Michigan Health Policy Forum

October 20, 2025

mahp
Michigan Association of Health Plans

OUR MISSION

Provide leadership for the promotion and advocacy of high-quality, affordable, accessible, and equitable health care for the people of Michigan.

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UPPER PENINSULA HEALTH PLAN

OBBBA Key Provisions (Managed Care)

- New Workforce Engagement Requirements
- 6-month Redeterminations
- Retroactive Eligibility Limits
- Co-Payments
- State Directed Payments and Health Care Related Provider Taxes

Work/Community Engagement (aka Work Requirements)

01

Takes effect Jan 1, 2027

02

Anticipated federal guidance due June 2026

03

Limited exemptions based on diagnosis/treatment

04

80 hours per month requirement

05

Applicable to HMP population only (19-64)

Work/Community Engagement

Preparation:

State needs to prepare to outreach to individuals beginning end of September 2026. Ex Parte review can occur. State Medicaid Programs can use payroll and other reliable data available. State intends to review the month immediately before application/renewal for compliance.

For Managed Care Organizations:

MCOs are prohibited from validating compliance. Likely result of enrollees waiting until end of month to submit “paperwork”, further exacerbating workflow problems. More “member churn” with healthier individuals more likely to be procedurally disenrolled. Additional strain on remaining risk pools.

6-Month Redetermination

- January 1, 2027 implementation
- Applies to HMP Only (other programs are 12-month renewals)
- Coupled with work requirements

<u>Implications:</u>

- Churn, churn, and more churn.
- Health Plans will do outreach, but there is a need to meet the people in their communities.
- CHW workers will be expected to do even more.
- Importance of CBOs in this process.
- However, likely to be limited (if any) additional administrative funds available.

Retroactive Eligibility Limits

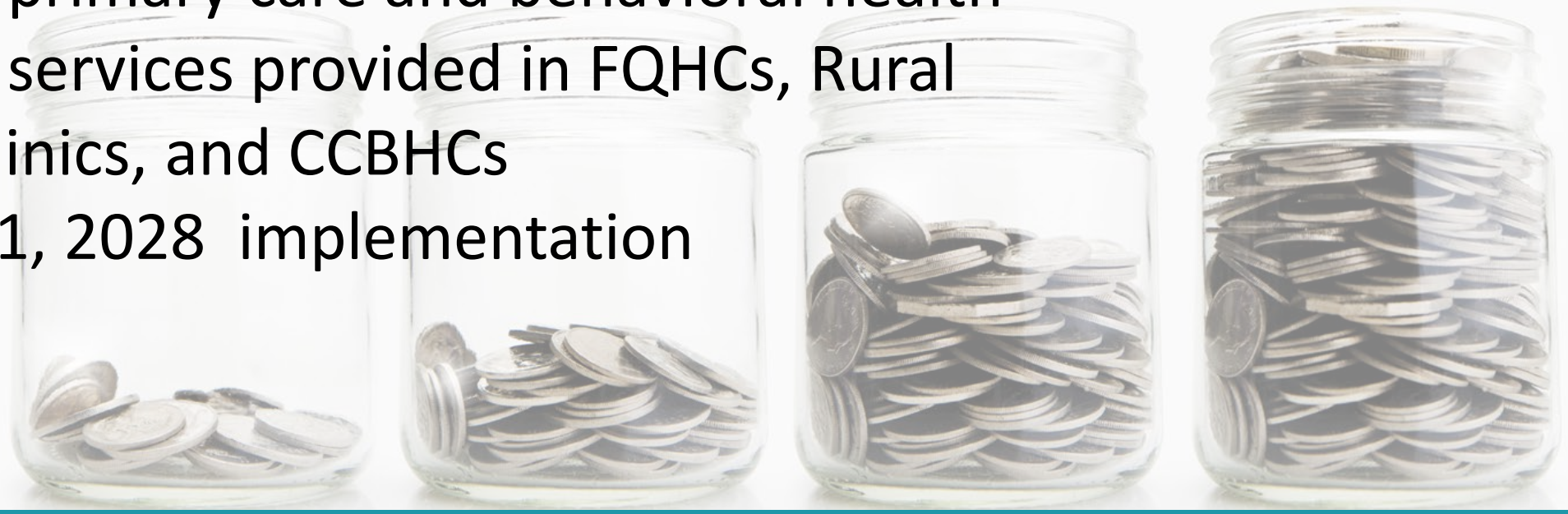
- All Medicaid eligibility programs.
- January 1, 2027 implementation
- HMP retro will be limited to 1 month
- All other programs will be limited to 2 months

Implications:

- Churn, churn, and more churn.
- Point Of Service identification and assistance with application.
- Awaiting further guidance to see if Health Plans can continue outreach and application assistance once member is disenrolled.

Co-Pay Requirements

- HMP adults with income above 100% FPL
- Cap charges at $35 per service and 5% of income
- Excludes primary care and behavioral health
- Excludes services provided in FQHCs, Rural Health Clinics, and CCBHCs
- October 1, 2028 implementation



Provider Tax Changes

Recent action by Congress in OBBBA and separately by the Centers for Medicare and Medicaid Services (CMS) will require that the structure of Michigan's Insurance Provider Assessment Act (IPA) will no longer be permissible.

