordable Care Act.

Approved by the Board of Directors October 2, 2012.

# Medicaid Expansion

## The People

- Medicaid Expansion (Expansion) will bring health coverage to about 470,000 uninsured low-income Michigan citizens.
- Expansion will bring health coverage to approximately 12,000-15,000 uninsured low-income Kalamazoo County residents.
- Of the 470,000 total uninsured, 44,000 uninsured veterans and 23,000 VA-only covered veterans may qualify under Expansion, including 29,000 family members of veterans.

## The Leverage and Savings

- It will bring approximately \$2 billion more in Medicaid funding here and save Michigan roughly \$200 million annually in healthcare spending.
- By leveraging federal funds, more than \$20 billion will flow into Michigan through 2023, saving the state's general fund \$1.2 billion through 2020.
- Michigan hospitals end up providing more than \$880 million a year in uncompensated care to patients who are unable to pay, costs that end up being shifted to people who have insurance, employers who pay for their employees', and taxpayers.
- It is estimated that up to \$1,000 of the annual cost of the health insurance premium for a family of four is to cover uncompensated care; Expansion will end this hidden tax.
- People who become Medicaid eligible under Expansion, who receive some or their entire healthcare through state-funded programs will move under a federally-funded program, saving Michigan taxpayers money.
- Reduced health care costs for everyone over the long term. Citizens with access to insurance are healthier. Healthy people cost less; individuals benefit, employers benefit, taxpayers benefit, and communities benefit.

## The Governor has a plan

- A statewide survey (Center for Healthcare Research and Transformation) showed that Michigan's existing network of primary care physicians is equipped to handle an influx of patients.
- It confirmed that 81% of Michigan's primary care physicians will have the capacity for those who are newly covered by Medicaid. Of that group, more than 90% said they will accept new Medicaid patients.
- To ensure the program remains financially stable and guard against changes in the federal commitment, Governor Snyder's budget recommendation calls for 50% of the savings achieved from the expansion to be deposited into a special health savings account for the first seven years. The account will help cover the increased share of the costs when the federal government scales back its funding from 100% for the first three years to 90% beginning in 2020. If managed correctly, that fund should help the State cover the costs until 2035.

# **Issue Paper**

**PAPERS EXAMINING CRITICAL ISSUES  
FACING THE MICHIGAN LEGISLATURE**

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## **FISCAL ANALYSIS OF GOVERNOR SNYDER'S MEDICAID EXPANSION PROPOSAL**

by

**Steve Angelotti  
Associate Director**

**March 2013**



## **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.



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## **ACKNOWLEDGMENTS**

The author wishes to express his appreciation to the State Budget Office and the Department of Community Health for their openness in sharing their Medicaid expansion analysis, assumptions, and spreadsheets. Thanks are also extended to Wendy Muncey of the Senate Fiscal Agency for her assistance in finalizing this report.

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## **EXECUTIVE SUMMARY**

The Senate Fiscal Agency (SFA) has examined the Snyder Administration's proposed expansion of the State's Medicaid program to cover those under 133% of the Federal poverty level (FPL) effective January 1, 2014. The SFA concurs with the Administration's belief that there would be significant General Fund/General Purpose (GF/GP) savings in the first few years of the expansion. The SFA also agrees that, eventually, GF/GP costs would exceed the GF/GP savings as the Federal match rate for the expansion population drops from 100% in 2014 to 90% in 2020.

Assuming the current Health Insurance Claims Assessment (HICA) rate of 1.0% is maintained, the SFA projects that total net GF/GP costs tied to the expansion would exceed total net GF/GP savings in FY 2027-28. Under different HICA assumptions, the total net GF/GP costs could exceed total net GF/GP savings two years earlier or one year later.

The analysis depends not only on the HICA issue, but also on the caseload growth rate and expenditure growth rate. The conclusions in this analysis also are tied to the initial cost per case. Information from Arizona's expansion of Medicaid coverage to a similar population indicates that costs might be higher than assumed in the Governor's proposed budget.

The analysis does not address possible economic benefits from the expansion. It also does not address the possibility that businesses would drop coverage and have their employees obtain health care coverage from the health exchanges or Medicaid.

In spite of these caveats, it is clear that net GF/GP savings would occur from the beginning and that net GF/GP costs would not exceed net GF/GP savings for a number of years. Even in the worst-case scenario, the crossover point where total net GF/GP costs from January 1, 2014, onward would exceed total net GF/GP savings from January 1, 2014, onward is fiscal year (FY) 2022-23, which would be the 10th year of the expansion. In the best-case scenario, that point would be reached in FY 2035-36, which is similar to the estimates put forth by the Administration.

The SFA does not believe the worst- or best-case scenario is likely and does not anticipate that the proposed expansion would cause any major budgetary stress in the foreseeable future. On the other hand, the SFA does not believe the early GF/GP savings would exceed 3.0% of the State's \$9.0 billion GF/GP budget. In the end, it is likely that the decision on whether to implement the expansion will be based more on policy considerations than on the potential fiscal impact of the expansion.

## **MEDICAID EXPANSION AND THE AFFORDABLE CARE ACT (ACA)**

One of the key components of the 2010 Patient Protection and Affordable Care Act (referred to below as the ACA) was 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 was 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 included 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 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 million in the number of uninsured individuals due to the ACA and projected that 17 million of that 30-million reduction would be due to the Medicaid expansion.

Some sources refer to expansion of Medicaid to 138% of the FPL. This is technically correct in one key way, as there would be a 5% income disregard applied; thus, an individual with an income at, say, 137% of the FPL would be eligible. To avoid confusion between the two figures and to be consistent with the explicit percentage in the legislation itself, this paper uses the 133% figure.

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 or 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 now have the option to decide whether to expand Medicaid. State governors have announced varying decisions on this front, with the legislatures for the most part yet to weigh in. The decision will be made via each state's budget process, but a more permanent decision could be made through statutory legislation.

## **The Snyder Administration's Decision**

On February 6, 2013, Governor Rick Snyder announced that his Administration would include expansion of the Medicaid program in his proposed FY 2013-14 budget, which was released the next day.

The Governor announced his support based on the goal of expanding insurance coverage and reducing uncompensated care. Governor Snyder noted that there would be significant GF/GP savings for the State in the initial years of the expansion as certain State-funded programs that provide services to the expansion population would see savings. He proposed setting aside half of those early savings in a fund to cover net GF/GP costs in the out years, when the 10% State match would result in net GF/GP costs. The Administration stated its belief that the fund would last through fiscal year 2034-35, and concluded that the State would not see a net GF/GP cost from the expansion for over 20 years.

## **The Basis of the Savings Projections**

The Administration's belief that there would be significant initial GF/GP savings from the expansion is tied to both expenditure and revenue issues. According to the Administration, there are three main areas in which the State would see a reduction in GF/GP expenditures due to the expansion:

Community Mental Health (CMH) non-Medicaid Services: The State provides \$274.1 million to local CMH boards to cover the low-income population that is not eligible for Medicaid and also to pay for non-Medicaid covered services. The Snyder Administration has estimated that \$203.9 million of that \$274.1 million is spent for Medicaid covered services for the population that would be eligible for Medicaid expansion. Therefore, instead of that \$203.9 million being a 100% State cost, it would become a 100% Federal cost, resulting in full-year savings of \$203.9 million GF/GP.

Termination of the Adult Benefits Waiver Program: The State operates a limited coverage capped enrollment program that provides coverage to 35,000 people who are not otherwise eligible for Medicaid. This population would be eligible for Medicaid expansion, so instead of \$34.8 million in State GF/GP money being spent to support the program, the costs would be picked up by the Federal government, resulting in full-year savings of \$34.8 million GF/GP.

