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MEDICAID EXPANSION: PRESCRIPTION FOR A HEALTHIER MICHIGAN

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Summary

In a Nutshell

- The Healthy Michigan Plan has led to [health insurance coverage](#) for more than 650,000 of Michigan's citizens and has [kept insurance premiums lower](#) for others, improving the physical, mental, and financial well-being of Michigan's citizens. The program also improved the state's economy by reducing uncompensated care among Michigan's hospitals, and by supporting health sector job creation/retention, a healthier workforce, and increased federal spending in the state.
- The Medicaid program allows for substantial innovation, experimentation and variation at the state level, allowing states to be true "laboratories of democracy." While new mechanisms like cost-sharing and Health Risk Assessments still need refinement, Michigan has begun to use the program to incentivize healthier lifestyles and responsible health care consumption. Michigan has also become a leader in using Medicaid to address the [social determinants of health](#), an approach that can both improve health outcomes and reduce healthcare spending.
- The many gains of the Healthy Michigan Plan may be lost because of [an imprecise and poorly designed cost versus savings policy mechanism](#) tied to the program that ignores a wide range of program benefits. At present, the Healthy Michigan Plan will be terminated if the state incurs a single penny of net costs from the program.

In 1965, Medicaid (along with Medicare) was enacted and added to the Social Security Act as a program to provide health insurance to categorically needy individuals (such as the blind, disabled, and low-income families with dependent children). Medicaid was designed as a joint endeavor between the federal government and state governments. Michigan began its Medicaid program in 1966. Over the past 50 years, Medicaid in Michigan has grown in scope and enrollment. In 2014, under the federal Affordable Care Act, Michigan expanded its Medicaid program to include the Healthy Michigan Plan.

As of December 2016, there were 1,794,867 traditional Medicaid enrollees in Michigan, including 498,872 aged/blind/disabled, 505,622 children and pregnant mothers, and 649,282 Healthy Michigan Plan enrollees. The low-income adult population insured by the Healthy Michigan Plan (commonly called the "working poor") has historically remained uninsured because of work in low-wage, part-time, or seasonal employment that does not provide health insurance as an employee

benefit, as well as inadequate income/resources to purchase health insurance.

Michigan Medicaid expenses have grown from an initial \$150 million expenditure in Fiscal Year (FY) 1968 to \$16.9 billion in FY2016. The Healthy Michigan Plan accounted for \$3.6 billion of the \$16.9 billion total. Michigan pays for just over a quarter of Medicaid dollars spent in the state (\$4.5 billion), while the remaining program costs are covered by federal funding. The 2014 expansion of Medicaid was fully funded by the federal government initially, with state cost sharing payments beginning in FY2017 and increasing to a maximum state contribution of 10 percent of program expenses in FY2020. In the future, increased state funding obligations for the Healthy Michigan Plan may make the program one of many sources of fiscal stress facing the state budget.

Health programs (primarily Medicaid) often rival education programs (K-12 and higher education) as the largest expense for states; at the same time, Medicaid is also the single largest draw of federal funds into states.

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Expanding Medicaid through the Healthy Michigan Plan has yielded substantial state budget savings through enhanced federal matching funds for previous Medicaid beneficiaries, and by shifting costs from other areas like mental health or prisoner hospitalization. The Healthy Michigan Plan has also yielded an estimated 30,000 – 40,000 jobs, an increase of \$2.2 billion to \$2.4 billion in personal income, and added \$145 million to \$153 million in new state tax revenue each year.

States that chose to expand Medicaid have all seen benefits relative to those that have not, including greater reductions in the number of uninsured, smaller increases in state Medicaid spending, larger reductions in uncompensated care, health sector job growth, and improved provider margins (particularly for rural facilities and struggling hospitals). Medicaid expansion has also contributed to lower costs for private insurance in Michigan and other expansion states.

The principal output of the Healthy Michigan Plan is providing health insurance to a substantial portion of the population that was previously uninsured and closing the gap in coverage that has long existed between the Medicaid eligible and privately insured (a gap that still exists in states that did not expand Medicaid). The number of uninsured in Michigan has been cut in half since federal enactment of the Affordable Care Act; this was primarily driven by increased Medicaid eligibility and enrollment through the Healthy Michigan Plan.

Analysis shows that the Healthy Michigan Plan has provided cost-effective, quality insurance to enrollees.

Substantial volumes of empirical research provide evidence that health insurance coverage through Medicaid reduces both morbidity and mortality. Having health insurance coverage also reduces stress and improves mental health—crucial for measures of total health and wellness—and improves personal and familial financial security. Furthermore, the Medicaid program also offers the state an opportunity to address non-clinical health factors, namely the social determinants of health.

After just three years of the program, it is impossible to fully or accurately measure the long-term impacts of the Healthy Michigan Plan. According to available data and previous research, the Healthy Michigan Plan may be expected to increase health care access, reduce physical and mental illness, improve health outcomes, increase life-expectancy, prioritize preventative services over emergency services, and increase individual financial security, peace of mind, and self-reported health status. Initial evidence confirming these expected outcomes has been observed in Michigan. Based on past trends, it is also plausible that the Healthy Michigan Plan will be able to constrain growth in cost without compromising quality, striking a delicate balance between efficiency, effectiveness, and equity.

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Introduction

Health care is indeed very complicated, and even within the context of health care policy, Medicaid law and regulation are especially complex and expansive. In a 1994 case, *Rehabilitation Association of Virginia, Inc. v. Kozlowski* (42 F.3d 1444, 1450), the 4th Federal Circuit Court characterized it as “among the most impenetrable texts within human experience” and “dense reading of the most tortuous kind.” Medicaid’s complexity makes state reforms to the program quite challenging.

Utilizing state records, program statistics, and available scientific literature, this report will analyze Medicaid in Michigan with specific focus on the Affordable Care Act’s expansion of Medicaid, known as the Healthy Michigan Plan. This report continues the Citizens Research Council’s past work^a of analyzing the costs, benefits, eligibility, utilization, and the overall nature of Medicaid in Michigan. Various criteria are proposed by which the nascent program may be evaluated, and these criteria are used to discern the quality and magnitude of any impact the Healthy Michigan Plan may be having on people in Michigan.

