State Notes

TOPICS OF LEGISLATIVE INTEREST

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Governor Granholm's Michigan First Healthcare Plan
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Background

In her State of the State address last month, Governor Jennifer Granholm proposed a new health insurance program called the "Michigan First Healthcare Plan". The proposal would provide health insurance coverage to uninsured adults under 200% of the poverty level by using $1.0 billion in Federal funds to cover an estimated 550,000 individuals.

The Michigan First Healthcare Plan was included in the Governor's fiscal year (FY) 2006-07 Department of Community Health (DCH) budget, with a starting date of April 1, 2007. Partial-year funding of $200.0 million, all Federal, was proposed in the Executive budget.

The Michigan First Healthcare Plan would require a Federal Medicaid waiver and the waiver process is in its earliest stages. Other states have had success negotiating with the Centers for Medicaid and Medicare Services (CMS) before submitting a formal waiver document. (For instance, Florida negotiated its waiver with CMS and then formally submitted its waiver, which was approved within weeks.) It appears that the Granholm Administration will try to go through a similar negotiation process with CMS and with the U.S. Department of Health and Human Services (HHS).

The traditional process involves submitting a waiver request to CMS, followed by a lengthy back and forth process involving numerous questions from CMS. Negotiation before submission should help shorten the process. It also would allow the State more flexibility to adjust its waiver request to fit what the Federal government would find acceptable. The State has retained the services of a consulting firm that was instrumental in obtaining waivers for other states, such as Massachusetts.

The Origin of the Proposal

The concept was partially inspired by the Michigan Adult Benefits Waiver (ABW) program, which went into effect during FY 2003-04. The financing of the proposal incorporates ideas from other states, though there are some key distinctions.

The ABW program involved unused Federal money from allocations dedicated to the expansion of children's health insurance up to 200.0% of poverty (in the MI-Child program). Because the number of uninsured children under 200.0% of poverty in most states proved to be well below estimates, there was a large Federal authorization that was unused. A number of states proposed using the untapped Federal authorization to expand coverage to low-income adults who otherwise would not have insurance. This approach was appealing to the State because Federal money was provided at an enhanced match rate of about 70.0% rather than the usual 56.0% or so in Michigan.

In Michigan, this was done in a way that did not increase General Fund/General Purpose (GF/GP) costs. About $300.0 million from the GF/GP budget is spent in Michigan on mental health non-Medicaid services, for individuals who are low-income but not Medicaid eligible. This money goes to the Community Mental Health (CMH) system.

It was estimated that about $40.0 million of this $300.0 million pool was spent for mental health services to individuals who would be eligible for ABW. Therefore, the ABW waiver proposal carved out this population, with the Federal financing to be provided at the enhanced match rate of 70.0%. This $40.0 million of mental health spending under ABW would consist of $12.0 million GF/GP (30.0%) and $28.0 million Federal (70.0%). This led to immediate GF/GP savings of $28.0 million. Of this, $10.0 million GF/GP was used to increase rates for CMHs. The remaining $18.0 million was used to help finance the rest of the program, which provides limited medical coverage for about 60,000 Michigan residents.

The Administration's proposal for the new program works a bit differently, though it is inspired by the notion of using the CMH non-Medicaid line as the source to earn Federal match funding.

The Justification for Seeking Federal Funding

The Administration points out that it is spending significant sums of money on otherwise uncompensated care, such as CMH non-Medicaid ($300.0 million GF/GP), CMH purchase of State services ($125.0 million GF/GP), and other smaller pools of funding including the Disproportionate Share Hospital (DSH) line and the ambulance line. Furthermore, it notes that there are other expenditures such as disproportionate share funding provided by Blue Cross to hospitals that the Administration contends could potentially be seen as State expenditures.

The Administration will note that the State puts up hundreds of millions in State resources to support uncompensated care. Then, through the waiver, it will ask the Federal government to provide Medicaid matching funds for these expenditures. The estimate in the proposal outlined by the Administration is that the Federal government would provide $1.0 billion per year in matching revenue. This $1.0 billion in funding then would allow the State to create a health insurance program for adults up to 200.0% of poverty, which the Administration estimates would cover 550,000 adults.

One concern about the waiver is paramount: If the Federal government provided $1.0 billion in new money per year to Michigan, could other states, citing a precedent in Michigan, submit similar proposals that would increase Federal Medicaid costs by tens of billions each year?

The Massachusetts Example and Its Applicability to Michigan

The Commonwealth of Massachusetts is in the process of implementing an insurance mandate to cover the estimated 450,000 people in Massachusetts without health insurance. Massachusetts officials believe that outreach efforts will bring another 100,000 people onto the Medicaid rolls. The Commonwealth will create another insurance product for the

estimated 200,000 uninsured with incomes over 300.0% of poverty, with most of the costs being borne by the recipients. Finally, Massachusetts will use Federal funding to create a sliding scale private insurance program for about 150,000 who have too much income to be Medicaid eligible but are below 300.0% of poverty.

The latter program will be financed with money currently being used to support a very large disproportionate share pool. That is one of the major differences between Michigan and Massachusetts: The funding for the Massachusetts program already is being received by Massachusetts and involves both a GF/GP and a Federal component, each in the hundreds of millions of dollars. This proposal is not being funded by new Federal dollars. For Michigan truly to imitate Massachusetts, this State would have to increase GF/GP spending by hundreds of millions to draw in the Federal match. What is being proposed currently by the Granholm Administration is identifying current nonmatchable State spending and then asking the Federal government for match funding.