Corrections Health Care: Individuals who are in large secure prison facilities are not eligible for Medicaid. However, such a prisoner, if he or she meets categorical and income/asset eligibility requirements, is Medicaid-eligible when outside the prison. For instance, such a person would be covered by Medicaid if he or she were taken to an off-site hospital for surgery. The expansion would result in roughly 80% of the prison population being Medicaid-eligible when off-site, thus resulting in a large decrease in GF/GP prison medical costs. Furthermore, many parolees would become eligible and would be covered, via expansion Medicaid, for parolee services such as mental health and substance abuse services. The Snyder Administration estimated full-year savings of \$32.3 million GF/GP.

The proposed budget also included much smaller savings from termination of a transitional Medicaid program, savings on the Plan First program, and savings on certain public health services such as immunization. In all cases, the costs would be shifted to the Federal government, resulting in savings for the State of about \$2.5 million GF/GP.

### Health Insurance Claims Assessment

The HICA tax, which is a 1.0% tax on all paid health claims, was implemented on January 1, 2012. The tax, which sunsets on December 31, 2013, was designed to raise \$400.0 million to support the Medicaid program. The HICA revenue is used to offset an equal amount of GF/GP revenue, thus reducing GF/GP costs. The legislation includes a cap to prevent the HICA revenue from exceeding \$400.0 million adjusted for inflation. Reaching the cap has not been a problem, as revenue has come in far below the assumption, at roughly \$270.0 million per year.

The Snyder Administration has discussed either changing HICA to a flexible rate (set at the amount necessary to bring in \$400.0 million adjusted for inflation) or increasing the rate to 1.5%. In either case, under present circumstances, the proposed change would result in HICA revenue of about \$400.0 million. As long as the "\$400.0 million plus inflation" cap was in place, any additional revenue above that amount would not offset GF/GP dollars, but rather would result in a lower effective HICA tax rate.

Expansion of Medicaid would result in a large increase in the HICA tax base. With full-year estimates of expansion expenditures in the range of \$2.0 billion Gross, a 1.5% tax rate would potentially result in a full-year increase in HICA revenue of \$30.0 million above the \$405.0 million estimated revenue if the HICA rate were set at 1.5%. Even continuing the current 1.0% tax rate (with a repeal of the sunset) would result in a full-year increase in HICA revenue of \$20.0 million above the estimated FY 2012-13 HICA revenue of \$270.0 million.

This additional revenue would not be available if the State chose not to expand Medicaid, so including the increased HICA revenue, if available, as a GF/GP offset is appropriate.

### **ELEMENTS OF A FISCAL ANALYSIS**

Estimating the fiscal impact of a broad-based complex policy change such as Medicaid expansion is a challenging task. The following is a discussion of the key elements of the fiscal analysis.

#### Estimating Costs

The cost of the health care portion of the program can be determined in a fairly straightforward manner. The cost is the caseload multiplied by the per-member capitation rate paid to the entity managing the care. The challenge is estimating the caseload and estimating the capitation rate. The Administration did considerable work on the caseload front (described in the Appendix). In effect, a consultant used income and demographic data to estimate how many people would be eligible for the expansion.

A secondary consideration on the caseload side is the "woodwork effect", which is described at greater length in the Appendix. In effect, the creation of the health exchanges and the tax penalty charged to people without insurance will lead uninsured people to seek insurance through the health exchanges created under the ACA. Some of these people will turn out to be eligible for regular Medicaid or the Medicaid expansion and will be referred to those programs. These people in effect will have "come out of the woodwork" and will increase the Medicaid caseload beyond what it would be with just the expansion.

### Estimating Savings

As described above, the three major savings items are transfer of most CMH non-Medicaid services funding to the expansion program, termination of the Adult Benefits Waiver (ABW), and State savings on Department of Corrections (DOC) health care services.

Of these, the termination of the ABW is the easiest to estimate, as the GF/GP funding for the program is explicitly appropriated. The DOC health care costs are more difficult to estimate, as one must estimate what percentage of the DOC population, both prisoners and parolees, would become Medicaid-eligible.

The CMH savings are even more difficult to estimate. One must first exclude CMH non-Medicaid spending on services that are not Medicaid-reimbursable, such as respite services, certain prevention efforts, and jail diversion. After that, it is necessary to estimate the percentage of the CMH non-Medicaid clientele that would be eligible for the Medicaid expansion.

### Ancillary Issues

The cost of a Medicaid expansion for the State goes beyond the health care costs. One must estimate administrative costs incurred by the Department of Community Health (which handles the program) and the Department of Human Services (which handles eligibility).

There are also indirect GF/GP savings to the State from HICA. The expansion of health care coverage would lead to an increase in claims paid by insurers, as the Medicaid expansion would be handled through contracts with Medicaid health maintenance organizations (HMOs). The Medicaid HMOs are subject to HICA; thus, HICA revenue could increase, offsetting GF/GP funding.

Another, more general issue, not reflected in this analysis is the match rate itself. While the legislation makes clear that the Federal government will match 90% of eligible costs for eligible clients from 2020 onward, some have expressed concern that the match rate could be changed by Congress and the President at some future date, resulting in greater State costs.

### Secondary Effects

Any significant legislation will have secondary effects, beyond the original goals of the legislation. In the case of Medicaid expansion, the primary effects are greater health care coverage for low-income individuals, considerable GF/GP savings in the early years, and eventual GF/GP net costs in the later years. Secondary effects, tied to behavioral changes or economic impacts, are more difficult to quantify.

One key secondary effect would be the impact on the economy, in particular State revenue, of increased demand for health services. More demand would mean more jobs and more facilities, leading to an increase in income, sales, and property tax revenue.

Another key effect would be the behavior of businesses in response to the incentives and disincentives contained in the ACA. It is possible that some businesses will respond to various insurance requirements by dropping insurance for their employees, assuming the employees will be able to obtain insurance through the exchanges or through Medicaid. If that is the case, the Medicaid expansion caseload could increase beyond the original forecast.

### Long-Term Trends

One cannot look at just one or two years, especially given the change in the match rate and the likely net GF/GP cost increase beginning several years after implementation. One has to estimate how caseloads will change in the long term and, perhaps more importantly, how the costs and savings will change over time. This requires an estimate of caseload growth and medical inflation.

### **THE SENATE FISCAL AGENCY ANALYSIS - ASSUMPTIONS**

The SFA analysis of the fiscal impact of Medicaid expansion is similar to the Administration's (described in the Appendix) in terms of approach: make justifiable assumptions about caseload, cost per case, and savings; then extrapolate the data into future years.

In a general sense, the SFA agrees with the Administration on the central fiscal point: Medicaid expansion would lead to large GF/GP savings in the first few years, with those savings eventually being offset by net GF/GP costs. It would be many years before the total net GF/GP costs from January 1, 2014, onward exceeded the total net GF/GP savings from January 1, 2014, onward. The SFA's analysis, while accepting certain Administration research, works from its own set of assumptions regarding caseload, cost per case, and other matters.

The main goal of this analysis is to provide the best estimate based on the most reasonable assumptions. It must be noted that the assumptions themselves can vary significantly yet be reasonable. This analysis also includes the fiscal impact based on what one could call the "best case" and "worst case" reasonable assumptions.

### Caseload Estimate

The SFA analysis accepts the Administration's base Medicaid expansion caseload numbers for FY 2013-14, FY 2014-15, and FY 2015-16 of 320,956, 401,316, and 450,987, respectively. These appear to be well-founded, based on work by an economist from the Massachusetts Institute of Technology (MIT). While some may quibble with the "take-up" rate (the Administration's projection that only 67% of those eligible would sign up in the first year), it is a moot point as the cost of the program would be 100% Federal in the first three years.