- The IPA has existed to generate non-federal matching funds to support the Medicaid program.

Currently the tax is structured with different tiers within this particular provider class and received a waiver for the broad-based and uniformity requirements effective April 2023 (first approved in 2018).

- Medicaid health plans
  - Less than 1,150,000 member months- $57.00 per member month
  - More than 1,150,000 member months- $1.20 per member month
- Commercial comprehensive major medical plans-$2.40 per month
- Medicaid PIHPs with less than 12,000,000 member months- $1.20 per member month

Provider Tax Changes

Michigan must change its law to come into compliance: HB 4968 (PA 25 of 2025)

Key Points:

- If CMS "end dates" the existing waiver, DHHS must alter the tax to be compliant with the broad-based and uniform requirements contained in OBBBA.
- The new tax structure must equalize the tax rate across all tiers and cannot exceed the "total revenue due for the tax year of April 1, 2024, through March 31, 2025.
- We are awaiting further guidance on the prospect of obtaining a transition period.
- Implications of potential changes:
  - To adjust the tax to meet the proposed CMS requirements, MDHHS could select an even $2.40 per member month tax.
  - To completely replace the revenue lost by cost shifting to commercial insurance, the rate is estimated to be $7.10 per member month – a nearly 300% tax increase.

State Directed Payments

- New tax caps on all provider taxes. Was 6%, will ramp down to 3.5% by 2032 (starts 2028)
- No new taxes on any of the 19 defined provider classes.
- Ramp down of State Directed Payments. Current “Average Commercial Rates” will need to be reduced to Medicare payment levels.
  - Hospital Rate Adjustment (HRA) $5.07 billion
  - Specialty Network Access Fee (SNAF) $610 million

OBBBA Medicaid Policy Timeline

NAMD National Association of Medicaid Directors

July 4, 2025

Restriction on Funding to Certain Family Planning Providers (Sec. 71113)

- Temporarily restricts federal funding for one year to certain 501(c)(3) providers that offer abortions, primarily deliver reproductive health services, and received at least $800,000 in Medicaid payments in FY 2023, among other characteristics.
- Effective: July 4, 2025 (for 1 year)

Provider Tax Provisions (Sec. 71115)

- Prohibits new provider taxes on previously untaxed provider classes, caps overall tax rates at levels in place on date of enactment, and phases down hold harmless thresholds in expansion states, excluding Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDDs).
- Effective: Taxes will be capped as they were structured on July 4, 2025. Cap goes into effect on October 1, 2026. Expansion state phase down begins in FY 2028.

State Directed Payment Limits (Sec. 71116)

- Caps state directed payments in managed care programs at 100% of Medicare rates in expansion states and 110% of Medicare rates in non-expansion states. Grandfathered payments must be reduced by 10 percentage points per year starting in 2028.
- Effective: For rating periods beginning on or after July 4, 2025

Dec. 31, 2025

Rural Health Fund (Sec. 71401)

- Establishes a $50 billion grant program (FY2026–2030) for states to improve rural health care delivery. States must implement at least three eligible activities; CMS must make award decisions by December 31, 2025.
- Award Decision Deadline: Dec 31, 2025
- Funding Period: FY 2026–2030

Oct. 1, 2026

Eligibility Changes for Immigrants (Sec. 71109)

- Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.
- Effective: Oct 1, 2026

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OBBBA Medicaid Policy Timeline

NAMD National Association of Medicaid Directors

Dec. 31, 2026

Work/Community Engagement Requirements (Sec. 71119)

- States must require certain expansion adults to complete 80 hours per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19–64, with limited exemptions and must be verified through ex parte processes.
- Effective: Dec 31, 2026; HHS must issue rule by June 1, 2026; States may request a good faith effort extension through Dec 31, 2028.

6-Month Redeterminations (Sec. 77107)

- Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver. Current 12-month requirement remains for all other populations.
- Effective: Dec 31, 2026; CMS guidance due by Dec 31, 2025

Jan. 1, 2027

Retroactive Coverage Limits (Sec. 71112)

- Reduces retroactive coverage in Medicaid from up to three months to one month for expansion adults and two months for all other groups.
- Effective: for applications submitted on or after Jan 1, 2027

July 1, 2028

HCBS Waiver Option (Sec. 71121)

- Creates a new 1915(c) waiver that allows states to offer Home and Community-Based Services (HCBS) without requiring institutional level of care. States must meet cost neutrality and reporting standards.
- Effective: July 1, 2028

Oct. 1, 2028

Cost Sharing for Expansion Adults (Sec. 71120)

- Requires states to implement cost-sharing on expansion adults with income above 100% Federal Poverty Level. Caps charges at $35 per service and 5% of income; excludes key services like primary care, behavioral health, and those provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Certified Community Behavioral Health Clinics (CCBHCs).
- Effective: Oct 1, 2028

This timeline does not include all Medicaid-related provisions from OBBBA.

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