

Updated January 2016 | Fact Sheet

Medicaid Expansion in Michigan

Michigan obtained approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Affordable Care Act's (ACA) Medicaid expansion through a Section 1115 demonstration waiver, called the "Healthy Michigan Plan." The waiver initially was approved on December 30, 2013, and was implemented beginning April 1, 2014. On December 17, 2015, CMS approved Michigan's waiver amendment, with new authorities to take effect in April 2018, after the expansion has been in effect for 48 months.¹

Under the current Healthy Michigan Plan, the state provides Medicaid coverage to all newly eligible adults with income up to and including 138% of the federal poverty level (FPL, \$16,243 per year for an individual in 2015).² An estimated 605,000 adults are enrolled in coverage through the waiver as of September, 2015.³ The waiver requires all beneficiaries to make monthly payments into a health savings account based on their average co-payments for services used in the previous six months (at state plan amounts). The waiver also requires beneficiaries from 100-138% FPL to make income-based monthly premium contributions to health savings accounts (2% of income). Health savings account payments can be reduced through compliance with specified healthy behaviors, and failure to pay copayments or premiums does not result in a loss of Medicaid eligibility. The waiver uses Michigan's pre-existing Medicaid Managed Care Organizations (MCOs), and Pre-paid Inpatient Health Plans (PIHPs) for mental health and substance abuse services, to serve the newly eligible population.

Under the approved waiver amendment, beneficiaries between 100% and 138% FPL who are not medically frail will choose between two coverage options as of April 2018:⁴

- Continued coverage through Medicaid managed care (the Healthy Michigan Plan), or
- Medicaid premium assistance for Marketplace coverage through a Qualified Health Plan (QHP) (the Marketplace Option).

If beneficiaries choose Medicaid managed care, they will be required to complete a healthy behavior, or they are subject to transition to a QHP. Beneficiaries above 100% FPL will face monthly premiums of up to 2% of income in both Medicaid managed care and QHPs, but failure to pay would not result in termination of eligibility.

As of December 2015, [31 states](#) (including DC) have adopted the ACA's Medicaid expansion. Michigan is one of six states (along with [Arkansas](#), [Indiana](#), [Iowa](#), [Montana](#), and [New Hampshire](#)) that are implementing the Medicaid expansion using a Section 1115 demonstration waiver as of 2016. [Pennsylvania](#) had initially implemented the Medicaid expansion using a Section 1115 demonstration but later transitioned to a traditional Medicaid expansion using state plan authority.

Table 1 highlights the components in Michigan’s original waiver and is updated to reflect approved changes in the waiver amendment effective in April 2018.

Table 1: Healthy Michigan Plan as Amended on December 17, 2015	
Element	Healthy Michigan Plan
Overview:	<p>Covers childless adults ages 19 to 64 from 0 to 138% FPL statewide through Medicaid managed care. Requires copayments at state plan amounts for all beneficiaries, which may be reduced by participating in specified healthy behavior activities. Copayments are paid into health savings accounts monthly based on the average copayments for services used in the previous six months. Also requires beneficiaries 100-138% FPL to pay monthly premiums (2% of income) into health savings accounts. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services, for failure to pay copays or premiums.</p> <p>Beginning April 2018, beneficiaries with incomes above 100% FPL who are not medically frail will choose between 2 options: continued coverage through Medicaid managed care or Marketplace QHP coverage with Medicaid premium assistance and cost-sharing subsidies. Those choosing Medicaid managed care must meet a healthy behavior requirement after a one year grace period.</p>
Duration:	12/30/13 to 12/31/18. Enrollment began 4/1/14.
Coverage Groups:	Adults ages 19-64 up to 138% FPL (childless adults 0-138% FPL, non-working parents from 37-138% FPL, and working parents from 64-138% FPL). ⁵
Exempt Populations:	<p>Noncitizens eligible only for emergency services, Program for All-Inclusive Care for the Elderly (PACE) participants, and individuals residing in intermediate care facilities for individuals with intellectual and developmental disabilities (ICFs/IDD).</p> <p>As of April 2018, newly eligible adults above 100% FPL who are medically frail will remain in Medicaid managed care and are not subject to being transferred to a Marketplace QHP with Medicaid premium assistance if they do not complete a healthy behavior (described below).</p>
Premiums:	<p>Beneficiaries above 100% FPL pay monthly premiums in the amount of 2% of income.</p> <p>Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay premiums. This applies to both those in Medicaid managed care and in QHP coverage, when that option becomes available in April 2018.</p> <p>Cost-sharing and premiums cannot exceed 5% of household income.</p>
Co-Payments:	<p>All demonstration beneficiaries have cost-sharing obligations based on their average prior 6 months of copays, billed at the end of each quarter. Cost-sharing is paid into health savings accounts and can be reduced through compliance with healthy behaviors. Amount of cost-sharing is based on state plan amounts and not changed from what would have been collected without the waiver.⁶ Cost-sharing for beneficiaries receiving coverage through Marketplace QHPs, when that option becomes available in April 2018, also will be limited to Medicaid state plan amounts.</p> <p>Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays. Copays in excess of 2% of income may be reduced through compliance with healthy behaviors. Cost-sharing and premiums cannot exceed 5% of household income. These provisions apply to beneficiaries in Medicaid managed care and those in QHP coverage</p>
Health Savings Account and Healthy Behavior Protocols:	<p>Health savings account and healthy behavior protocols were developed by the state and approved by CMS. The health savings account protocol describes the online accounts used by beneficiaries enrolled in MCOs and the healthy behavior protocol describes the services beneficiaries can engage in to decrease cost-sharing requirements and how engaging in these activities decreases their required cost-sharing. Changes to the protocols are also subject to CMS approval.⁷</p> <p>The state must submit a revised healthy behavior protocol to CMS by July 1, 2017 to</p>