The SFA goes beyond the base caseload to assume a "woodwork effect" that is twice of the Administration's, and also assumes one-sixth of the woodwork effect Medicaid cases would be Medicaid expansion cases. While this analysis was also done by the same MIT economist, at full maturity the woodwork caseload for regular Medicaid and Medicaid expansion is about 33,000 cases, or 1.4% of total Medicaid cases. It seems likely, based on past experience, particularly with the MICHild program (where some who applied turned out to be Medicaid-eligible rather than MICHild-eligible), the percentage of those eligible for Medicaid yet not enrolled is greater than 1.4%.

### Cost per Case

The SFA analysis accepts the Administration's initial cost of \$5,116 per case for physical health built into the FY 2013-14 budget and \$5,178 per case built into the FY 2014-15 budget. The SFA does have concerns, outlined below, based on the experience in Arizona. The SFA analysis uses a higher number for behavioral health, starting at \$1,300 per case in FY 2013-14, compared to the Administration's \$1,199.

### Arizona's 2001 Expansion

The State of Arizona expanded coverage to childless adults up to 100% of the FPL under a Medicaid waiver in 2001. A report by the Kaiser Commission on Medicaid and the Uninsured found that the childless adults covered tended to be more similar to disabled adults than to Medicaid parents, although they were younger than the disabled adults (source: <http://www.kff.org/medicaid/upload/8310.pdf>). Disabled adults have significantly greater per-person costs under Medicaid than the nondisabled adult parent population.

The report also found that the childless adults had more demand for mental health services than the nondisabled adult parents, although not nearly as much demand as the disabled adults. One can argue whether such trends are captured in the capitation rates estimated in Michigan, but there exist some important data: Arizona's actual expenditures on this population.

Arizona's actual expenditures in FY 2010-11 (before enrollment was frozen by the State of Arizona) on behavioral health services for nondisabled single adults were \$483.9 million for 363,300 clients (source: <http://www.azleg.gov/jlbc/bhspending.pdf>, Arizona Joint Legislative Budget Committee). That equates to \$1,332 per client for behavioral health. On the physical health side, expenditures were \$2,203.2 million for the same 363,300 clients (source: <http://www.azleg.gov/jlbc/AHCCCSHistoricalSpending.pdf>, Arizona Joint Legislative Budget Committee). That equates to \$6,064 per client for physical health.

Given this experience, it seems prudent to increase the behavioral health cost. Increasing both costs by 20% to roughly the Arizona amounts, adjusted for inflation between 2011 and 2014, is reflected in the "worst case" analysis below.

### Savings

The SFA accepts the Administration's estimates on CMH non-Medicaid savings, ABW savings, and DOC savings, as well as the more minor savings.

### Administrative Costs

The SFA accepts the Administration's estimate of \$10.0 million GF/GP in administrative costs in FY 2013-14 and \$11.0 million GF/GP in administrative costs in subsequent years. These appear to be reasonable estimates.

### Match Rate Note

Because the match rates change on January 1 of each year (going from 100% to 95% on January 1, 2017, for instance), the fiscal year match rates are actually a blend: one quarter of the prior calendar year rate and three quarters of the new calendar year rate. For instance, the match rate drops from 93% to 90% on January 1, 2020. For FY 2019-20, that drop leads to a blended match rate of 90.75%, which is the rate used in the analysis for FY 2019-20.

### HICA Revenue

It is difficult to address the HICA issue. At present, the HICA rate is 1.0% through December 31, 2013, the day before the expansion would start. Revenue from HICA is capped at \$400.0 million plus inflation, though there is little chance of that cap being reached at a 1.0% rate.

The Administration has proposed a flexible HICA rate, one that would bring in \$400.0 million, adjusted for inflation. There has also been discussion of a flat 1.5% rate. It is not clear whether such legislation would include removal of the cap or a large increase in it. Given that a 1.5% rate would generate just over \$400.0 million, the expansion, with a 1.5% HICA rate and the cap, would not actually increase HICA revenue. A 1.5% rate with removal of the cap would bring in more revenue, and continuing the 1.0% rate with or without the cap would bring in more revenue. Of course, if no action is taken and HICA expires on December 31, 2013, there will be no revenue.

For the purposes of this analysis, it is assumed that HICA continues at the 1.0% rate in future years. This actually produces a greater HICA fiscal benefit due to expansion than would a 1.5% rate with the cap remaining in place. The HICA rate is applied to 84% of the amount spent on the expansion population, as this is the Administration's estimate of what percentage of expenditures will be spent on paid health claims subject to the tax.

### Trending

The SFA assumes a 2.5% increase in cost per case from FY 2014-15 onward. This amount reflects typical Medicaid cost growth per case over the last decade. Other medical cost inflation estimates will be used in the best-case and worst-case scenarios. The SFA assumes a 2.0% per year caseload growth from FY 2015-16 onward. This is similar to the Administration's assumption from FY 2022-23 onward. Other caseload growth rate estimates will be used in the best-case and worst-case scenarios.

The SFA also assumes that the DOC savings and the "other savings" would trend forward at 3.0% per year. In other words, absent Medicaid expansion, DOC health care costs will increase by 3.0% per year. This adjustment was not made to the CMH and ABW numbers, as the former is effectively a block grant that has not been increased in years and the latter is a capped enrollment program.

### The Health Savings Fund

This analysis does not take the Administration's approach of creating a Health Savings Fund. The Administration proposed setting aside half of net expansion GF/GP savings in the Fund to help cover out-year costs. (See Appendix for a fuller description.) This analysis is more focused on the overall picture, that is, the cumulative effect of the expansion on Michigan's GF/GP spending over the years. The next section includes an estimate, based on the assumptions listed above, of when the proposed Fund would be exhausted.

## **THE SENATE FISCAL AGENCY ANALYSIS - RESULTS**

### The Basic Analysis

The summary of the SFA analysis through FY 2027-28 may be seen in Table 1. As the match rate drops from 93% to 90% on January 1, 2020, GF/GP costs would exceed GF/GP savings beginning in FY 2019-20. It is the SFA's conclusion, based on what the Agency believes to be the most reasonable assumptions, that total net GF/GP costs from Medicaid expansion would exceed total net GF/GP savings in FY 2027-28. For purposes of this analysis, the term "crossover point" will be used to describe the fiscal year in which total net GF/GP costs from the expansion from January 1, 2014, onward would exceed total net GF/GP savings.

