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Coverage Expansion Options

Prepared for the Advisory Council to the Michigan HRSA State Planning Grant

The attached chart shows the costs of various options to expand coverage to additional uninsured individuals in Michigan. The detailed assumptions used in this model are attached, but there are several key assumptions that should be noted:

- The household survey estimate is the basis for the total number of uninsured, while the distributions among categories are based on Current Population Survey (CPS) data from the US Census Bureau.
- The estimates assume that about 90% of those eligible for coverage will enroll. This may be a high estimate. In our current model of employer-based and government-funded healthcare, there are always individuals "in transition" that may be without coverage for a few months as their circumstances change.
- The benefits package used for modeling is the Medicaid benefit package, and any expansion is at Medicare rates. Alternatively these programs could be provided through the private marketplace for about the same price. The private insurance prices might be similar with slightly reduced benefits, higher copayments, and higher (commercial) payment rates to health care providers. [1]
- The model assumes that costs for those over 100% of poverty are 30% lower due to higher copayments, premium sharing and healthier individuals.

These calculations do not assume a Medicaid waiver, such as the Michigan First Healthcare Plan. Clearly a waiver would be desirable that would allow the state to gain federal matching funds for the cost of providing health care to individuals that would otherwise not meet the Medicaid categorical requirements. For purposes of this document they are labeled "childless adults". They do not qualify for Medicaid because they do not fit into the Medicaid categories of aged, blind, disabled, children, parents of minor children, or pregnant women. Without a federal waiver, the full cost of covering "childless adults" is borne by the state in this model. Childless adults represent more than half of the low-income uninsured population in Michigan.

Description of Coverage Expansion Options

1 – Outreach to existing eligible individuals

As proposed by the Models Development Workgroup, a first step to provide health coverage to all Michiganians would be to seek to enroll those that are eligible for the program but not currently enrolled. Using the Household Survey, we estimate that there are 119,000 such individuals. Data from the Michigan Department of Human Services (DHS) shows that at any

[1] For example, the model's average of $208 to $260 per person for adult coverage (without maternity costs) is within the range of the premiums for individual coverage offered by Blue Cross Blue Shield.

point in time there are about 50,000 Medicaid applications in process, some of which cover entire families. As a result, we assume that half of the existing eligibles are already in the process of becoming Medicaid clients. The attached model shows that if 50% of this population, or 56,500 individuals currently eligible for Medicaid but not enrolled in the program became Medicaid enrollees, the increased cost to the state would be $40 million.[2]

2 – Expand Medicaid to cover parents and young adults up to 100% of poverty

This option would extend Medicaid eligibility to an additional 38,000 individuals (of whom we assume 34,000 would enroll). This change can be made with a simple Medicaid state plan amendment at a state cost of $32 million. However, without a federal waiver the benefits and provider rates would be the same as for current Medicaid enrollees. Since these are very low income individuals, even with a waiver the per-member costs would be similar to those for the current Medicaid enrollees. However, as part of a waiver program, the provider rates could be increased to Medicare rates for just the new enrollees. The state cost of this option would be $42 million.

To the extent that any of these individuals currently use state supported mental health or substance abuse services, or are enrolled in county health plans there may be some offsetting savings.

3a. – Extend ambulatory benefits to all persons up to 100% of FPL

The remaining uninsured individuals under 100% of poverty would be the childless adults. These individuals currently receive very limited ambulatory benefits from county health plans (CHPs) in 71 of Michigan's 83 counties. However even in these 71 counties, the CHPs do not have sufficient capacity to serve all of these individuals. (For example, the program in Wayne County can only enroll about 5,000 individuals.)

In addition, the "Plan B" or volunteer programs of the CHPs cover only a very limited set of benefits, primarily physician services and pharmacy. This option would extend a more comprehensive ambulatory benefit, including outpatient hospital services, to all childless adults with incomes below the poverty line.

This option may be troubling to some since it would not cover inpatient care. In fact this option could exacerbate the losses of Michigan's hospitals as physicians identify the need for inpatient care.

Without a federal waiver the state would bear 100% of the cost. With a federal waiver (like the proposed Michigan First Healthcare Plan) states can cover these individuals with federal Medicaid funds by pointing to savings in the "regular" Medicaid program as part of the "budget neutrality test" in the waiver and by using existing public expenditures for "costs not otherwise matchable"

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[2] These individuals would be enrolled in Medicaid HMOs at current Medicaid rates. However it is unlikely that the cost of these individuals is as great as the cost for current enrollees. Hospitals have a strong incentive to assist these individuals with Medicaid applications if they need inpatient care or high cost outpatient services. Therefore it is likely that their service utilization will be lower. However in a capitation model, this will not alter the capitation rates for several years. (We can also assume that they are not using the public mental health system as those providers also would have assisted them in applying for Medicaid coverage.)