The other significant difference in the Massachusetts case is the insurance mandate. There is one key advantage to a mandate: It puts everyone in the insurance pool, which avoids the problem of adverse selection. Adverse selection is a common problem with insurance expansion, as those most likely to opt for insurance are those who are most likely to use the system, so the more expensive cases end up in the system and the less expensive ones do not join, which raises average costs.

Cost Neutrality

There is one issue that is key to any waiver request: Over the five-year life of a waiver, the waiver must be cost neutral to the Federal government.

This sort of situation has come up before in Michigan–for instance, during the discussions of the managed care waiver 10 years ago, the Federal government approved the waiver because it was shown that there should not be a Federal cost increase. The Engler Administration showed trend lines of expenditures if the system remained on a fee-for-service basis, then compared those to the projected costs of a managed care system, and demonstrated the likelihood of Federal savings.

In the case of managed care, there was a two-fold savings–overall Gross expenditures were projected to be lower than they would be otherwise, so both the Federal government and the State saved money. With the Administration's proposal, Federal expenditures would increase by about $1.0 billion per year. So the question arises: How can the Administration claim that this proposal would be cost-neutral to the Federal government?

The Administration indicates that it will start with a base year, then project future Medicaid expenditures if current trends continue. Its belief is that more and more people with employer-paid health insurance have been and will continue to be forced onto the Medicaid rolls, thereby increasing Federal costs over time, a trend that the Administration's proposal seeks to reverse.

The Administration also points to a recent waiver request by New York State that proposed using claimed savings from New York's shift to managed care.

Michigan's argument will be that the State has saved the Federal government over $2.0 billion over the last nine years due to the shift to managed care. The Administration will argue that the trend line expenditures, when started from the correct baseline and assuming there had been no shift to managed care but continued shifts of people from employer-paid health insurance to Medicaid, would show Federal Michigan Medicaid costs in the near future of at least $1.0 billion per year more than there would be under the Administration's proposal.

It remains to be seen whether the CMS will accept the estimate of $2.0 billion or more in Federal savings. That would equate to at least $400.0 million Gross per year on a managed care budget of about $2.0 billion Gross.

If the Federal government is supportive of the general concept and wishes to approve this waiver, the argument about managed care savings could give the government a strong enough justification to state that the plan meets the cost neutrality requirement.

The Insurance Product

The Administration also has discussed the way the insurance would be provided. The legwork on this part of the proposal is being done by the Office of Financial and Insurance Services (OFIS) in the Department of Labor and Economic Growth.

The vision is of private insurance with more limited benefits than typical coverage. Under Senate Bill 88 (Public Act 306 of 2005), managed care plans will be able to offer more limited coverage. The program would not be an entitlement; it would cover only as many people as can be covered with the available resources. Individuals would choose among various private insurers. There would be premiums and copayments.

The idea is that private insurance would pay providers rates well above Medicaid rates, perhaps even approaching Medicare rates for services. This would ensure participation by providers.

How Many Could Be Covered by the Funding?

Setting aside $1.0 billion to cover 550,000 people equates to just over $1,800 per adult per year. The Senate Fiscal Agency is not aware of any managed care firm in this State that would accept $1,800 per adult, especially given concerns about adverse selection. This concern is compounded by the expectation that payment rates will be well above Medicaid rates.

There are two ways around this. The first is cost-sharing through premiums and copayments. Cost-sharing in this instance would have to be very large to make up the gap between the average cost to the government and the average cost to the insurer.

Second, benefits would have to be limited. The sorts of limitations necessary to fill the gap would make this a restricted benefit coverage. The Administration envisions primary care (such as office visits), emergency care, inpatient hospital care, and mental health services being covered, although the financial constraints would imply limitations on either services or payments.

Other Issues

The Administration has indicated that mental health services for those covered in the program would be provided through the CMH system, which would infuse some extra funding into the public mental health system.

Because the proposal has been included in the Governor's FY 2006-07 budget proposal, the Legislature will have a significant say in the structure and financing of the program.

One concern about the program is that some companies would drop employer-paid health coverage and encourage employees to join the program (also known as "crowd-out"). The Administration is considering requiring a person to be without insurance for six months preceding eligibility. Other states have had experience with new coverage and have come up with ways to address the issue of "crowd-out", and the Administration indicates that it will try to incorporate some of those ideas.

Summary

The proposal will have to go through a long process to achieve approval. The most basic question is whether the Federal government will provide $1.0 billion per year in new money to Michigan without the State's contributing any new State funds. There are also concerns as to whether $1.0 billion will be sufficient to cover 550,000 adults.

The Federal government has been willing to approve what some would term "aggressive" waivers. Even if the Administration's proposal proves to be too "aggressive" to meet Federal approval, the more informal negotiation process will allow greater flexibility in terms of putting together a more scaled-back proposal that could be approved and significantly expand health care coverage in the State.

It is also possible that the Federal government will see this as an opportunity to reduce the number of uninsured and support the program, even if in a modified form. If such a program is approved, it will be important for the Legislature to exert oversight to ensure that the proposal is workable for the State, the recipients, and the providers.