Table 1

**MEDICAID EXPANSION COSTS AND SAVINGS  
FIFTEEN YEAR PROJECTION**

<b>MEDICAID EXPANSION -- COSTS</b>	<b>FY 2013-14 *</b>	<b>FY 2014-15</b>	<b>FY 2015-16</b>	<b>FY 2016-17</b>	<b>FY 2017-18</b>	<b>FY 2018-19</b>	<b>FY 2019-20</b>	<b>FY 2020-21</b>
<b>Expansion match rate</b>	100%	100%	100%	96.25%	94.25%	93.25%	90.75%	90%
<b>Caseload including woodwork effect cases</b>	324,719	406,671	461,603	470,952	480,489	490,218	500,142	510,266
<b>Average cost per case, physical health</b>	\$5,116	\$5,178	\$5,308	\$5,440	\$5,576	\$5,716	\$5,859	\$6,005
<b>Average cost per case, behavioral health</b>	\$1,300	\$1,330	\$1,363	\$1,397	\$1,432	\$1,468	\$1,505	\$1,542
<b>Total average cost per case</b>	\$6,416	\$6,508	\$6,671	\$6,838	\$7,009	\$7,184	\$7,363	\$7,548
<b>Total Gross costs</b>	\$1,562,441,842	\$2,646,717,734	\$3,079,339,559	\$3,220,248,018	\$3,367,595,141	\$3,521,674,822	\$3,682,794,360	\$3,851,275,069
<b>Total GF/GP costs of expansion</b>	\$0	\$0	\$0	\$120,759,301	\$193,636,721	\$237,713,050	\$340,658,478	\$385,127,507
<b>GF/GP administrative costs</b>	\$10,000,000	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000
<b>Total GF/GP Costs</b>	\$10,000,000	\$11,000,000	\$11,000,000	\$131,759,301	\$204,636,721	\$248,713,050	\$351,658,478	\$396,127,507
<b>MEDICAID EXPANSION -- SAVINGS</b>								
<b>CMH non-Medicaid savings</b>	(\$152,931,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)
<b>ABW savings</b>	(\$26,104,500)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)
<b>Corrections savings</b>	(\$24,212,200)	(\$32,282,900)	(\$33,251,400)	(\$34,248,900)	(\$35,276,400)	(\$36,334,700)	(\$37,424,700)	(\$38,547,400)
<b>Other savings</b>	(\$1,972,200)	(\$2,629,600)	(\$2,708,488)	(\$2,789,743)	(\$2,873,435)	(\$2,959,638)	(\$3,048,427)	(\$3,139,880)
<b>Total programmatic savings</b>	(\$205,220,000)	(\$273,626,600)	(\$274,673,988)	(\$275,752,743)	(\$276,863,935)	(\$278,008,438)	(\$279,187,227)	(\$280,401,380)
<b>HICA revenue (1.0% times 84% of costs)</b>	(\$13,124,500)	(\$22,232,400)	(\$25,866,500)	(\$27,050,100)	(\$28,287,800)	(\$29,582,100)	(\$30,935,500)	(\$32,350,700)
<b>Total GF/GP savings in given fiscal year</b>	(\$218,344,500)	(\$295,859,000)	(\$300,540,488)	(\$302,802,843)	(\$305,151,735)	(\$307,590,538)	(\$310,122,727)	(\$312,752,080)
<b>Net GF/GP costs/(savings) in given fiscal year</b>	(\$208,344,500)	(\$284,859,000)	(\$289,540,488)	(\$171,043,542)	(\$100,515,014)	(\$58,877,487)	\$41,535,751	\$83,375,427
<b>Cumulative effect of expansion on Michigan's total GF/GP spending:</b>	(\$208,344,500)	(\$493,203,500)	(\$782,743,988)	(\$953,787,530)	(\$1,054,302,544)	(\$1,113,180,032)	(\$1,071,644,281)	(\$988,268,854)
<b>Deposit into/(withdrawal from) Health Savings Fund if one is created and 1/2 of GF/GP savings is deposited **</b>	\$104,172,300	\$142,429,500	\$144,770,200	\$85,521,800	\$50,257,500	\$29,438,700	(\$41,535,800)	(\$83,375,400)
<b>Cumulative amount of money in Health Savings Fund at end of fiscal year</b>	\$104,172,300	\$246,601,800	\$391,372,000	\$476,893,800	\$527,151,300	\$556,590,000	\$515,054,200	\$431,678,800

\* Program takes effect on January 1, 2014, so FY 2013-14 costs and savings cover 3/4ths of the fiscal year.

\*\* GF/GP costs begin to exceed savings in FY 2019-20, so net GF/GP costs are withdrawn from fund beginning in that year.

Table 1 - continued

**MEDICAID EXPANSION COSTS AND SAVINGS  
FIFTEEN YEAR PROJECTION**

MEDICAID EXPANSION -- COSTS	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28
Expansion match rate	90%	90%	90%	90%	90%	90%	90%
Caseload including woodwork effect cases	520,593	531,128	541,753	552,568	563,640	574,912	586,411
Average cost per case, physical health	\$6,155	\$6,309	\$6,467	\$6,629	\$6,794	\$6,964	\$7,138
Average cost per case, behavioral health	\$1,581	\$1,620	\$1,661	\$1,703	\$1,745	\$1,789	\$1,833
Total average cost per case	\$7,736	\$7,930	\$8,128	\$8,331	\$8,539	\$8,753	\$8,972
Total Gross costs	\$4,027,452,917	\$4,211,679,195	\$4,403,326,019	\$4,603,676,409	\$4,813,145,108	\$5,032,142,044	\$5,261,104,507
Total GF/GP costs of expansion	\$402,745,292	\$421,167,919	\$440,332,602	\$460,367,641	\$481,314,511	\$503,214,204	\$526,110,451
GF/GP administrative costs	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000	\$11,000,000
Total GF/GP Costs	\$413,745,292	\$432,167,919	\$451,332,602	\$471,367,641	\$492,314,511	\$514,214,204	\$537,110,451
<b>MEDICAID EXPANSION -- SAVINGS</b>							
CMH non-Medicaid savings	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)
ABW savings	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)
Corrections savings	(\$39,703,800)	(\$40,894,900)	(\$42,121,700)	(\$43,385,400)	(\$44,687,000)	(\$46,027,600)	(\$47,408,400)
Other savings	(\$3,234,076)	(\$3,331,099)	(\$3,431,032)	(\$3,533,963)	(\$3,639,981)	(\$3,749,181)	(\$3,861,656)
Total programmatic savings	(\$281,651,976)	(\$282,940,099)	(\$284,266,832)	(\$285,633,463)	(\$287,041,081)	(\$288,490,881)	(\$289,984,156)
HICA revenue (1.0% times 84% of costs)	(\$33,830,600)	(\$35,378,100)	(\$36,987,900)	(\$38,670,900)	(\$40,430,400)	(\$42,270,000)	(\$44,193,300)
Total GF/GP savings in given fiscal year	(\$315,482,576)	(\$318,318,199)	(\$321,254,732)	(\$324,304,363)	(\$327,471,481)	(\$330,760,881)	(\$334,177,456)
Net GF/GP costs/(savings) in given fiscal year	\$98,262,715	\$113,849,721	\$130,077,870	\$147,063,278	\$164,843,029	\$183,453,324	\$202,932,994
Cumulative effect of expansion on Michigan's total GF/GP spending:	(\$890,006,138)	(\$776,156,417)	(\$646,078,547)	(\$499,015,269)	(\$334,172,239)	(\$150,718,916)	\$52,214,079
Deposit into/(withdrawal from) Health Savings Fund if one is created and 1/2 of GF/GP savings is deposited **	(\$98,262,700)	(\$113,849,700)	(\$130,077,900)	(\$147,063,300)			
Cumulative amount of money in Health SavingsFund at end of fiscal year	\$333,416,100	\$219,566,400	\$89,488,500	(\$57,574,800)			

\* Program takes effect on January 1, 2014, so FY 2013-14 costs and savings cover 3/4ths of the fiscal year.

\*\* GF/GP costs begin to exceed savings in FY 2019-20, so net GF/GP costs are withdrawn from fund beginning in that year.

It should be noted that perhaps the key factor in this result is the HICA revenue. If HICA sunsets or if HICA is raised to 1.5% with the cap remaining in place, there would be no GF/GP Medicaid expansion benefit tied to HICA. If that one assumption is changed, the point at which total net GF/GP costs from January 1, 2014, onward would exceed total net GF/GP savings is FY 2025-26. On the other hand, if HICA is raised to 1.5% with the cap removed or significantly increased, then the crossover point becomes FY 2028-29. The HICA assumption alone can make up to a three-year difference in the estimated crossover point.

Under the 1.0% HICA assumption, the cumulative GF/GP savings reach their peak in FY 2018-19 at \$1.11 billion. They begin to decline as annual GF/GP costs exceed annual GF/GP savings. By FY 2027-28, annual costs exceed savings by \$202.9 million GF/GP.