"Childless adults" is the largest group of low-income uninsured individuals. The model assumes that there are 118,000 uninsured childless adults with incomes below 100% of poverty, of whom about 50,000 are currently enrolled in county health plans. The CHP enrollees would receive expanded coverage as part of this option. The cost of this option at Medicaid rates is $133 million, with no federal matching funds. At Medicare rates the cost increases to $187 million. It is likely that a significant amount of state-funded mental health and substance abuse services are provided to this group. But only with a waiver could the current state spending on this group be counted as the non-federal share of expanded services.

3b. Add inpatient coverage for all persons up to 100% of FPL

As mentioned above, option 3a does not include inpatient hospital services. Based on data from the Medical Services Administration on the utilization of inpatient care for this population, the model assumes a cost of $70 per person per month to add an inpatient benefit at Medicaid rates ($81 at Medicare rates). The cost of this option is $131 million at Medicaid rates and $150 million at Medicare rates.

4. Extend Coverage to all persons up to 200% of FPL

Parents, disabled individuals and young adults would qualify more readily for federal Medicaid funding than childless adults. Unfortunately more than 60% of the uninsured with incomes between 100% and 200% of poverty are childless adults.

In developing this option we assume that costs per member per month are less than the costs for a Medicaid enrollee due to higher cost sharing, narrower benefits, and a healthier population. The model also assumes that employers will participate in the costs for this population, as many already do for employees in this income range. For purposes of discussion the total cost is set at 80% of the costs for comparable groups with incomes below 100% of poverty. . At Medicaid rates the cost for this group would be $333 million, of which the state share is $258 million. At Medicare rates the cost is $432 million, of which the state share would be $336 million without a federal Medicaid waiver.

The cost of this option could be altered significantly by setting limits on benefits (such as limiting the number of days of inpatient care or using a very restrictive drug formulary), by not covering certain services, and by leveraging employer contributions.

Detailed Assumptions

Enrollment Assumptions

1. The pending waiver amendment to limit coverage of existing 19 to 20 year old individuals and caretaker relatives is assumed to be withdrawn.
2. The household survey is the basis of the total number of uninsured, but the distribution comes from CPS data. About 40,000 individual that indicated coverage from a "county program" are added to the uninsured total in the household survey.
3. At most 90% of the eligible individuals in each category will enroll in the program(s) since many of these may be individuals in transition.

4. For those already eligible for Medicaid, we assume that 50% have a Medicaid application already in process. This is based on data from the Department of Human Services which indicates that there are about 50,000 Medicaid applications in process at any point in time.

Rate Assumptions

1. The average per capita costs for those eligible for the existing Medicaid program are the same as the current average Medicaid capitation rates. Costs of maternity are excluded as pregnant women are already covered up to 185% of poverty. Costs of mental health and substance abuse services are assumed to be part of the existing publicly funded system.
    a. The $213 for parents is from the data provided by MDCH to the Models Development Workgroup and is consistent with HMA review of current Medicaid capitation rates.
    b. The $62 for children is from an HMA review of current Medicaid capitation rates.
    c. The rate of $604 per disabled person is based on an HMA review of current Medicaid capitation rates.
    d. The $75 rate for young adults is based on the data provided by MDCH to the Models Development Workgroup.
2. Even if program expansions are based on higher provider reimbursement rates, such as Medicare rates, services for the individuals eligible under current policy will be financed using the current Medicaid rate structure.
3. Parents in families with incomes below 100% of poverty and young adults ages 19 to 20 under 100% FPL will have costs similar to those of existing Medicaid enrollees.
4. Parents and young adults with incomes between 100% and 200% of poverty will have health care utilization patterns similar to those of existing Medicaid enrollees.
5. Costs for individuals with incomes above 100% of poverty are 20% lower than those for Medicaid individuals due to higher copayments (and possibly small premiums), slightly narrower benefit packages and lower use of services (due to better health status). (This 20% value represents a conservative placeholder in the analysis.)
6. Disabled individuals with incomes above the poverty level will have costs that are lower than current Medicaid capitation rates, and are more similar to Medicaid costs for Freedom to Work enrollees (which are below $400 per member per month). Any high cost services for this population are already covered under “spend-down Medicaid”, also known as “Medicaid with a deductible”.
7. Use of full Medicare rates increases costs by about 30% in the aggregate. (While Medicaid rates for physician services are 60% of Medicare, rates for inpatient hospital and ancillary services are closer to Medicare, and pharmacy rates will not be impacted at all.