

Comments on the Michigan First Health Care Plan **January 4, 2007**

Thank you for the invitation to participate in the meeting with advocacy groups regarding the Michigan First Health Care Plan (MI First). We appreciate the opportunity to hear more about the development of this important program and to provide input into its design. As you know, Paraprofessional Healthcare Institute (PHI) is particularly interested in MI First because it could provide health insurance coverage to thousands of uninsured direct-care workers across the state. Direct-care workers are the backbone of Michigan's long-term care system, providing the hands-on care to the elderly and individuals with disabilities. Despite the important health care services these workers provide, many lack health insurance coverage ensure that their health care needs are met.

This document highlights our thoughts, recommendations, and questions regarding the proposed design of MI First, both in terms of initial thoughts we heard at that meeting and other elements of a well-rounded product. Our comments are focused on the areas of premium costs and the proposed individual annual maximum benefit, crowd-out and the healthy behavior component of MI First. We hope these comments are useful as you continue to develop this important program.

Premiums and Annual Maximum Plan Benefit Cost

Premiums

At the meeting with advocacy stakeholders, you indicated that MI First would keep premiums at or below 5% of income. We are happy to see this design element, as research shows that when costs exceed this level, low-income individuals are less likely to enroll in coverage. However, we recommend that all out-of-pocket costs, including co-payments and premiums be at or below 5% of income in total. To facilitate this, PHI recommends the following:

- **Set premium levels at 3% of income.** Establishing premiums at 3% of income, allows room for MI First to have for affordable and reasonable co-payments that will keep up-front health care costs at a level that will not restrict access.
- **Set premiums on a sliding scale.** We also recommend that allowing a sliding scale premium for those with income above 150% of FPL. Individuals and families with

incomes below 150% of FPL will have no premiums. The chart below details premium amounts for each income level.

**PHI Suggested Premiums
for Michigan First Participants¹**

<i>Monthly Family Income</i>	<i>Monthly Premium</i>
<i>Less than 150% of poverty level</i> Less than \$1,225 for a single person Less than \$2,500 for a family of four	None
<i>150-185% of poverty level</i> \$1,225 - \$1,511 for a single person \$2,500 - \$3,083 for a family of four	\$15
<i>185-200% of poverty level</i> \$1,511 - \$1,633 for a single person \$3,083 - \$3,333 for a family of four	\$35

Annual Maximum Plan Benefit Cost

The proposed annual maximum plan benefit cost of \$35,000 to \$50,000 raises concerns regarding the availability of health care services to individuals with more expensive health care conditions, particularly those with chronic conditions. While we understand the design of MI First is to provide basic preventive health care services, it is important to consider appropriate safeguards to address the needs of individuals with chronic conditions and/or individuals who find themselves with unexpected, high-cost acute care needs.

A substantial portion of health care costs can be attributed to chronic disease or are related to specific acute incidents. According to the National Health Expenditure Data, \$1.9 trillion was spent in 2004 on health care – 90% of which was on health care services². The NHE estimates the annual health care cost per person is \$6,280. This figure does not fully reflect the high cost of care for people with major medical conditions because about half of the population has very minimal health care costs, averaging at less than \$700 per person. In contrast, 5% of the population accounts for almost half (49%) of health care costs with expenditures of \$11,487 per person. When looking at health care costs by condition, the 15 most expensive health conditions account for 44% of health care costs. The five most expensive conditions are diabetes, heart disease, asthma, hypertension, and mental health

¹ Premiums in this chart are set based on the income level for a single person and not a family. This is because families at this income level will also be eligible for MI Child and will be paying an additional \$5 premium under that program for their children. Setting premiums at this level will assure that health care costs do not limit access to services.

² Kaiser Family Foundation. *Trends and Indicators in the Changing Health Care Marketplace*. Available on-line at <http://www.kff.org/insurance/7031/print-sec1.cfm>

disorders. While these conditions are manageable, they also come with expensive or extensive treatment needs as the disease progresses.