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Element	Healthy Michigan Plan
	<p>implement the new healthy behavior requirements for non-medically frail beneficiaries with incomes above 100% FPL as of April 2018; these requirements cannot be more restrictive than those approved in August 2014. These beneficiaries will have a one year grace period to complete a healthy behavior before they are subject to being moved from Medicaid managed care to Marketplace premium assistance. Enrollees who move from Medicaid managed care to Marketplace premium assistance (for failure to complete a healthy behavior) will be automatically transitioned without additional eligibility determinations. Those who are newly enrolled or whose income increases above 100% FPL in or after April 2018, will have one year of Medicaid managed care coverage to complete a healthy behavior before they are subject to QHP enrollment. By April 1, 2017, the state must submit a transition plan for how the new waiver provisions will be implemented for beneficiaries above 100% FPL in April 2018.</p>
Delivery Systems and Benefits:	<p>No Medicaid benefits are waived.</p> <p>Medicaid MCOs and PIHPs (for mental health and substance abuse services) are used to serve the newly eligible population. Beneficiaries in Medicaid managed care receive an Alternative Benefits Plan (ABP) that contains the same benefits as the state plan benefit package.</p> <p>Beneficiaries receiving Medicaid premium assistance for Marketplace coverage (beginning in April 2018) will receive an ABP that may be specific to the QHP in which they are enrolled. Michigan will provide wrap-around coverage on a fee-for-service basis for non-emergency medical transportation, EPSDT and family planning services and supplies including access to out-of-network family planning providers for beneficiaries in QHPs. These beneficiaries will also have access to at least one QHP in each service area that contracts with an FQHC/RHC. QHP enrollees may have prescription drug prior authorization requests decided within 72 hours instead of 24 hours, with a 72 hour supply dispensed in an emergency.</p> <p>Those newly determined eligible for waiver coverage will initially be placed in fee-for-service until an MCO is selected or auto-assignment occurs.</p>
Plan Choice and Auto-Assignment:	<p>Enrollment broker assists beneficiaries with MCO selection before relying on auto-assignment.</p> <p>According to the waiver, MCO auto-assignment first takes into account beneficiary's prior or current MCO history and then MCO affiliation of beneficiary's historic providers.</p> <p>In rural counties,⁸ there will only be one MCO. In all other areas, beneficiaries will have a choice of MCOs. There will be one PIHP per region.</p> <p>MCO lock-in for 12 months after initial 90 days to switch plans.</p> <p>The state will develop an auto-assignment methodology for QHP enrollment when that option becomes available in April 2018,</p>
Financing:	<p>The budget neutrality limit calculations for the waiver are estimated to be the PMPM for each year increased by 5.1% multiplied by the number of eligible member months and adding the products across years and applying the federal share.</p>
Cost-effectiveness:	<p>Michigan may apply state-developed measures in evaluating the cost-effectiveness of Marketplace premium assistance.</p>
Evaluation:	<p>An evaluation design was developed by the state and approved by CMS to examine the following topics: uncompensated care costs, reduction in number of uninsured, impact on healthy behaviors and health outcomes, beneficiary views on impact of demonstration, impact of contribution requirements, and impact of health accounts.⁹ The state must submit a draft evaluation design update reflecting the waiver amendment provisions by April 2016.</p>

Endnotes

¹ The state legislation authorizing Medicaid expansion called for the termination of the Healthy Michigan Plan on April 30, 2016 if the state failed to obtain approval of the waiver amendment by December 31, 2015. Mich. Comp. Laws § 400.105d, [http://www.legislature.mi.gov/\(S\(wobdpchgm1olcvuemkv15bic\)\)/mileg.aspx?page=getObject&objectName=mcl-400-105d](http://www.legislature.mi.gov/(S(wobdpchgm1olcvuemkv15bic))/mileg.aspx?page=getObject&objectName=mcl-400-105d).

² Marilyn Tavenner, Administrator of the Centers for Medicare and Medicaid Services, Waiver Approval Letter, December 30, 2013, accessed on January 3, 2014, https://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf.

³ Healthy Michigan Section 1115 Demonstration, Centers for Medicare and Medicaid Services, Special Terms and Conditions Approved December 17, 2015. https://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf

⁴ Healthy Michigan Section 1115 Demonstration, Centers for Medicare and Medicaid Services, Special Terms and Conditions Approved December 17, 2015. https://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf

⁵ Childless adults ages 19-64 from 0 to 35% FPL eligible for Michigan's limited benefit package covered by the Adult Benefits Waiver that existed prior to initial implementation of the Healthy Michigan Plan transitioned to full Medicaid coverage as part of the new expansion group.

⁶ Beneficiaries are subject to co-pays according to the current state plan (inpatient hospital admission (except emergent admission), \$50; non-emergency use of the ER, brand-name drugs, dental visit, or hearing aid, \$3; physician, podiatry, or vision office visits, \$2; outpatient hospital or chiropractic visit or generic drugs, \$1).

⁷ Health savings account protocol is Attachment E, and the healthy behaviors protocol is Attachment F of the waiver's [Special Terms and Conditions](#).

⁸ Counties considered rural are Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft.

⁹ Evaluation plan is Attachment B of the waiver's [Special Terms and Conditions](#).