Medicaid is often highlighted as a major cost center for states, but it is also the single largest draw of federal revenue into states. Expanding Medicaid has increased the number of Medicaid beneficiaries and therefore also overall program spending; however Medicaid expansion has also yielded immense, outsized economic benefits relative to these new costs by creating jobs, increasing personal income and state revenue, reducing uncompensated care, and bolstering the health sector in general.

^a See Citizens Research Council Publications: Report 376 (Feb. 2012), *Options for Managing Medicaid Funding and Cost Growth*; Memo 1071 (Feb. 2003), *Medicaid – What it is and How it Works*; Memo 1072 (March 2003), *Medicaid Health Care Services*; Memo 1074 (July 2003), *Medicaid Eligibility*; Report 333 (April 2001) *Outline of State of Michigan Health Programs*; Report 255 (June 1978), *A Report to the Michigan Task Force on Medicaid and Health Care Costs*

Medicaid spending is inextricably linked to factors that affect overall health care spending, such as the relative price of services and rates of service utilization. It is imperative that public policy tackles the ongoing macro problem of increasing health care costs and spending that consume an ever-growing portion of U.S. gross domestic product (GDP), currently around 18 percent.¹ Because Medicaid enrollment is economically driven, surges in program enrollment and utilization will overlap with periods of recession that leave states financially compromised.

Expanded Medicaid through the Healthy Michigan Plan has facilitated health insurance coverage for over 650,000 of Michigan’s citizens and has kept insurance premiums lower for others. Health insurance significantly decreases rates of morbidity and mortality, reduces stress and depression, and improves financial security among the insured. By expanding Medicaid, Michigan gave many more of its citizens access to a regular source of care, peace of mind, financial security, preventative services, and the ability to address serious medical conditions when they do emerge.

Michigan must carefully assess any positive or negative outcomes from the Healthy Michigan Plan, evaluate the benefits of the program relative to its costs to state taxpayers, determine whether comparable or superior benefits could be attained by another approach (either public or private) bearing comparable or lower costs, and ultimately determine the appropriateness of further state investment in expanded Medicaid access and coverage.

Glossary

Federal Patient Protection and Affordable Care Act of 2010 (ACA) – A set of federally adopted health-care and insurance reforms.

Adult Benefits Waiver (ABW) – Prior to the Healthy Michigan Plan, the Adult Benefits Waiver program extended Medicaid benefits to a limited number of low-income, childless adults in Michigan through a Section 1115 Demonstration Waiver.

Anomie – (in sociology) A condition of instability due to the breakdown of social standards that otherwise regulate behaviors.

Capitation – (in health care) A payment system that provides a specified payment amount for each enrolled person (per “head”) for a set period of time. The same payment is made whether or not care is sought and even if the cost of care exceeds the capitated payment amount.

Centers for Disease Control and Prevention (CDC) – A major operating component of the Department of Health and Human Services (HHS), the CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States.

Centers for Medicare & Medicaid Services (CMS) – A major part of the Department of Health and Human Services (HHS), the CMS administers the federal Medicare Program, works with states to administer Medicaid and the Children’s Health Insurance Program (CHIP). CMS is also charged with various related responsibilities, such as standards for long-term care facilities, clinical laboratories, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Disproportionate Share Hospital (DSH) – A designation applied to hospitals that treat large numbers of indigent persons. The designation allows the hospital to receive special funding from federal, state, and local sources, such as Medicaid and Medicare.

Federal Poverty Level (FPL) – A measure of economic position specified by the poverty guidelines in the Federal Register by the U.S. Department of Health and Human Services (HHS).

The U.S. Department of Health & Human Services (HHS) – A collection of agencies with the mission to enhance and protect the health and well-being of all Americans, including Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), The Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Managed Care – A health care delivery system organized to manage utilization, cost, and quality. Managed Care has been the dominant system in the United States since the 1980s, partly due to the Health Maintenance Organization Act of 1973.

Managed Care Organization (MCO) – A health plan provider, such as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), that agrees to provide managed care through a contracted health plan.

Medically Indigent – This term has been used in the United States to describe individuals who lack health insurance, who are not eligible for public programs (like Medicare or Medicaid), and who are unable to purchase private health insurance.

Morbidity – The state of being diseased or the proportion of disease in a given time, place, or population.

Mortality – The state of being subject to death or the proportion of death in a given time, place, or population.

Metropolitan Statistical Area (MSA) – Geographic areas that are generally characterized by a large population center and adjacent communities with a high degree of integration and economic/social linkages. The U.S. Office of Management and Budget (OMB) defines MSAs according to published standards that are applied to Census Bureau data.

Self-Efficacy – Confidence in one’s ability to exert control over one’s self and one’s environment; belief in one’s own ability to succeed.

Section 1115 Demonstration Waiver – These waivers allow states to try new approaches or ideas in state Medicaid programs that differ from federal rules for the program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

Value-Based Payment (VBP) – A strategy used by health purchasers to link payments to outcomes rather than to the number of services provided.

Medicaid in Michigan – A Brief History

Medicaid—created in 1965 by adding Title XIX to the Social Security Act—is a means-tested public health insurance program for individuals whose income and resources cannot adequately support purchasing health insurance. Medicaid is implemented, managed, and funded by states with additional revenue and oversight from the federal government through the Centers for Medicare and Medicaid Services (CMS). The federal government sets minimum standards for eligibility and benefits, as well as regulations regarding financing, service delivery, reimbursement rates, and other facets of the program. Beyond these federal guidelines, states have traditionally had substantial flexibility to design their own Medicaid programs to meet the needs of the state’s population.

Medicaid’s original purpose was to provide health care services to “categorically needy” individuals who were receiving federally funded income maintenance (welfare). In 1965, these included the aged, the blind, the disabled, and families and children who were receiving Aid to Families with Dependent Children (AFDC was replaced by the Temporary Assistance to Needy Families [TANF] program with the passage of welfare reform in 1996). States were mandated to include these “categorically needy” individuals in Medicaid programs and were given the option of also including “medically indigent” persons.

All states voluntarily participate in the Medicaid program; the last state to opt-in was Arizona in 1982. Michigan began its Medicaid program in 1966 and has since expanded eligibility and benefits considerably beyond the floors set by the federal government. Title XIX required that eligibility for Medicaid be established by the state agency responsible for welfare eligibility determination. It also required that each state designate a “single state agency” to be responsible to the federal government for the administration of the program. Some states designated the Public Health Department as the single state agency but many others, including Michigan, placed initial responsibility for Medicaid in the state’s social service agency. Section 105 of Public Act 321 of 1966, which authorized Medicaid in Michigan, stipulated that the Department of Social Services

was to “establish a program for medical assistance for the medically indigent under Title XIX”. Today, eligibility determination and program administration are both handled by the Michigan Department of Health and Human Services, a department with responsibility for both public health and social services in Michigan.

