Michigan Association of Health Plans

Senate Subcommittee on Department of Community Health Appropriations

July 17, 2008

(Presentation of Rick Murdock, Executive Director of Michigan Association of Health Plans)

Thank you Senator Kahn and members of the Subcommittee for holding a hearing on this important issue that our state will be facing as we contemplate the FY 10 budget development. I would like to take a few moments today to outline the issue at hand, some history regarding the development of the HMO QAAP and then the options that may be considered. While this is an issue that affects our Medicaid Health Plans and other partners in the Medicaid program, I do want to make it clear that the MAHP has not taken a position yet regarding any recommended solution. We believe as you do, that the first step is to create greater awareness of the pending issues and that in open deliberation we can jointly arrived at a solution.

Current Issue

Most States are experiencing increasing difficulty in raising their share of the Medicaid program's cost. The current economic slowdown is exacerbating this problem. Enrollment and expenditures in the Medicaid program grow as the economy weakens and state revenues decline. To protect Medicaid beneficiaries, Michigan continues to need access to an array of mechanisms they can be used to raise funds to support the Medicaid programs. Due to the historical and bipartisan support that transcends administrations, Michigan has been aggressive in the use of "Special Medicaid Financing Initiatives". These initiatives provided not only the necessary resources to protect the Medicaid safety net that we have come to depend on, but it continued to use non-GF revenue.

One source of funding has been a tax on Health Maintenance Organizations (HMOs) that have a Medicaid contract with the State. As we know, the Federal Deficit Reduction Act of 2005 (DRA) specifically limited the future state use of such taxes. However, The DRA grandfathered eight states that had the approval of an HMO provider tax so that these new requirements would not apply until October 1, 2009.

These eight states (California, Georgia, Kentucky, Michigan, Missouri, Ohio, Oregon and Pennsylvania) all are using a Medicaid HMO provider tax that has been approved by the Centers for Medicare & Medicaid Services (CMS) to help fund state Medicaid programs.

In Michigan, the HMO provider tax is not only applied on all premiums earned by Medicaid Health Plans but is applied to the Medicaid premium (capitation) paid to Community Mental Health programs, as they are defined as a managed care organization.

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Therefore the combined amount of provider tax is substantial (more than $300 Million in FY 09 producing gross spending with federal matching funds of nearly $800 Million. Without adjusting for the loss of such funds starting in October 2009 the Medicaid safety net will be at risk.

Legislative History

Michigan's use of any provider tax (QAAP) began in 2002 with the enactment of legislation creating Michigan's HMO provider tax. The impetus for this legislation came from the membership of MAHP in order to develop a means to provide necessary revenue at a time when additional general fund support was limited and before the federal rules requiring "actuarial sound funding for Medicaid Health Plans were implemented. Through extensive legal research by MAHP members and collaboration with the Administration and Legislature, legislation was enacted, (PA 304 of 2002). Unfortunately, the federal government indicated that that legislation required additional safeguards in order to secure federal approval and federal matching dollars, and a amended version was enacted later in 2002, (PA 621 of 2002). As indicated above, the Community Mental Health Programs were added under the definition of managed care in legislation passed in 2005, (PA 83 of 2005). This history highlights the fact that both Republican and Democratic Administrations have been supportive of these initiatives as have Republican and Democratic sponsors of legislation.

I might add that currently H.B. 6062 has been introduced this recently to further amend the QAAP in order to continue the effective date into FY 09 and we are hopeful for both House and Senate action prior to the start of the Fiscal Year.

Cumulative Value

So, why is this issue? Beyond the immediate issue of maintaining the safety net in Medicaid— which is at risk here, is the potential for unraveling the Medicaid managed care program is a major concern if this issue is perceived only as a shortfall in support of managed care as opposed to what it is: *An overall Medicaid shortfall*.

As we provided detail in the advocacy for the FY 09 budget the demonstrated audited outcomes of the Michigan Medicaid managed care program are its strongest features. This is due to the nature of the performance-based contract, the inherent flexibility of a managed care system that results in innovations, and the emphasis on prevention, care coordination and disease management. This has meant nearly $2.5 billion in total savings compared to alternatives in the fee for service program between FY 00 and FY 06 or between $350 and $400 million each year and is displayed below. This return on investment enabled both the State of Michigan and the Federal Government to redirect the savings into other high priority areas. Further, these cost savings are accompanied by increasing improvements in health status measures for children and adults that are determined by audited record review, and greater access to needed health care

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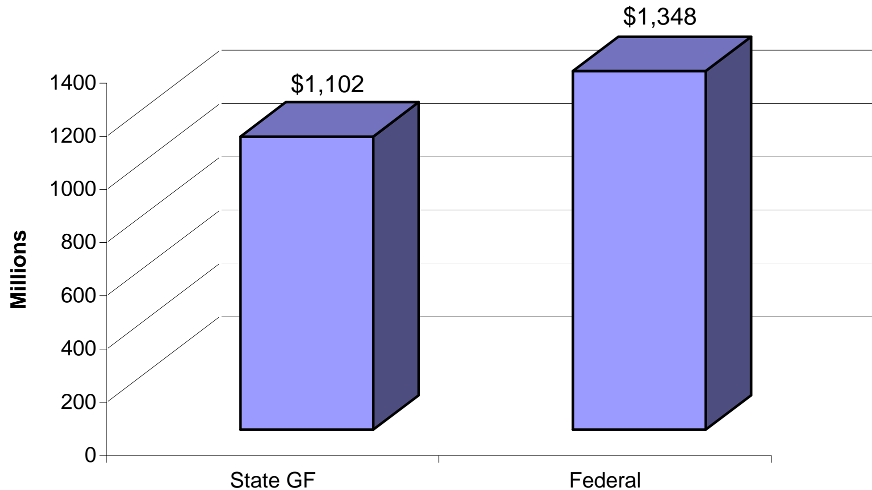
services documented by provider file contract information retained by the state.