A net increase of \$202.9 million GF/GP in FY 2027-28 over what may be spent without expansion might seem large, but it should be considered in context. The analysis forecasts an excess of costs over savings in FY 2027-28, 15 years from now. Annual GF/GP adjustments to Medicaid for expenditures and changes in the regular Medicaid match rate are often in excess of \$100.0 million. There would be no net GF/GP cost over the first 14 years.

#### The Best-Case Scenario

The best-case scenario assumes a 1.5% HICA with the cap raised or removed, agrees with the Administration's initial average cost and caseload numbers, and assumes 1.5% medical inflation and a 1.5% caseload growth rate. In this case, the crossover point occurs in FY 2035-36. Much as is the case with the basic analysis, the estimate is highly dependent on the HICA rate. If the rate is set at 1.5% and the cap is not removed (or if HICA sunsets), the crossover point shifts to FY 2029-30, a difference of six years.

Overall, the best-case scenario is largely similar to the Administration's in terms of crossover point and expenditure growth.

#### The Worst-Case Scenario

The worst-case scenario assumes either a 1.5% HICA with the current cap or a HICA sunset, thus no net HICA revenue. It assumes a 3.0% inflation rate and a 3.0% caseload growth. It assumes a doubled woodwork effect. Finally, based on the Arizona experience, it assumes initial costs per case similar to FY 2010-11 costs, adjusted for inflation, about 20% greater than those projected by the Administration.

In this case, the crossover point occurs in FY 2022-23. If the HICA cap were raised and the rate set at 1.5%, the crossover point would occur at the end of FY 2024-25.

Table 2 shows the assumptions and results for the regular analysis, the best-case, and the worst-case scenarios.

Table 2

## COMPARISON OF THE ASSUMPTIONS IN THE ANALYSIS

	<u>Senate Fiscal Agency Assumptions</u>	<u>Best Case Assumptions</u>	<u>Worst Case Assumptions</u>
<b><u>Base Program Costs</u></b>			
FY 2013-14 caseload	324,719	320,956	328,481
FY 2014-15 caseload	406,671	401,316	412,025
FY 2015-16 caseload	461,603	450,987	472,220
Caseload growth rate after FY 2015-16	2.00%	1.50%	3.00%
Initial FY 2013-14 average cost per case, physical health	\$5,116	\$5,116	\$6,100
FY 2014-15 average cost per case, physical health	\$5,178	\$5,178	\$6,314
Annual inflation rate	2.50%	1.50%	3.00%
Initial FY 2013-14 average cost per case, behavioral health	\$1,300	\$1,199	\$1,500
FY 2014-15 average cost per case, behavioral health	\$1,330	\$1,087	\$1,540
Annual inflation rate	2.50%	1.50%	3.00%
Initial FY 2013-14 average cost per case, total	\$6,416	\$6,315	\$7,600
FY 2014-15 average cost per case, total	\$6,508	\$6,265	\$7,854
<b><u>Savings</u></b>			
<b><u>Mental Health Savings</u></b>			
FY 2013-14 (three quarters of fiscal year)	(\$152,931,100)	(\$152,931,100)	(\$152,931,100)
FY 2014-15 and beyond (full year)	(\$203,908,100)	(\$203,908,100)	(\$203,908,100)
<b><u>ABW Savings (physical plus mental health)</u></b>			
FY 2013-14 (three quarters of fiscal year)	(\$26,104,500)	(\$26,104,500)	(\$26,104,500)
FY 2014-15 and beyond (full year)	(\$34,806,000)	(\$34,806,000)	(\$34,806,000)
<b><u>Corrections Savings</u></b>			
FY 2013-14 (three quarters of fiscal year)	(\$24,212,200)	(\$24,212,200)	(\$24,212,200)
FY 2014-15 and beyond (full year)	(\$32,282,900)	(\$32,282,900)	(\$32,282,900)
Annual inflation rate on Corrections savings	3.00%	3.00%	3.00%
<b><u>Other Savings</u></b>			
FY 2013-14 (three quarters of fiscal year)	(\$1,972,200)	(\$1,972,200)	(\$1,972,200)
FY 2014-15 and beyond (full year)	(\$2,629,600)	(\$2,629,600)	(\$2,629,600)
Annual inflation rate on other savings	3.00%	3.00%	3.00%
<b><u>HICA Revenue</u></b>			
Effective HICA rate, FY 2013-14 and beyond	1.00%	1.50% *	0.00% **

\* assumes 1.5% HICA rate with an increase or elimination of \$400.0 million plus inflation cap

\*\* assumes sunset of HICA or a 1.5% HICA rate with no change in the cap, thus no HICA benefit from expansion

### Why the Best-Case and Worst-Case Scenarios are Extremes

The assumptions used in deriving the best- and worst-case scenarios are not inherently related. Caseload growth is correlated with the overall economy but not specifically correlated with medical inflation. The HICA decision is a policy decision not tied to inflation or economic indicators. The initial cost per case is not tied to any of these factors either.

What all this lack of correlation means is that the best- and worst-case scenarios represent "drawing to an inside straight", in other words, all factors going as well as possible or as badly as possible. While two of the four factors cited above may tilt in one direction with the others remaining stable (or going the other way), it is unlikely that all four would tilt in one direction. Therefore, the best- and worst-case scenarios are useful for delineating the plausible limits of the analysis, but do not in any way represent a reasonably expected outcome.

### The Health Savings Fund

The final row in Table 1 displays what is estimated to happen under the SFA analysis if half of the GF/GP savings were deposited in a health savings fund, as Governor Snyder proposed. The fund would build up to \$556.6 million in FY 2018-19 before net GF/GP costs began to exceed net GF/GP savings in FY 2019-20. After that point the fund would begin to be spent and would be exhausted in FY 2024-25. This is different from the FY 2027-28 crossover point mentioned above because the crossover point reflects the point at which the cumulative effect of the expansion on Michigan's GF/GP spending would become zero. The health savings fund approach is a separate construct to reserve some of the savings to cover future costs.

### **CAVEATS**

HICA: As noted above, the policy on HICA probably has as much influence over this analysis as the initial cost per enrollee, the caseload growth rate, or the inflation rate. The decision on HICA is a policy decision largely independent of the decision on expanding Medicaid. Ironically, an increase in the HICA rate without a raise in the revenue cap would make the fiscal impact of the expansion worse rather than better (although it would make the State's overall fiscal situation better, even accounting for the lack of expansion revenue).

Woodwork Effect: This analysis assumes a greater woodwork effect than does the Administration'. It is very difficult to estimate this effect – and it would be difficult to measure even after expansion because people who show up at the exchange and get referred to Medicaid may have been headed for Medicaid anyway, and the health exchange could just be the first place they tried. The woodwork effect does not have a major impact on the cost estimate.

Behavioral Health Costs: The Administration assumed smaller initial behavioral health costs than those built into the SFA analysis. It is difficult to estimate the demand for behavioral health services for the population that would be subject to the expansion. There is some anecdotal evidence indicating that this population may prove to be high consumers of such services, perhaps with some pent-up demand. At this point, these people do not have an entitlement to a full range of services, with waiting lists for services not being uncommon. Therefore, this is perhaps the most unpredictable initial cost.

Caseload Growth: Caseload growth in the regular Medicaid program is correlated with the economy, but the overall trend has been slow growth except when the economy is very strong or very weak. It is not certain what the underlying caseload growth would be.

Medical Inflation: Medicaid cost per case has shown steady growth over the years. There is no question there will be medical inflation, though its magnitude is difficult to forecast. Past experience indicates that a 2% to 3% rate is most likely.