Medicaid has evolved over time. It has become the largest single source of health insurance in the United States, providing coverage to over 62 million people, including children, adult individuals, and low-income families. Medicaid is also the largest source of long-term care, aiding the disabled, elderly, and those living in nursing homes throughout the country.² The standard Medicaid population includes many individuals with expensive and complex medical needs who would be either underinsured or uninsured without the program. Traditional beneficiaries of the Medicaid program in Michigan have been low-income children, seniors, and people with disabilities. Michigan has also historically offered benefits to low-income parents with dependent children.

The federal Patient Protection and Affordable Care Act (ACA) of 2010 proposed expansion of state Medicaid programs to cover all low-income adults for whom employers do not provide insurance and for whom purchasing private insurance would be unfeasible at current cost levels. Expansion of Medicaid was meant to provide insurance to individuals who fell between traditional Medicaid eligibility and the income requirements established for purchasing health insurance through the ACA’s non-group marketplace.

There continues to be substantial variability among Medicaid programs in each state (attributable to differing state needs, values, and priorities, in addition to various examples of state-level experimentation/innovation). The Medicaid expansion experience, likewise, has varied in size and scope among the states that have enacted the ACA’s Medicaid expansion, since some states (like Michigan) already provided various levels of Medicaid coverage for parents and/or childless adults prior to the ACA, while others did not.

As of July 2017, total monthly enrollment in Michigan

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for Medicaid and the Children’s Health Insurance Program (CHIP) was around 2.36 million.³ Presently, nearly one in four Michigan residents receive some form of Medicaid coverage.⁴ Medicaid also provides coverage for around 46 percent of all births in Michigan.⁵

Medicaid Program Costs and Finance

Given continuing growth in program scope and eligibility coupled with contemporary periods of very high need, it is unsurprising that Medicaid started to create significant budget stress for states in the early 2000s. Medicaid continues to pose financing challenges, and it rivals K-12 education spending as the single largest source of state budget pressure.

From an initial expenditure of \$150 million in Fiscal Year (FY) 1968, Michigan Medicaid expenses have grown to \$16.9 billion in FY2016. Three major factors have driven this growth: 1) the ever-increasing cost of health care and services, 2) an increase in the number of eligible beneficiaries and the creation of new groups (e.g., CHIP and Healthy Michigan Plan), and 3) the expansion of the types of services covered by

Medicaid. Rates of utilization also affect overall costs, causing state and federal expenditures to rise and fall in proportion to overall service utilization. A fraction of Medicaid spending growth may also be explained by some previously separate state services being absorbed into Medicaid (e.g., Medicaid’s evolving role in mental health and substance abuse services).

While Medicaid spending has grown substantially in Michigan over time, it has done so with no unusual trends or notable variations from peer states or the nation as a whole. For instance, a major increase in Michigan’s Medicaid spending (7.9 percent) occurred in the 2007-2010 period, due in no small part to high unemployment and greater Medicaid eligibility (during a period wherein two of Detroit’s “Big 3” automakers declared bankruptcy and the stock market collapsed nationally).^b Growth in the 2010-2014 period slowed (3.9 percent three-year average) and Michigan saw smaller growth relative to both the Great Lakes Region (5.8 percent) and the U.S. as a whole (5.2 percent). (See **Table 1** and **Chart 1.**)

Michigan’s FY2018 Federal Medical Assistance Percent-

^b See Citizens Research Council Report 376 (February 2012), “Options for Managing Medicaid Funding and Cost Growth.”

Table 1
Medicaid Spending Growth Compared
Three-Year Averages FY2004-2014

Location	FY 2004-2007	FY 2007-2010	FY 2010-2014
<i>United States</i>	<i>3.6%</i>	<i>6.8%</i>	<i>5.2%</i>
Michigan	3.9%	7.9%	3.9%
Illinois	7.6%	6.6%	2.2%
Indiana	1.3%	5.0%	11.4%
Minnesota	3.2%	7.0%	7.3%
Ohio	3.7%	5.3%	6.4%
Pennsylvania	3.9%	5.6%	5.9%
Wisconsin	3.2%	9.7%	3.5%

Source: Kaiser Family Foundation. (n.d.). “Average Annual Growth in Medicaid Spending.” *State Health Facts*. <https://www.kff.org/medicaid/state-indicator/growth-in-medic-aid-spending/>

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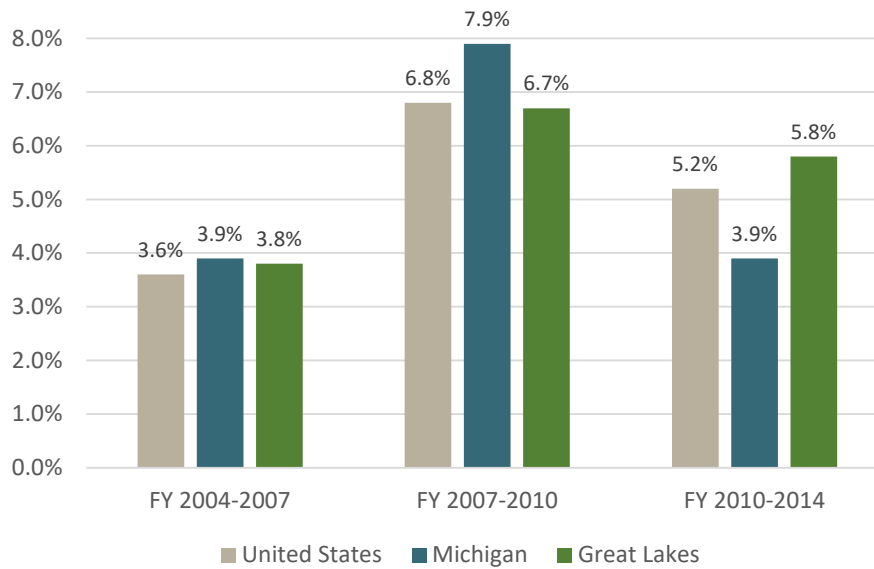
age (FMAP) is 64.78 percent.⁶ This means that for each dollar spent on Michigan’s Medicaid program, the federal government pays 64.78 cents and the state pays the remaining 35.22 cents. Stated differently: for every dollar state government spends on traditional Medicaid, the federal government matches that dollar with \$1.84. Some programs under the umbrella of Medicaid, such

as the Healthy Michigan Plan (or the Children’s Health Insurance Program – CHIP) have enhanced FMAPs that offer a higher federal share. State FMAPs since FY2013 can be compared among Great Lakes Region states in **Table 2**.