The timing of health care costs also vary and can fluctuate over time due to a one-time acute care need or because of acute episodes related to chronic conditions. The NHE data also shows that an otherwise healthy individual could have one acute episode such as pneumonia or a hunting accident that increases their health care costs for one year, only to have it level off in subsequent years. Further, individuals with chronic health conditions such as diabetes or hypertension, may have acute episodes that require hospitalization or extensive treatment.

Given the impact that specific health care conditions and acute incidents have on health care expenditures, we recommend consideration of the following to safeguard to minimize the negative effects that the proposed limit would present:

- **Establish a system to monitor costs against the cap.** As stated previously, people with chronic conditions may experience an increase in medical expenses due to an acute incident related to their condition. This monitoring will also provide valuable data for future policy discussions regarding catastrophic coverage for individuals who exceed the cap due to short-term, unexpected health care needs.
- **Screen MI First enrollees for Medicaid eligibility as they approach the cap.** As individuals with chronic health conditions approach the cap, we recommend that there be a system and process in place either with the plan or the Exchange to actively screen these individuals for categorical eligibility for Medicaid and secure Medicaid coverage when the cap is exceeded.

Crowd-Out

As you know, crowd-out occurs when individuals do not take available employer-sponsored insurance (ESI) or when employers drop insurance when public coverage becomes available³. The underlying assumption with crowd-out is the concern that the introduction of public coverage will be a motivation for individuals and businesses to drop ESI. Crowd-out only occurs when an individual has public coverage when they would otherwise have ESI or other private insurance.

Research shows that crowd-out is difficult to measure, and is often confused with substitution – when an individual chooses public coverage over available ESI.

While we understand that Michigan First does not want to weaken the availability of and take up of ESI, efforts must be made to ensure that any provisions that attempt to limit crowd-out do not undermine the intent of Michigan First – to provide affordable coverage to uninsured, low-income, working individuals. When developing provisions to limit crowd-out in MI First, it is important to understand who the uninsured are, why they lack coverage, and the reasons that businesses drop or alter ESI. Once these elements are understood, it is easier to see why crowd-out may not be a significant concern for MI First,

³ Davidson, G., Blewett, L., Call, K.T (June 2004). *Public Program Crowd-Out of Private Coverage: What are the Issues?*. The Robert Wood Johnson Foundation – The Synthesis Project. Available on-line at www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no5_researchreport.pdf

and policies to limit crowd-out, may in fact keep coverage out of reach for those who need it and for whom MI First is designed.

For most individuals eligible for MI First, the risk of crowd-out may be minimal for two reasons. First, many of the uninsured are already not eligible or cannot afford available ESI or other private coverage. Second, many businesses are considering either dropping ESI or shifting the cost to employees. These are circumstances occurring without MI First or a public coverage option for individuals with incomes between 35 and 200 percent of poverty and who are therefore currently ineligible for Medicaid.

Recent research on the uninsured in Michigan by the State Planning Project for the Uninsured (SPP) shows that 70% of those without insurance are working individuals – many of whom are either ineligible because they work part-time or they cannot afford it⁴. The biggest factor contributing to high rates of uninsurance is simply the cost. Low-wage workers – those earning \$10.00 or less an hour - simply cannot afford coverage when premiums rise at a level almost ten times faster than wages.

Economic factors often play into decisions that businesses make regarding health insurance coverage. During periods of recession, businesses often face the difficult decision to either raise the employee premium share in response to increases in employer premium costs or drop coverage all together. According to the SPP survey of employers, one-third indicated they would be shifting the cost of premiums to employees, reducing benefits, or offering a high-deductible plan with an health savings account⁵. A recent study completed by PHI among various long-term care employers – employers of individuals who will likely be eligible for MI First - shows that over half of the respondents currently providing coverage are concerned that they will not be able to continue doing so in the next two years.

