MAY 2018

Children, Families, Health, and Human Services Interim Committee
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# MEDICAID EXPANSION: POTENTIAL CONSIDERATIONS

## Background

Because Montana's Medicaid expansion program will sunset on June 30, 2019, without further action by voters or the Legislature, the Children, Families, Health, and Human Services Interim Committee has devoted time during the 2017-2018 interim to reviewing the effects of Medicaid expansion. At their March 2018 meeting, members suggested that a list of potential decision points be compiled for the committee's consideration during the remainder of the interim.

This briefing paper summarizes information the committee has received to date and provides a list of items the committee may want to consider if it decides to take action related to any aspect of the expansion program.

## Montana's Expansion Law: Special Provisions and Current Status

The 2015 Legislature approved Senate Bill 405, the Montana Health and Economic Livelihood Partnership (HELP) Act, to expand Medicaid to nondisabled, childless adults who are 19 to 64 years of age and who have incomes of up to 138% of the federal poverty level. Both the bill and the subsequent federal waivers for carrying out the law imposed some specific requirements on the program and on enrollees, as summarized below.

- **Premiums**: Enrollees with incomes above 50% of poverty must pay monthly premiums equal to 2% of their incomes. SB 405 required premiums of all enrollees, but the Centers for Medicare and Medicaid Services (CMS) prohibited premiums for with incomes at or below 50% of poverty. Those individuals made up 72% of expansion enrollees as of March 1, 2018.

- **Disenrollment**: Enrollees with incomes above 100% of poverty must be removed from the program if they fail to pay their premiums within 90 days of being notified that payment is overdue. However, CMS allowed the state to re-enroll people after the Department of Revenue sends a notice of the debt, rather than upon assessment or payment of the overdue amount, as originally required under SB 405.

- **Taxpayer Integrity Fee**: Enrollees with assets that exceed a primary residence, one vehicle, and $50,000 in cash or cash equivalent must pay a "taxpayer integrity fee" of $100 a month plus $4 a month for each $1,000 in assets above the base amount. The Revenue Department has notified several people they may be subject to the fee but has not collected any revenue from the fee.

- **HELP-Link**: Enrollees have the opportunity to participate in a voluntary workforce development program known as HELP-Link and operated by the Department of Labor and Industry. When Montana's waiver was approved in 2015, CMS did not allow states to require people to work in order to obtain Medicaid. CMS this year has approved work or other community engagement requirements in three states, and requests from other states are pending.

- **TPA**: The HELP Act required the state to contract with a third-party administrator (TPA) to create a provider network and process premiums and claims for most enrollees. However, CMS said people at or below 50% of poverty could not be included in the TPA arrangement, meaning most enrollees were not a part of program run by Blue Cross Blue Shield of Montana. In addition, Senate Bill 261 in 2017 required cancellation of the TPA contract if state revenues for fiscal year 2017 failed to meet certain targets. Revenues did not meet the target levels, and the Department of Public Health and Human Services (DPHHS) allowed the contract to expire Dec. 31, 2017. The department has taken over the activities formerly handled by Blue Cross.

- **Continuous Eligibility**: DPHHS asked CMS to allow expansion enrollees to remain in the program for a full 12 months, even if their income increases above 138% of poverty during that time. CMS approved this request for what is known as "continuous eligibility," but decided not to pay the enhanced matching rate for all expansion enrollees. That resulted in a slightly lower level of federal match than anticipated.

SB 405 also changed other health care-related laws. The following changes also will sunset in 2019 without further action:

- Health care services for people in the custody of the Department of Corrections or in a DPHHS institution must be paid at Medicaid rates if the costs aren't covered by insurance, Medicaid, or another governmental program.
- Plaintiffs in medical malpractice lawsuits must accomplish service of their lawsuits within 6 months after filing and must file suit within 2 years of the action, rather than 3 years as previously allowed under law.
- DPHHS is to make efforts to reform the Medicaid program.
- A 12-member oversight committee of legislators, state agency representatives, and public members must meet at least quarterly to review the Medicaid program, monitor the expansion effort, and make recommendations to the Legislature. The governor appointed four additional ex-officio members to the panel.

## On the Horizon: Initiative 185

Advocates of Medicaid expansion began gathering signatures in mid-April for a ballot measure that would raise tobacco taxes and permanently expand Medicaid by removing the HELP ACT sunset. Initiative 185 would require money from the tobacco tax increase to be used as follows:

- up to $2 million per fiscal year for veterans' services, including suicide prevention efforts;
- up to $3 million per fiscal year to fund tobacco use prevention or cessation programs;
- up to $5 million per fiscal year to increase the number of home and community-based services waiver slots for elderly and physically disabled individuals; and
- up to $25 million per fiscal year to pay for the state's share of costs for Medicaid expansion. Those costs are projected to total $82.5 million in the current 2-year budget period.

I-185 also encourages the Legislature to "investigate enhancements to the HELP Act," including changes to the HELP- Link workforce program and any items proposed in the HELP Act Oversight Committee report, including cost-sharing mechanisms. Backers must gather 25,468 signatures by July 20 for the measure to go on the November ballot. The signatures must include at least 5% of the voters in 34 House districts.

### Potential Legal Issue

The Legislative Services Division review of the initiative proposal, required under state law, identified a potential substantive issue because repealing the sunset provision means the existing statutory appropriation for Medicaid expansion will continue. This type of appropriation does not allocate a specific dollar amount for a program, as typically occurs with a general

appropriation bill. Instead, it's a permanent section of law that contains language allowing a state agency to spend whatever amount of money is necessary to provide a specific service — in this case, to pay for Medicaid expansion costs.