Michigan has had a higher FMAP than most neighboring

Chart 1

Medicaid Spending Growth Compared, FY 2004-2014



Source: Kaiser Family Foundation. (n.d.). “Average Annual Growth in Medicaid Spending.” *State Health Facts*. <https://www.kff.org/medicaid/state-indicator/growth-in-medicaid-spending/>

Table 2

Medicaid Federal Medical Assistance Percentages in the Great Lakes Region

	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
<i>United States</i>	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
Michigan	66.39%	66.32%	65.54%	65.60%	65.15%	64.78%
Illinois	50.00%	50.00%	50.76%	50.89%	51.30%	50.74%
Indiana	67.16%	66.92%	66.52%	66.60%	66.74%	65.59%
Minnesota	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
Ohio	63.58%	63.02%	62.64%	62.47%	62.32%	62.78%
Pennsylvania	54.28%	53.52%	51.82%	52.01%	51.78%	51.82%
Wisconsin	59.74%	59.06%	58.27%	58.23%	58.51%	58.77%

Source: Kaiser Family Foundation. (n.d.). “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.” *State Health Facts*. <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>

Federal Financing and Reimbursement for Medicaid

Medicaid is jointly funded by states and the federal government, with the federal government paying a specified share of total program expenditures in each state, called the Federal Medical Assistance Percentage (FMAP).

FMAP varies state by state, and is established using metrics to determine relative state wealth (such as per capita personal income). To limit the effect of economic fluctuations, FMAPs are adjusted on a three-year cycle.

The statutory minimum for an FMAP is 50 percent (in the wealthiest states), and the maximum regular FMAP is 82 percent. On average, states receive an FMAP of 57 percent, leaving the states to fund 43 percent of their Medicaid programs. Because of financial troubles in Michigan over the last decade, Michigan's FMAP rose to more than 70 percent in FY2009, and has steadily fallen to its current level of just below 65 percent. Prior to Michigan's single state recession, the FMAP in Michigan was much lower (56.71 percent as recently as FY2005), reflecting the general wealth of Michigan relative to other states.

Some Medicaid groups may receive a different FMAP than traditional services.

- The enhanced FMAP for the Children's Health Insurance Program (CHIP) has ranged historically between 65 to 81 percent—however this funding is capped and may be exhausted by states, unlike the entitlement funding structure of traditional Medicaid.
- The Healthy Michigan Plan (and other state expansions of Medicaid that created a new adult group) were granted an enhanced FMAP by the Affordable Care Act of 100 percent decreasing gradually to 90 percent.

To be eligible for federal Medicaid funding, states must ensure that they will be able to fund their share of expenditures for care under their state Medicaid plan. Federally recognized and accepted funding sources for state Medicaid payments include: legislative appropriations to the state Medicaid agency (in Michigan, the Department of Health and Human Services), inter-governmental transfers (IGTs), certified public expenditures (CPEs), and permissible taxes/provider donations.

States may establish their own Medicaid provider payment rates, and generally pay for services on either a fee-for-service or through managed care. States may also develop fee-for-service rates based upon the cost of providing the service, prevailing rates paid by commercial payers in the private market, and/or a percentage of what Medicare pays for a given service.

With Medicaid managed care, states may contract with health plans and organizations to provide care for Medicaid enrollees in exchange for capitated (per-person) payments based on the number of enrollees covered by the managed care plan. The majority of Medicaid beneficiaries nationwide (including in Michigan) are covered through managed care arrangements.

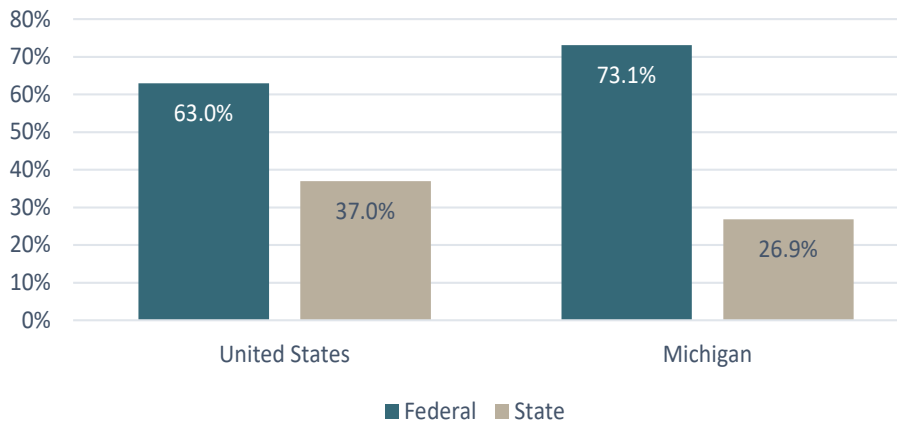
states (excepting Indiana) since FY2009. Because the FMAP is determined by various economic indicators, problems in Michigan’s economy in the early 2000’s led to a substantial increase in the FMAP. Likewise, Medicaid enrollment is economically driven (with greater demand for the program during recessions or other periods that cause individuals and families to face economic hardships). The increased FMAP has offset some of the state’s financial burden related to growth in Medicaid enrollment.

Of the total FY2016 \$16.9 billion Medicaid expenditures in Michigan (excluding administrative costs), the federal government paid \$12.3 billion (73.1 percent).⁷ This federal share of spending exceeds Michigan’s FY2016 FMAP (65.6 percent) primarily because of higher rates of federal payment for CHIP and the Healthy Michigan Plan. Michigan contributed only 26.9 percent of total Medicaid dollars spent in the state in FY2016 (see **Chart 2**).