The Arizona Experience: While one should never overgeneralize based on one state with significantly different demographics, the Arizona experience with an expansion to 100% of the FPL indicates that the health care needs – and health care costs – for this population may be greater than assumed by the Administration and the SFA. If this is the case and costs reflect the Arizona averages (that is, are roughly 20% greater than assumed in the SFA analysis), then the crossover point would change from FY 2027-28 to FY 2024-25.

## **SECONDARY EFFECTS AND OTHER CONSIDERATIONS**

Arizona notwithstanding, the sort of expansion that is being proposed for the Medicaid Program has never been tried on such a scale. It is impossible to determine the likelihood of any secondary effects, let alone their magnitude.

Economic Benefits: As noted earlier, a \$2.0 billion full-year increase in health care spending would likely lead to more employment and economic activity in the State. The revenue impact of this is difficult to estimate and leads to long standing discussions about opportunity cost; therefore, it was not quantified in this analysis.

Business Behavior: Again, the structure of the penalties for businesses not offering health insurance and the expanded coverage through Medicaid expansion and the exchanges may lead to some businesses dropping insurance coverage. While this might happen to some degree whether or not Michigan expands Medicaid, the expansion could make it more likely that some businesses with a low wage scale would stop providing health insurance. If this resulted in a cascade effect, with other businesses following suit, both the expansion Medicaid and the regular Medicaid caseloads could increase well beyond expectations.

Federal Match Rate: The match rate is slated to drop to 90.0% in 2020. The Obama Administration has unsuccessfully proposed a "blended" match rate, set between the "traditional" match rate for regular Medicaid and the expansion match rate. Perhaps more notably, it has assumed savings resulting from this change, which implies a net reduction in Federal support. Any significant reduction in Federal support, whether through a blended rate or a reduction in the expansion match rate, would render this analysis relatively meaningless.

## **CONCLUSION**

Even in the worst-case scenario, the proposed expansion of Medicaid would result in large GF/GP savings during the first five years, with net GF/GP costs from January 1, 2014, onward not exceeding savings until the 10<sup>th</sup> year of the expansion. The SFA does not believe the worst-case scenario to be likely, but it is important to use that example to illustrate how long the savings, even in that case, would last.

The SFA believes that, assuming a continuation of HICA at 1.0%, the net total GF/GP costs from January 1, 2014, onward would exceed the net total GF/GP savings realized in the 15<sup>th</sup> year of the expansion, FY 2027-28. If the HICA revenue cannot be realized, either because of the sunset of HICA or an increase in HICA without an adjustment to the HICA cap, then the crossover point would be FY 2025-26.

The SFA has not addressed the Governor's proposed Health Savings Fund. It should be noted that this is simply a way to capture the GF/GP savings to offset later net costs. This analysis looks at global GF/GP savings and global GF/GP costs, so is fairly similar.

While the assumptions used can vary, particularly in regard to initial costs and caseload, HICA, medical inflation, and caseload growth, the overall point does not change. In any of these cases, expanding the Medicaid program would not result in any net GF/GP costs to the State in the short or medium term.

The estimated savings would not provide a huge windfall in a \$9.0 billion GF/GP budget, nor would the net GF/GP costs in the out years cause a huge budget crisis in a decade or two. The fiscal impact on the State as a whole, barring significant changes in the ACA, would not be trivial but would not make or break the State's long-term finances.

As the SFA has stated more than once, the decision on whether to approve the Medicaid expansion will be a matter of policy, not fiscal impact.

## THE SNYDER ADMINISTRATION'S ANALYSIS OF MEDICAID EXPANSION

This paper was written not to critique the Snyder Administration's analysis of the expansion but rather to offer a separate Senate Fiscal Agency analysis of the fiscal impact of the expansion. It is important, however, to outline the parameters of the Administration's analysis, as they provide an excellent guide for how to estimate the costs and savings tied to the expansion.

### Caseload and the "Woodwork Effect"

The Administration used an outside consultant to project the caseload, the "take-up" rate (the percentage of those eligible who enroll in a given year), and the so-called "woodwork effect". The consultant modeled the anticipated caseload based on population and income data and made reasonable assumptions about the rate at which eligible people would enroll, with 67% of those eligible assumed to enroll in FY 2013-14 and 84% in FY 2014-15, with the rate climbing to 94% in FY 2015-16. It should be noted that the take-up rate in the first three years has no impact on the fiscal analysis, as the Federal government would pay 100% of the cost in the first three years.

The Medicaid expansion caseload itself was projected to be just over 320,000 in FY 2013-14, just over 400,000 in FY 2014-15, and climbing to over 450,000 in FY 2015-16, with slow growth after that.

The "woodwork effect" refers to those who would approach the health exchanges to purchase insurance but would be found to be eligible either for "regular" Medicaid or the Medicaid expansion. In other words, there are people in this State who are eligible for Medicaid, or who would be eligible for the Medicaid expansion, but who have not enrolled. The creation of the health exchanges and the insurance mandate would lead some if not most of these people to come forward to seek insurance, to avoid the tax penalty for not having insurance. If these people were actually eligible for Medicaid (either the regular program or the expansion, if Michigan opted for the expansion), they would be enrolled in Medicaid. Thus, there's the notion of new Medicaid enrollees "coming out of the woodwork", or the "woodwork effect". These people would not be enrolled in Medicaid if not for the ACA. To the extent that some of these people were eligible for expansion Medicaid, this "woodwork effect" would represent an increased cost tied to expansion.

The Administration projected a comparatively slow take-up rate for the woodwork effect, with the number increasing from just over 11,000 in FY 2013-14 to more than 31,000 in FY 2014-15. It is not clear how many of these are assumed to be expansion cases; it is likely that the vast majority would be regular Medicaid cases.

### Physical and Behavioral Health Costs

The Administration, in proposing an FY 2013-14 and FY 2014-15 budget for the Medicaid expansion, included two line items, one for physical health services, and one for behavioral health services.

The Administration proposed appropriating \$1.23 billion in FY 2013-14 for physical health, to cover an estimated 321,000 cases for three quarters of the year, or an annualized cost of \$5,116 per case for physical health. The proposal for FY 2014-15 included \$2.08 billion to cover an estimated 401,000 cases, or a cost of \$5,178 per case.

On the behavioral health side, the Administration proposed appropriating \$288.6 million for the 321,000 cases for three quarters, or \$1,199 per case. The proposal for FY 2014-15 included \$436.1 million for the 401,000 cases, or \$1,087 per case.

In its analysis, the Administration projected costs per case forward, with an inflationary adjustment, such that the cost per case for physical and behavioral health combined in FY 2022-23 would be \$6,655 per case. (Separate numbers for physical and behavioral health were not provided.) This would represent a 0.76% per year inflationary increase between FY 2014-15 and FY 2022-23.

#### Savings due to Expansion

As noted above, the State would see considerable GF/GP savings if the Medicaid expansion were implemented. The expansion population consumes considerable State resources, especially in community mental health (CMH), the Adult Benefits Waiver, and Department of Corrections (DOC) health care services.

The Administration estimated that about \$65.2 million of the \$273.1 million CMH non-Medicaid line covers non-Medicaid reimbursable services or individuals who would not be eligible for the Medicaid expansion. The majority of this, \$35.8 million, is for services that Medicaid does not reimburse, such as some transportation services, respite care, certain prevention services, and jail diversion. The remainder, \$29.4 million, reflects the projection that 14.9% of the clientele were people who would not be eligible for the expansion due to income. The Administration chose to assume that almost \$70.0 million would be left in the line and projected full-year GF/GP savings of \$203.9 million (\$152.9 million over the last three quarters of FY 2013-14).

As noted previously, the Administration assumed termination of the Adult Benefits Waiver (savings of \$34.8 million GF/GP full year), reduction in DOC health care costs (savings of \$32.3 million GF/GP full year), and other minor savings of \$2.5 million GF/GP.