It is with great pride that we continue to note that the performance of Michigan's Medicaid Managed care programs remains among the best in the country as documented by the National Committee on Quality Assurance, NCQA. In the last national rankings reported in October of 2007, 10 of the top 50 Medicaid Plans in the United Stated are from Michigan. ***Continuing to invest in Medicaid managed care will continue to provide these results for Michigan***.

According to the Centers for Medicare and Medicaid Services (CMS), 43 percent of the Medicaid population was enrolled in managed care as of 2006—and nearly 66% in Michigan. A number of states, though, have "carved out" some of the highest-cost services from their managed care programs, and most states have excluded entire eligibility categories—generally the high-cost populations—from their managed care initiatives. As a result, while more than half of all Medicaid beneficiaries are enrolled in managed care, more than 80 percent of national Medicaid spending remains in the FFS setting.

Given the adverse budget pressures currently confronting states, policymakers are understandably interested in assessing whether such Medicaid managed care expansion might ease these fiscal pressures. We believe that continuing to expand managed care in Medicaid can ease the fiscal pressure from the loss of the HMO tax.

Savings Opportunities

Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care and containing costs in the FFS setting. The FFS model is an unstructured system of care that creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively. Health maintenance organizations (HMOs), on the other hand, combine within one entity the responsibility for both the financing and delivery of health care and thus have strong incentives –

and means – to coordinate care and, in turn, reduce the costs of inpatient and other expensive categories of health care services, where Medicaid spending is concentrated.

Initiatives to generate savings in the Medicaid FFS setting have predominantly focused on price controls, whereby states cut their payments to providers. While this approach may result in savings, it is not without risks. Low payments drive mainstream physicians out of the Medicaid program, impeding Medicaid beneficiaries' access to primary, preventive and specialty care services and funneling Medicaid care toward more expensive institutional-based services.

Medicaid managed care plans have opportunities to achieve savings through a number of mechanisms, including but not limited to the following:

- Improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients
- Investing in enrollee outreach and education initiatives designed to promote utilization of preventive services and healthy behaviors
- Providing a "medical home" to an individual and utilizing a physician's expertise to refer patients to the appropriate place in the system (as opposed to relying on the patient's ability to self-refer appropriately)
- Providing individualized case management services and disease management services
- Channeling care to providers who practice in a cost-effective manner
- Using lower cost services and products where such services and products are available and clinically appropriate (in lieu of higher-cost alternatives)
- Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness

Options

As we look at this issue created by the loss of the HMO provider tax, there are a number of options that can be pursued. As I indicated at the outset, our Association has not taken a position on any of these options at this time, except for pursuing federal relief.

1. **Amend Federal Law** to either extend the "grandfather clause" for Michigan and the 7 other states or permanently exempt them. MAHP will be pursuing this option with our national affiliate, AHIP and the other states; however the timing of this approach would have to take place next calendar year and the likelihood, given the other Medicaid issues that have been placed on moratorium until Spring of 2009 is daunting.

2. **Reform, Revise and Redirect.** This approach would place the burden on those administering the Medicaid program and those participating in its operation. This would likely require the issues of eligibility and benefits to be revisited. It would also require the Administration to seek some of the flexibility provided under the Deficit Reduction Act. Reform may also include moving more population into managed care and creating further

savings that may result. This approach may also be inclusive of looking at other provider taxes. If this option is to be pursued, then work must begin soon to have various approvals in place prior to October 1, 2009.

3. **Enact Broad-based insurance tax.** This approach is the only acceptable approach by the federal government in replacing the HMO tax. This approach would approve revenue from a tax for federal match if it broad-based and is applied uniformly to all insurance carriers. However, the impact of this option is significant. The issue of increasing the cost to other payers (business, government, and individuals) at this point in our economy is a very serious issue. We also need to understand that at least 45% of the insurance carried in this state is provided through self-insurance programs that are typically exempt from any state assessment or tax.

   As you will recall much of the debate in the Individual Market Reform centered on the need to avoid increasing the cost of insurance for individuals. We appreciated and **continue to support the Senate version of the Individual Market Reform** for that reason and for the need to fully understand all of the implications of insurance reform before we moved forward and avoid creating a high risk pool at this time that does not address the more important needs of the uninsured and Medicaid program.

   We believe if this option is pursued, then the assessment must be as broad based as possible in order for the assessment/tax to be as low as possible. Therefore, if this option were pursued, unless there was a mechanism to include the self-insured plans, the assessment or tax would still create a significant increase that would be passed on to other payers and could result in fewer individuals taking up insurance coverage due to price increase. The State of Maine recently enacted legislation that should be reviewed if this option is pursued. Their legislation assesses all carriers, including self insured plans.

4. **Do nothing.** Unless the economy makes a sudden and quick turnaround and results in a drop of Medicaid enrollment, this approach will require the eligibility and/or benefit changes that have been maintained in Medicaid. The likely impact will then also increase uncompensated care provided by Michigan Hospitals and have the collateral effect of increasing the cost of premiums by other carriers to cover the increased hospital costs.

Summary

The pending expiration of the HMO tax will create challenges for the Legislature and the Administration. There are several options that can be pursued all of which would need to be determined and be underway in the remaining months of this year. We believe that rather than imposing a solution that the legislature and administration should convene a process to bring affected parties together to arrive at a balanced and planned transition. Thank you for holding this session today and we hope to work closely with you on this issue over the next months.