At one time, Medicaid (like most private health insurance plans) mainly compensated health care service providers on a fee-for-service basis. As many private insurance models shifted to managed care, Medicaid has followed suit. Managed care is designed to reduce costs by incentivizing primary care and prevention, while limiting utilization of high-cost treatments, as well as negotiating competitive reimbursement rates with providers. The majority of Medicaid spending in Michigan (62 percent) is now used to finance managed care plans for eligible beneficiaries, spreading some of the state’s risk for plan enrollees between private insurers and providers (see **Chart 3**). The use of managed care creates stability in public budgeting, with the state paying a capitated amount and insurers assuming risk for potentially high-cost enrollees.

Chart 2

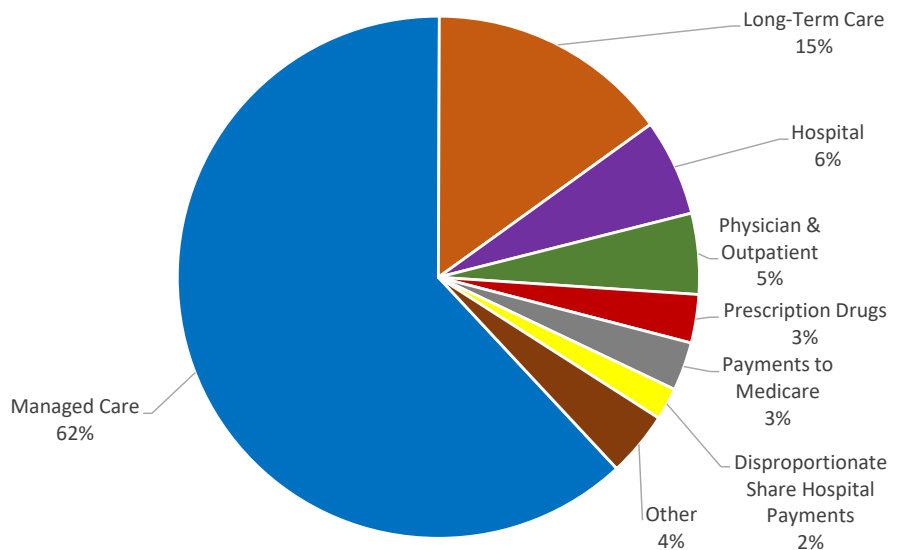
U.S. and Michigan Shares of Medicaid Spending, FY2016



Source: Kaiser Family Foundation. (n.d.). "Federal and State Share of Medicaid Spending." *State Health Facts*. <https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/>

Chart 3

Allocation of Medicaid Dollars in Michigan, FY2016



Source: Kaiser Family Foundation. (2017). "Medicaid in Michigan." *State Fact Sheets*. files.kff.org/attachment/fact-sheet-medicare-state-M

The Affordable Care Act

Enacted in 2010, the Patient Protection and Affordable Care Act, or simply Affordable Care Act (ACA), marked an incremental, yet significant, shift in U.S. health policy. It was a national adaptation of a set of long-discussed health insurance reforms that had been successfully pioneered at the state level in Massachusetts in 2006. Congresses and Presidents for more than a century (as far back as Theodore Roosevelt) have sought comprehensive health insurance reform with the goal of achieving health insurance coverage for the entire population.⁸ The ACA borrowed much of its content and structure from earlier discussions and proposals seeking health insurance reforms.

The U.S. has traditionally relied primarily on employer-sponsored health plans to provide citizens with health insurance. The ACA continued this private, market-based approach to health insurance, making modifications to the private health insurance market intended to correct market failures through new regulatory structure and expanding existing state Medicaid programs to insure more low-income adults. Conversely, the ACA did not create a new publicly administered health insurance option.

The ACA was enacted with the expressed goals of expanding health insurance coverage and access, controlling costs, and improving health service delivery (although the primary focus of the law seems to have been the first dimension of health insurance coverage and access). It also sought to provide the insured with better financial security in the event of a catastrophic health event. Prior to passage of the ACA, 62 percent of personal bankruptcies across the U. S. were caused by medical debt (the ACA cut the total number of personal bankruptcies from all causes in half since 2010 and virtually eliminated bankruptcies related to medical debt throughout the U.S.).⁹

In the simplest terms, the ACA contained three key mechanisms:

1. Marketplace Reforms
2. New Marketplaces for Individuals and Small Businesses
3. Medicaid Expansion

Marketplace Reforms

The ACA enacted numerous marketplace reforms intended to increase access to health insurance for individuals. Key among them were requirements that insurance companies cover everyone regardless of health status and pre-existing health conditions and limits on how much can be charged for a health insurance plan based on factors like the enrollee's age or gender.

To stabilize the private insurance market and prevent people from waiting until they become sick to enroll in a health insurance plan, the ACA created an individual mandate requiring all U.S. citizens and legal residents to have qualifying health coverage (or else face tax penalties). Varying exemptions to the individual mandate include financial hardship, religious objections, and short-term lapses in coverage, as well as specified populations (including Native Americans, the incarcerated, and undocumented immigrants). In the *National Federation of Independent Business v. Sebelius*¹⁰ decision, the U.S. Supreme Court upheld the constitutionality of the individual mandate to carry minimal health insurance coverage.

Alternatively referred to as either an employer mandate or employer shared responsibility provisions, the ACA also created a fee-per-employee for employers (with 50 or more full-time equivalent employees) who do not provide health insurance benefits to full-time workers. The ACA also provided tax credits to qualifying small employers that offer health benefits.

Other notable ACA reforms include establishing a set of essential health benefits^c (EHB), allowing dependent coverage up to age 26 on individual and group plans, reducing the cost of preventative services, and requiring nutritional labeling on food from chain restaurants and vending machines.

^c Essential health benefits are services categorized by the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

The ACA also created various insurance market rules and consumer protections, and required insurance companies to have a medical loss ratio (the amount of premiums spent on clinical services and quality, as opposed to administrative costs or profit) of not less than 85 percent for large group markets and 80 percent for small group and non-group markets.

The ACA included various new taxes to pay for its provisions and subsidies.

Marketplace for Individual and Small Business Insurance Plans

The ACA laid the foundation to establish state-based (or multi-state, or state-federal partnerships) health benefit exchanges where consumers could make comparisons between available health insurance plan options. The purpose of the exchanges was to utilize market principles of competition, transparency, and consumer choice to enhance the quality of health plans. Different level plans (bronze, silver, gold, platinum) with comparable coverage were created so that consumers would be able to make better-informed purchasing decisions when comparing products.