Article III, section 4, of the Montana Constitution prohibits voters from enacting appropriations by initiative. The Legislative Services Division legal review noted that the initiative would lead to the appropriation of continued funding for Medicaid expansion, even though it doesn't contain a dollar amount for the appropriation. The legal review also said that no case law exists on the question of extending a statutory appropriation by initiative, but it suggested that initiative sponsors could address the potential problem by allowing the statutory appropriation to sunset.[1]

The sponsors chose not to revise the proposal, so the statutory appropriation would continue if the initiative is approved. The sponsors said the initiative does not contain "an actual appropriation of money" and that the Montana Supreme Court has not accepted legal challenges on initiatives that don't contain an actual appropriation.[2]

## Federal Changes to Medicaid Regulations

CMS has approved waivers in recent months that have let states impose requirements that were not previously allowed for state Medicaid programs. These include:

- requiring enrollees to work or participate in other "community engagement" activities for a specified amount of time in order to receive benefits;
- imposing premiums as high as 4% and minimum monthly payments for all enrollees regardless of income or imposing premium surcharges based on unhealthy behaviors;
- allowing disenrollment of people who don't provide necessary documentation for eligibility redetermination or who fail to report a change in circumstances that could affect their eligibility;
- eliminating or limiting the usual 3-month retroactive eligibility period for some enrollees;
- eliminating coverage of nonemergency transportation for some enrollees.

CMS is still reviewing requests by states to impose lifetime limits on Medicaid eligibility, allow more frequent eligibility determinations, require drug screening and testing, and limit coverage under Medicaid expansion to people with incomes of 100% or less of poverty.

## Potential Items for Committee Consideration

The table on the following page outlines, by topic area, items covered in Montana's current waiver, contained in I-185, or raised by recent CMS decisions. The table presumes removal of the sunset provision on the HELP Act and indicates the next steps if the committee answers "yes" to any of the questions.

In addition to legislation, some items also would require DPHHS to seek changes to the expansion waiver. Legislation would need to direct DPHHS to apply for those changes.

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[1] "Review of Statutory Initiative to Raise Tobacco Taxes to Fund Health Care Programs, Jaret Coles, Legal Services Division, March 7, 2018, P. 3.

[2] "Re: Review of Statutory Initiative to Raise Tobacco Taxes to Fund Health Care Programs, Jessie Luther, March 9, 2018, P. 2.

| SB 405 Topic | Yes/No | If Yes, Then… |
|---|---|---|
| **Premiums** | Should the premium be eliminated? | Legislation is needed to remove the requirement. |
| | Should the premium remain at 2%? | No further action is needed. |
| | Should the premium be set at a different level? | What should the premium level be? |
| | Should enrollees at or below 50% of poverty pay premiums or pay a minimum monthly fee? | What should the premium or minimum payment be? |
| **Disenrollment** | Should the disenrollment exceptions for failure to pay premiums be continued? | No further action is needed. |
| | Should any disenrollment exceptions be removed or added for failure to pay premiums or for other actions? | What would those be? |
| | Should enrollees be disenrolled for any reasons other than failure to pay premiums? | What other actions or failures to act would lead to disenrollment? |
| **Taxpayer Fee** | Should the fee be retained as is? | No further action is needed. |
| | Should the fee be eliminated? | Legislation is needed to remove references to the fee. |
| | Should the fee or the process for collecting it be modified? | What changes should be made? |
| **HELP-Link** | Should the program be retained? | No further action is needed. |
| | Should the program be eliminated? | Legislation is needed to eliminate the program. |
| | Should the program be mandatory? | How should participation be defined?<br>What are the consequences for failing to participate? |
| | Should the program be modified in other ways? | What changes should be made? |
| **TPA** | Should the SB 261-triggered cancellation of the TPA contract remain in place? | Legislation is needed to eliminate the TPA references. |
| | Should the SB 261-triggered cancellation of the TPA contract be reversed? | Legislation is needed to direct DPHHS to issue an RFP and apply for another waiver. |
| **Continuous Eligibility** | Should the state stop allowing 12-month eligibility for expansion enrollees? | How often should eligibility be redetermined? |
| **Oversight Committee** | Should the committee be retained? | Should changes be made to the membership or duties? Should the number of members be limited? |
| | Should the committee be eliminated? | Legislation is needed. |
| **Medical Malpractice** | Should the 6-month service of lawsuit requirement be maintained or eliminated? | Legislation is needed to retain the provision if I-185 is not approved and to eliminate it if I-185 passes. |
| | Should the 3-year deadline for filing a lawsuit be maintained or revert to 2 years? | Legislation is needed to retain the provision if I-185 is not approved and to revert if I-185 passes. |
| **Costs for People in the State's Custody** | Should the provision tying reimbursement to Medicaid rates be eliminated or retained? | Legislation is needed to eliminate the provision if I-185 passes or to retain it if I-185 fails. |
| | Should the rate be changed in some other way? | What changes are needed? |
| **Waiver Topics** | **Yes/No** | **If Yes, Then…** |
| **Community Engagement** | Should a community engagement requirement be added? | How should the requirement be structured? What activities would be counted? Who would be exempt from the requirement? What is the penalty for noncompliance? |
| **Premium Surcharges** | Should a surcharge be added to premiums for certain unhealthy behaviors? | What behaviors would be subject to a surcharge? What would the surcharge be? |
| **Retroactive Eligibility** | Should the 3-month retroactive eligibility period be eliminated or limited? | What limitations would be imposed? Would certain groups be exempted? |
| **Nonemergency Transportation** | Should nonemergency transportation be limited to certain groups of enrollees? | How would the services be limited? |