If the cost of coverage continues to rise at a level almost ten times faster than wages, and employers respond to difficult economic times by shifting the cost of coverage or dropping it altogether, MI First will not face a problem of crowd-out – it will be available to meet considerable demand for affordable coverage.

The more popular crowd-out mechanisms such as imposing waiting periods or basing eligibility on whether individuals have “affordable” coverage available to them may create barriers to coverage that do little to reduce crowd-out. While many states have instituted waiting periods for eligibility for public programs, there is no evidence that suggest these are effective in reducing crowd-out¹.

While establishing crowd-out provisions may be inevitable in MI First, we recommend that not be based solely on the availability of ESI, without considering the *real* affordability of such coverage for low-wage workers. We further ask that you consider the factors that we

⁴ Michigan State Planning Project for the Uninsured (2006). *Michigan Household Health Insurance Survey Report*. Available on-line at: <http://www.michigan.gov/documents/mdch/Report-HouseholdSurveyWAppedices>

⁵ Michigan State Planning Project for the Uninsured (2006). *Michigan Employer Health Insurance Survey Report*. Available on-line at http://www.michigan.gov/documents/mdch/Report-EmployerSurvey-092106_173453_7.pdf

have discussed above that contribute to individuals being uninsured and the instability of ESI for individuals currently insured in Michigan.

Healthy Behavior/Wellness Programs

As health plans and employers become concerned about controlling health care costs and improving health outcomes, they are looking to establishing programs that promote a healthy lifestyle among their enrollees. The goal of such programs to reduce the occurrence of heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. These conditions are partly attributed to behavioral factors such as smoking, physical inactivity, and poor nutrition, that can be addressed by helping people develop the skills, knowledge, and support to change these behaviors.

While healthy behavior programs will help reduce health care costs, those programs take time and targeted resources to see a return on the initial investment. As you consider instituting a healthy behavior/wellness program in MI First, we recommend you consider the following:

- **Look at existing Michigan models targeting towards low-income populations.** Healthy behavior programs, such as the *3C Program* in the Access Health Plan in Muskegon County, have been successful in providing adequate supports and incentives to encourage healthy behavior. According to representatives from the Access Health Plan, they have seen an increase in participation in their wellness program when they tied it to modest discounts in premiums and co-payments.
- **Provide adequate care coordination and supports to promote and maintain healthy behavior.** MI First's healthy behavior program should help individuals develop skills to change their behavior as well as access to supports that will help maintain a healthy lifestyle. A healthy behavior program should be viewed as long-term investment into changing both the behavior of participants *and* the health care systems approach to managing chronic disease. Care management should be a component of such a program to monitor and track the care of individuals with chronic diseases. Successful healthy behavior programs also facilitate access to resources and services available in participants' communities such as a nutritional counseling, smoking cessation programs, or exercise to maintain a healthy lifestyle. For example, Access Health Plan's wellness program refers individuals to existing smoking cessation programs through the local health department. .

Additional Questions

From the information that has been provided regarding MI First, we have some additional questions.

- **County Health Plans** – County Health Plans play a vital role in providing access to necessary health care services to uninsured individuals across the state.
 - How will County Health Plans be impacted by Michigan First?

- Will individuals in existing “Plan A” programs (Adult Benefit Waiver for individuals with incomes less than 35% of FPL) be automatically enrolled or eligible for MI First?
 - Will there be a continued need for the current “Plan B” program (Low-Income Uninsured Programs for individuals with income less than 150% FPL) and
 - Will there be a continued need for the current Third Share programs that use public, employer and employee funds to secure basic health care coverage?
- **Continued Input** – As you continue developing MI First, we hope to continue to receiving information and providing input. In addition, we would like to know if there will be opportunities for the uninsured to review more detailed descriptions of the benefit and premium proposals and to provide reactions to those proposals. . The HCHCW campaign has contact with both direct-care workers and employers that could share their perspectives regarding the availability of health insurance.

Thank you for your time and consideration in seeking our input into this process. We look forward to hearing from you and working with you as MI First progresses.

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