Individual health plans are subsidized by premium credits and cost sharing subsidies for individuals and families with incomes from 100 to 400 percent of the federal poverty level. Subsidies are available to U.S. citizens or legal immigrants who are ineligible for Medicaid.

The Small Business Health Options Program (SHOP) Marketplace helps small businesses provide health insurance to employees and is generally available to employers with 1 to 50 full-time equivalent employees (FTEs). Employers with fewer than 25 employees may qualify for a Small Business Health Care Tax Credit.

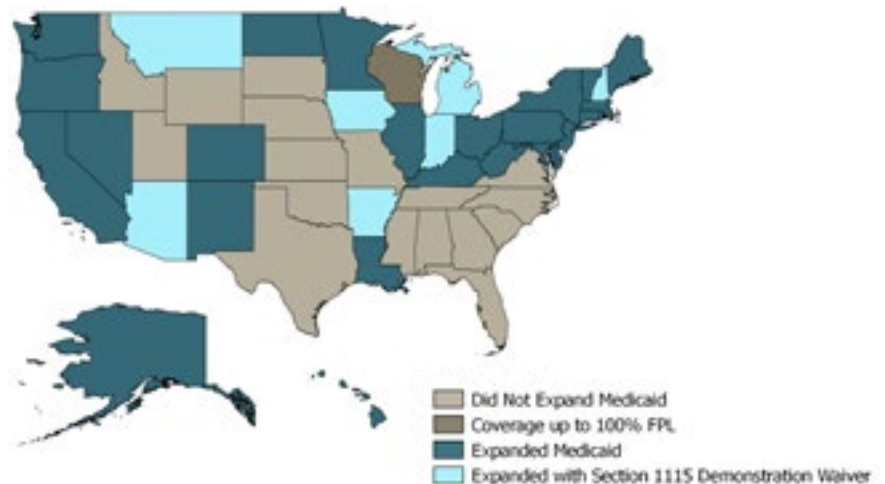
Medicaid Expansion

The ACA originally mandated that all states would expand Medicaid to cover low-income adults up to 133 percent of the federal poverty level (FPL) or else lose all federal funding for Medicaid. Medicaid was viewed as the most practical and cost-effective mechanism (rather than a subsidized marketplace plan) for covering the poorest individuals (who statistically have some of the highest health risks). The *National Federation of Independent Business v. Sebelius* decision struck down mandatory Medicaid expansion as unconstitutional, thereby limiting federal enforcement of state-level Medicaid expansion. Subsequently, states were able to voluntarily expand Medicaid.

To date, 32 states (including Michigan) have expanded their Medicaid programs under the ACA. Seven states that expanded Medicaid (again, including Michigan) did so through Section 1115 Demonstration waivers. In 2017, Maine became the first state to expand Medicaid through a public referendum. The District of Columbia has also expanded Medicaid. Wisconsin, while not adopting the ACA's Medicaid expansion, does cover adults up to 100 percent of the FPL under the state's Medicaid program. The following map shows the distribution of Medicaid expansion across states (See **Map 1**).

Map 1

Status of State Medicaid Expansion Decisions, November 2017



Source: Compilation by the Citizens Research Council of Michigan.

The Healthy Michigan Plan

Enactment

On September 16, 2013, Governor Rick Snyder directed the expansion of Medicaid in Michigan by signing Public Act (PA) 107 of 2013 into law. In April of 2014, Michigan began implementation of the Healthy Michigan Plan, a state-specific version of Medicaid expansion under the ACA accomplished through a Section 1115 Demonstration waiver. Waivers are used to allow states to expand coverages, innovate, or otherwise implement state Medicaid in some way that deviates from the usual federal guidelines. The waiver expanded Michigan’s Adult Benefits Waiver (ABW) program—a previous Section 1115 Demonstration.

Prior to the federal expansion of Medicaid, states could only provide insurance to childless adults through state-

funded programs or federal waivers. Five states had provided coverage to childless adults that was comparable to Medicaid, and 15 others (including Michigan) provided some coverage to the beneficiaries that was inferior to Medicaid. Medicaid coverage for parents of Medicaid eligible children was also limited prior to expansion, with 17 states restricting eligibility to 50 percent FPL, and another 17 states limiting coverage to less than 100 percent FPL.¹¹

Michigan’s Adult Benefits Waiver for non-pregnant childless adults often had extensive waiting lists and was unable to meet demands for enrollments. Moreover, the program did not cover a number of medical services (e.g. inpatient hospitalization, dentistry, optometry, podiatry, occupational/physical/speech

Federal Poverty Level

Income contingent eligibility for Medicaid, including the Healthy Michigan Plan, is based upon an individual’s financial position relative to what is referred to as the Federal Poverty Level (FPL). The FPL is a measure of economic status determined in the poverty guidelines in the Federal Register by the U.S. Department of Health and Human Services (HHS). These guidelines are an administrative simplification of the Census Bureau’s poverty threshold measures and are used in determining financial eligibility for a variety of federal programs, such as Head Start, the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children’s Health Insurance Program (CHIP).

Table 3

2017 Poverty Guidelines for the 48 Contiguous States* and the District of Columbia

* Alaska and Hawaii have differing guidelines

Persons in Family/Household	Federal Poverty Level (FPL)	138% of the Federal Poverty Level
1	\$12,060	\$16,642.80
2	\$16,240	\$22,411.20
3	\$20,420	\$28,179.60
4	\$24,600	\$33,948.00
5	\$28,780	\$39,716.40
6	\$32,960	\$45,484.80
7	\$37,140	\$51,253.20
8	\$41,320	\$57,021.60
For each additional Person	+ \$4,180	

Source: Citizens Research Council calculations using data from the U.S. Department of Health and Human Services: <https://aspe.hhs.gov/poverty-guidelines>

therapy, eyeglasses, hearing aids, prosthetics/orthotics, hospice, and home health) and provided limited coverage for other health care needs.¹²