#### Administrative Costs

The Administration used the administrative costs of the regular Medicaid program as a percentage of expenditures to forecast administrative costs for the Medicaid expansion. It estimated a \$10.0 million GF/GP cost in the first year, with that increasing to an \$11.0 million GF/GP cost in subsequent years. Part of these costs would be realized in the Department of Human Services (DHS) as the DHS handles enrollment, though, for now, the administrative costs were reflected in the proposed FY 2013-14 DCH budget.

#### Increased HICA Revenue

The Administration projected increased Health Insurance Claims Assessment (HICA) revenue tied to the expansion, assuming a 1.5% rate and implicitly assumes removal of or an increase in the revenue cap to ensure full capture of the revenue. The assumption was \$10.7 million in HICA revenue offsetting GF/GP in FY 2013-14, with that climbing to \$11.9 million in FY 2014-15 and continuing to increase in subsequent years.

#### Net Savings

Once these items are combined, it is apparent that the Administration is projecting a very large net savings in the early years of expansion: \$205.9 million in GF/GP savings in FY 2013-14, with that increasing to a full-year savings amount of \$274.5 million in FY 2014-15.

### The Reduced Match Rate

In calendar year 2017, the match rate drops from 100% Federal to 95%. It then drops to 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter. Once the rate drops below 100%, the State starts facing costs to support the program. The Administration's analysis forecasts GF/GP costs from the State match requirement of \$99.8 million in FY 2016-17, \$158.0 million in FY 2017-18, \$190.8 million in FY 2018-19, \$269.7 million in FY 2019-20, and \$300.8 million in FY 2020-21.

### Savings versus Costs

The Administration estimates that, during FY 2019-20, the GF/GP costs of the expansion would be nearly equal to the GF/GP savings from the expansion, and would slightly exceed the savings in FY 2020-21. In subsequent years the costs would exceed the savings, and by FY 2031-32 the Administration estimates that the costs would exceed the savings by \$100.2 million GF/GP.

### The Health Savings Fund

Due to the significant savings in the early years, and the out-year costs, the Administration has proposed creation of a "Health Savings Fund", to set aside 50% of the estimated savings over the first seven years of the expansion, with that funding being used to cover the net increased costs in the years after FY 2019-20. This would be a way to assure that there was funding available to cover the increased costs for a number of years after the costs exceeded savings. In effect, it represents setting aside the savings in a Medicaid "rainy day fund" to offset costs years down the road.

The Administration estimates a deposit of \$103.0 million in the Fund in FY 2013-14, with future deposits over the subsequent six years leading to maximum funding of \$574.9 million in FY 2019-20. The Administration then forecasts money from the Fund being used to offset costs, with the Fund being zeroed out in FY 2034-35.

**A RESOLUTION OF SUPPORT FOR THE IMMEDIATE NEED TO INCREASE  
MICHIGAN'S INVESTMENT IN ROAD INFRASTRUCTURE**

**WHEREAS**, legislative inaction is causing Michigan roads to deteriorate at a rate of \$3 million daily – more than \$1 billion annually. According to the Michigan Transportation Asset Management Council (TAMC), the cost of returning all roads to good condition in 2004 was \$3.68 billion. By 2011, TAMC estimated the cost had ballooned to \$11.5 billion; and

**WHEREAS**, Michigan's roads are consistently ranked among the nation's worst. Motorists are already paying for these poor road conditions by approximately \$357 annually in unnecessary repairs to their vehicles due to poor roads. In addition, one-third of all fatal and serious traffic crashes in Michigan can be linked, in part, to poor road conditions; and

**WHEREAS**, Michigan's gasoline tax – the user fee that is the primary source of transportation funding – has not increased since 1997. At the same time, the gas tax revenue collected today, when adjusted for inflation, is equal to that which was collected in 1974; and

**WHEREAS**, Michigan's Townships including the Kalamazoo County Board of Commissioners have done everything they can with the resources available to them, but there simply isn't enough money to maintain our infrastructure. There is no way to cut or reform ourselves out of a more than \$1.5 billion annual funding shortfall; and

**WHEREAS**, we risk a future fiscal crisis if the investment in Michigan's infrastructure is not increased to improve the 35 percent of Michigan's roads and 36 percent of Kalamazoo County roads currently ranked in fair/poor condition; and

**WHEREAS**, we are quickly passing the tipping point where we can't afford to bring our road and bridge network back to good condition. By 2018, the percent in poor condition is expected to jump more than 65 percent without a significant increase in funding our roads and bridges will never be in better condition than they are in today. They will be worse; and

**NOW, THEREFORE, BE IT RESOLVED** by the Kalamazoo County Board of Commissioners that we hereby urge Governor Rick Snyder and the Michigan Legislature to increase the level of investment in Michigan's road system and distribute the revenue within the existing Public Act 51 formula in order to save taxpayer money, save lives, and repair our roads and bridges.

**BE IT FURTHER RESOLVED**, that copy of this resolution is transmitted to the Michigan Speaker of the House Jase Bolger, Senate Majority Leader Randy Richardville, Michigan State Senator Tonya Schuitmaker, Michigan State Representatives Sean McCann, Margaret O'Brien, and Aric Nesbitt, and to Michigan Governor Rick Snyder.

STATE OF MICHIGAN            )  
  ) SS  
COUNTY OF KALAMAZOO    )

I, Timothy A. Snow, County Clerk/Register, do hereby certify that the foregoing is a true copy of a Resolution adopted by the Kalamazoo County Board of Commissioners at a regular session held on May 21, 2013.

\_\_\_\_\_  
Timothy A. Snow  
County Clerk/Register

**A RESOLUTION REGARDING PROPOSED CHANGES TO  
THE MICHIGAN MENTAL HEALTH CODE**

**WHEREAS**, consistent with the 1963 Constitution of the State of Michigan, Article IV, Section 51, which declares that the health of the people of the State is a matter of primary public concern, and as required by the 1963 Constitution of the State of Michigan, Article VIII, Section 8, which declares that services for the care, treatment, education, or rehabilitation of those who are seriously mentally disabled shall always be fostered and supported; and

**WHEREAS**, Michigan law requires that the Michigan Department of Community Health (the Department) shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the State; and

**WHEREAS**, to this end, the Department has the general powers and duties to administer the provisions of chapter 2 of the Michigan Mental Health Code so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state; and

**WHEREAS**, pursuant to chapter 2 of the Michigan Mental Health Code it shall be the objective of the Department to shift primary responsibility for the direct delivery of public mental health services from the State to community mental health services programs whenever a community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area; and

**WHEREAS**, pursuant to the Michigan Mental Health Code the Department shall endeavor to develop and establish arrangements and procedures for the effective coordination and integration of all public mental health services and integration of all public mental health services, and for the cooperation between public and nonpublic services, for the purpose of providing a unified system of statewide mental health care; and

**WHEREAS**, Kalamazoo Community Mental Health and Substance Abuse Services Authority is a public governmental entity established by and separate from the county that created it; and

**WHEREAS**, the purpose of Kalamazoo Community Mental Health and Substance Abuse Services Authority is to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic services area, regardless of an individual's ability to pay; and

over →

**WHEREAS**, the Kalamazoo Community Mental Health and Substance Abuse Services Authority Board received and reviewed proposed amendments to the Michigan Mental Health Code that, if enacted, would give powers to community mental health services programs and community mental health services program-created regional entities to establish, govern, fund, and operate nonprofit organizations;

**NOW THEREFORE BE IT RESOLVED**; that the Kalamazoo Community Mental Health and Substance Abuse Services Authority Board opposes proposed amendments to the Michigan Mental Health Code that would give powers to community mental health services programs and community mental health services program-created regional entities to establish, govern, fund, and operate nonprofit organizations.