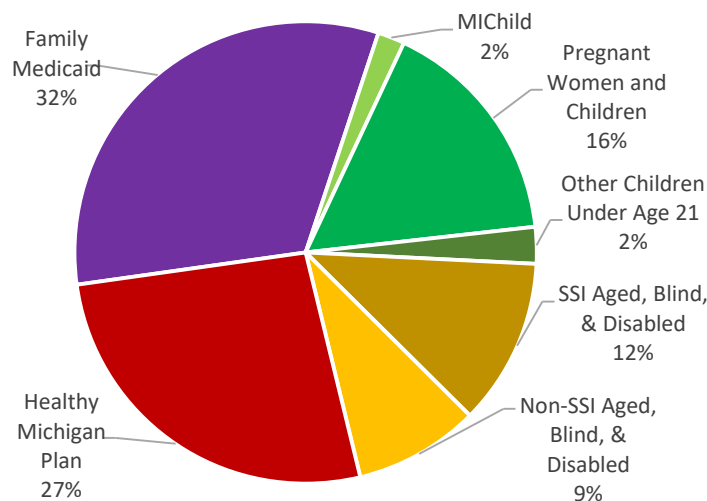
Under the current Healthy Michigan Plan, the state provides Medicaid coverage to an expanded adult eligibility group, including all adults with incomes up to and including 133 percent^d of the federal poverty level (\$16,643 per year for an individual or \$33,948 for a household of four). The plan offers health benefits comparable to traditional Medicaid coverage to all beneficiaries, including federally mandated essential health benefits.

Enrollment and Access

Enrollment. As of December 2016, there were 649,282 Healthy Michigan Plan enrollees, in addition to 1,794,867 traditional Medicaid enrollees (including 498,872 aged/blind/disabled and 505,622 children and pregnant mothers).¹³ The number of beneficiaries receiving insurance through expanded Medicaid in

^d While the ACA expanded Medicaid to individuals with incomes up to and including 133 percent FPL, eligibility calculations utilize the Modified Adjusted Gross Income (MAGI) methodology and include an income disregard equal to five percentage points of the FPL, making the effective eligibility level 138 percent FPL.

Chart 4
Eligible Medicaid Beneficiaries in Michigan by Enrollee Group, December 2016



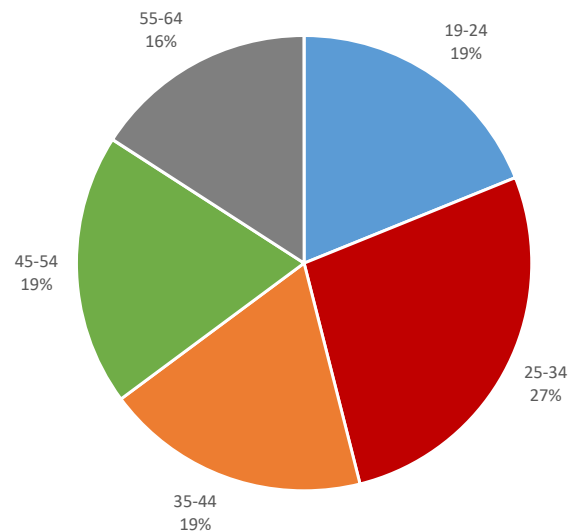
Source: Michigan Department of Health and Human Services. (2016). "Green Book Report of Key Program Statistics." www.michigan.gov/documents/mdhhs/2016_12_Green-Book_549141_7.pdf

Michigan has surpassed all pre-expansion estimates. According to Michigan Governor Rick Snyder, the program exceeded expectations and surpassed its one-year enrollment goal of 322,000 in the first 100 days.¹⁴

Healthy Michigan Plan enrollees now account for more than a quarter of the total beneficiaries of Medicaid in Michigan. **Chart 4** shows an estimated distribution of eligible Michigan Medicaid recipients by enrollee group.

When stratified by age, program benefits are spread among all ages; however, the greatest enrollment is among younger adults. This is unsurprising, as younger adults tend to have lower incomes and are more likely to be uninsured. The highest concentration of the uninsured is in the 25-34 age group, and rates of uninsurance are higher among males. For males in the 25-34 age group, one in five remain uninsured throughout the U.S.¹⁵ **Chart 5** shows that 46 percent of Healthy Michigan Plan enrollees are in the 19-34 age group.

Chart 5
Enrollees in Healthy Michigan Plan by Age August 2017



Source: Michigan Department of Health and Human Services. (2014). "Healthy Michigan Plan Progress Report." www.michigan.gov/documents/mdch/Website_Healthy_Michigan_Plan_Progress_Report_12-01-2014_475355_7.pdf

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Just as the Healthy Michigan Plan serves enrollees of all age groups (excluding children and Medicare eligible seniors), the plan provides insurance coverage to residents of both rural and urban counties alike.

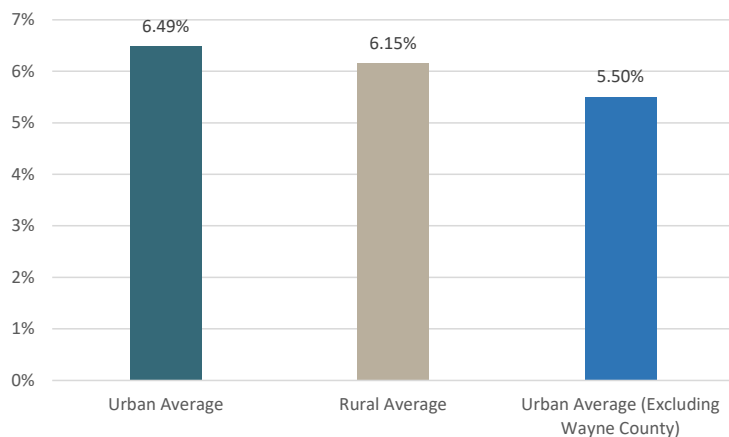
Chart 6 shows that the difference in coverage levels between residents of urban and rural counties differs by less than half of one percent (because of the large population and relatively high number of Healthy Michigan Plan enrollees in Detroit/Wayne County, the urban average is skewed a full percentage point higher). Around six percent of the state population gets health insurance through the Healthy Michigan Plan.