**BE IT FURTHER RESOLVED**; that the Kalamazoo Community Mental Health and Substance Abuse Services Board believes if these amendments are introduced to the legislature and enacted, they would unnecessarily move the public mental health system in Michigan away from its constitutional and statutory purpose and responsibilities as a county-sponsored safety net of governmental entities to serve adults with serious mental illnesses, children with serious emotional disturbance, adults and children with serious intellectual and developmental disabilities, and children and adults with serious substance use disorders.

**BE IT FURTHER RESOLVED**; that the Kalamazoo Community Mental Health and Substance Abuse Services Board believes that if these amendments are introduced to the legislature and enacted, they would extend governmental powers to allow governmental competition with private non-profit organizations in the State of Michigan.

**BE IT FURTHER RESOLVED**; that the Kalamazoo Community Mental Health and Substance Abuse Services Board believes that if these amendments are introduced to the legislature and enacted, they could potentially lead to the creation of governmental monopolies among multiple community mental health services programs and community mental health services program-created regional entities that govern, fund, and operate private non-profit organizations.

**BE IT FURTHER RESOLVED**; that the Kalamazoo Community Mental Health and Substance Abuse Services Board will take action to make its concerns and opposition to these amendments known to the Department, the Legislature of the State of Michigan and the public and individuals served.

Resolved by board motion on the 26<sup>th</sup> day of March, 2013.

  
Patricia M. Guenther  
Chair

  
Moses L. Walker  
Vice Chair

**Response to the Proposed Mental Health Code Amendments  
To Permit Community Mental Health Services Programs  
to Create, Own, and Govern Non-Profit Organizations  
Prepared by Jeff Patton, Chief Executive Officer  
Kalamazoo Community Mental Health and Substance Abuse Services  
Tuesday, February 26, 2013**

There are pros and cons for the public community mental health system to pursue amendments to the Michigan Mental Health Code to permit county-sponsored Community Mental Health Services Programs (CMHSPs) to create, own, and govern non-profit organizations. These amendments may benefit CMHSPs that are interested in or have established Federally Qualified Health Centers (FQHCs), FQHC look-alikes, and rural health clinics. Currently, Michigan law does not permit county governments and CMHSP entities created by counties to directly form a private nonprofit corporation. A brief legal analysis was provided to the Michigan Department of Community Health in 1998 which offered the following:

CMHSP Entities may attempt to create or participate in a non-profit corporation to further their collaborative efforts. A county cannot directly form a private nonprofit corporation "in the absence of constitutional or statutory provision. Michigan precedent, however, suggests that a county possibly can participate as a member of a nonprofit corporation, furnish initial funding to a nonprofit corporation and pay ongoing membership dues to a corporation, provided it can be demonstrated that the county advancing a public purpose and is not giving away anything of value in exchange for adequate consideration. In determining whether a county's contributions to a nonprofit corporation are in exchange for adequate consideration, Michigan courts and the Attorney General's Office have given deference to any decision by the legislature specifically to allow public entities to participate in a particular type of non-profit corporation. In the context of the Michigan Economic Development Corporations Act, which facilitates economic development projects by public agencies (including without limitation "commercial" projects), for example, the AGO determined that the statute properly conferred upon a county the discretion to transfer public funds to such a nonprofit corporation in order to engage in economic development activities on the county's behalf...The AGO...has indicated that, absent explicit legislative authority, one or more municipalities cannot form a nonprofit corporation, or contribute or appropriate public funds to a nonprofit corporation. This restriction against formation of a nonprofit corporation has been applied by the AGO to disallow such activity even if the legislature has generally, by statute, encouraged inter-governmental cooperation.

The establishment of a nonprofit entity, in which multiple CMHSP Entities were members, would create potential conflict of interest concerns. Fairly stringent conflict of interest policies apply to prohibit CMHSP Entities from contracting with any third parties when certain governing board or senior management overlap exists. Assuming a CMHSP Entity might contract to obtain administrative managed care services from a larger collaborative nonprofit corporation among multiple CMHSP Entities, such a conflict might

arise. Note that the conflict of interest also would need to be addressed in the event a collaborative among multiple CMHSP Entities were pursued through the Urban Cooperation Act.

Because Accountable Care Organizations (ACOs) are considered provider organizations, payers such as Medicaid Health Plans and Community Mental Health Services Program (CMHSP) Prepaid Inpatient Health Plans (PIHPs) would be prohibited or certainly legally challenged to create or be directly involved in the governance and operations of these types of organizations. CMHSPs, because of their provider status are strategically positioned to be part of ACOs that are created locally with their community health system partners. I am not convinced that singular formation of ACOs by CMHSPs or multiple county CMHSPs is advisable or necessary, particularly given the emphasis placed on integrating behavioral and physical health systems. Regional Entities as future PIHPs are not provider organizations, but payers of specialty Medicaid services. For this reason, I oppose amendments to the Michigan Mental Health Code that will give this type of enabling legislation to CMHSP created Regional Entities.

The downside to amending the Mental Health Code to permit CMHSPs to create and govern non-profit organizations, particularly for purposes of forming ACOs, is that it moves the public system away from its constitutional and statutory purpose. There are many non-profits organizations in the world -- some large and some very small. They all exist in a very competitive environment not only among and between themselves, but with the much larger for profit sector. The main question that public mental health system must be prepared to answer is: *Will the creation, ownership and governance of non-profit organizations address a public interest concern?* I do not believe it does because of the very existence and variety of private non-profit and for profit organizations that have very important purposes and missions in our society.

The other more pressing and related question is whether the CMHSP creation of non-profit organizations violate Stark and other antitrust laws, particularly those identified in the recent roll-out of the Medicare ACOs. Will CMHSPs fall within antitrust safety zones or for those that do not require formal federal antitrust reviews? A case could possibly be made for rural CMHSPs that are within Primary Service Areas (PSAs) that are within sparsely populated areas and have severe shortages of providers and services. But larger CMHSPs or regional networks of CMHSPs that form non-profits and the singled focused CMHSP "Safety Net" ACOs, may trigger such reviews stemming from charges of being anticompetitive with their commercial counterparts. Certainly, Moreover, it is highly probable that the CMHSP system and counties that create them will be scrutinized harshly for what may be perceived as monopolistic and anticompetitive with private nonprofit and for profit corporations. It also brings into question and criticism the role of government, which continues to be the center of political discourse. Even if permitted to create, own and govern separate non-profit organizations, CMHSPs will not be able to escape public scrutiny and governmental oversight.

This reminds me of when I was Executive Director of a Community Health Center (Family Health Center, Inc.) in Kalamazoo in the 80s. The federal government was pushing and encouraging Community Health Centers to aggressively compete with the private for profit sector. The reasoning behind this was to reduce the Centers' reliance on federal support. Through federal planning grants, some Community Health Centers were transformed into the first Health Maintenance Organizations (HMOs). Most did not acquire this designation and either remained non-profit Community Health Centers or became what is now called Federally Qualified Health Centers (FQHCs). So, why is the Michigan Department of Community Health encouraging and supporting the movement of the public mental health system into the private non-profit sector? This is a question that should be publicly answered.

CMHSPs could risk the permanent loss of its public identity, constitutional mission, purpose, and immunity. Given the enormous challenges facing the public mental health system as the safety net for persons with serious mental illnesses, children and youth with serious emotional disturbance, persons with serious intellectual and developmental disabilities, and persons with serious substance use and addictive disorders, the CMHSP system should remain focused on its mission and purpose and not impose itself in the arena of non-profit and for-profit organizations. The loss of its public identity, constitutional mission, purpose, and immunity will have disastrous consequences.