Considering Medicaid as a whole, rural counties tend to have higher rates of Medicaid enrollees and individuals receiving disability assistance than urban counties. Relatedly, rural physicians are more likely to accept Medicaid than their urban counterparts within Metropolitan Statistical Areas (MSA).¹⁶

Uninsured in Michigan. Michigan has dramatically reduced the number of uninsured persons since the federal passage of the Affordable Care Act and state enactment of the Healthy Michigan Plan. Today, around six percent of the Michigan population remains uninsured (see **Chart 7**), including individuals who cannot afford private health insurance and do not qualify for public assistance, adults and children who

Chart 6

Average Monthly Healthy Michigan Plan Enrollees in Urban and Rural Counties (percent of total population), 2016

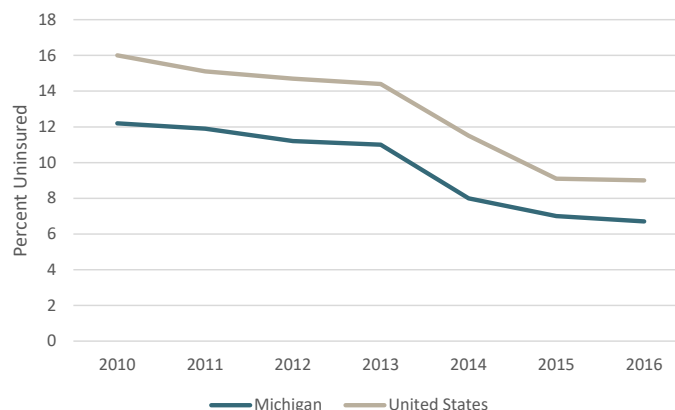


Source: Citizens Research Council calculations. Beneficiary data from Michigan Department of Health and Human Services. Population Data and Urban/Rural classification from U.S. Census Bureau.

may be eligible for Medicaid but have not applied or are not receiving benefits, and some others who may have access to insurance but choose to go without. A

Chart 7

Individuals (all ages) without insurance Michigan and United States, 2010-2016



Sources: CDC, National Center for Health Statistics, National Health Interview Survey

precipitous decline in the number of uninsured may be observed in 2014, coinciding with the start of the Healthy Michigan Plan.

Among the insured, just over half (53 percent) of Michigan residents receive insurance from their employer and another six percent receive private insurance through non-group sources (like the Affordable Care Act's subsidized non-group marketplace for individuals). The remainder get insurance from either Medicare, Medicaid, or both (see **Chart 8**). This leaves around six percent of Michigan's population without health insurance. Among this six percent, some may be eligible for Medicaid but not enrolled in the program, and the rest most likely either have incomes above Medicaid eligibility but find non-group marketplace plans cost-prohibitive (despite subsidies) or have simply chosen not to purchase insurance.

Without question, the Healthy Michigan Plan has played a central role in reducing the number of uninsured in Michigan and offering more comprehensive coverage to others. More Michiganders have obtained insurance through the Healthy Michigan Plan than through the individual marketplace established

by the ACA. Importantly, the Healthy Michigan Plan also bridges the gap in eligibility between traditional Medicaid eligibility and ACA subsidies to purchase individual private health insurance plans.

Access. While health insurance coverage is unquestionably important (as a means of financial protection and as a vehicle for accessing care), insured status is not exactly the same thing as health care access. To measure access, one needs to assess a variety of indicators associated with insured status.

ACA coverage expansion (both adult Medicaid and individually subsidized non-group plan insurance) was associated with higher rates of having a regular and affordable source of care, greater access to preventative health services and primary care, more ambulatory care visits, increased use of prescription medication, and better medication adherence.¹⁷ Even after controlling for socioeconomic and demographic characteristics, non-elderly adults with Medicaid are far more likely to have a regular source of care than the uninsured, and are more likely to utilize health services and report timely care and less likely to delay or forego needed care overall or because of cost.¹⁸ Further evidence has clearly shown that insurance through Medicaid

facilitates outpatient physician care.¹⁹ This body of research indicates that Medicaid expansion improves health care access among the previously uninsured.

Medicaid expansion has also facilitated more individuals accessing preventive health care services. Of the 348,236 individuals who were on the Healthy Michigan Plan for at least 11 of the 12 months in FY2016, around three out of four (73.95 percent) utilized at least one service categorized as preventative. A total of 1,324,754 claims or encounters were categorized as preventative for the total population of Healthy Michigan Plan enrollees during FY2016.

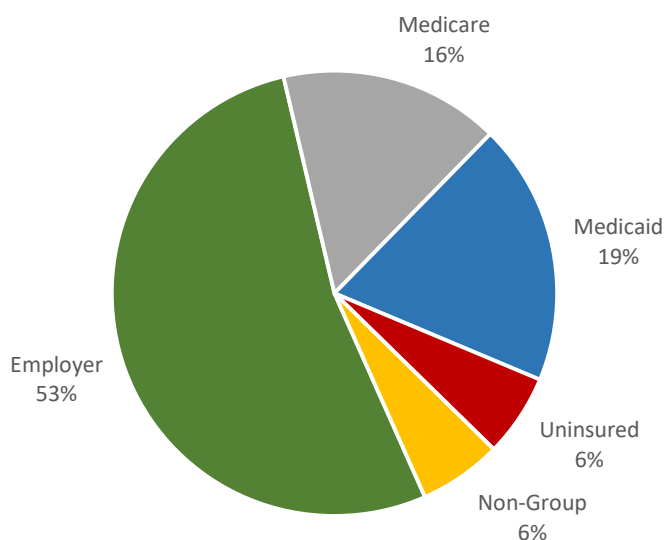
In questioning the degree or quality of access afforded by Medicaid expansion, some point to the fact that fewer physicians accept Medicaid patients relative to those that are privately insured, particularly in urban areas.²⁰ Physician participation rates alone, however, are a poor measure of access to care. A low Medicaid participation rate among physicians may indicate that care for Medicaid patients is more concentrated within traditional safety-net providers—Federally Qualified Health Centers (FQHCs), for instance, possess specialized expertise for providing excellent service and care to low-income populations—rather than indicating any specific impediment to care.²¹

Primary care appointment availability is a more useful measure of access. One fear that was expressed prior to implementation of the Healthy Michigan Plan was that there would not be the available capacity among medical providers to treat a sudden influx of newly insured individuals. This problem has not materialized. Research found that “one year following Medicaid expansion in Michigan, appointment availability for new Medicaid patients [actually] increased. Furthermore, median new patient wait times remained within two weeks, with more than 95% falling within the 90-day requirement of the Healthy Michigan law.”²²

This is perhaps attributable to increasing proportions of appointments scheduled with nonphysician providers (NPPs). Previous research from the Citizens Research Council of Michigan concluded that primary care provided by NPPs (namely Nurse Practitioners and Physicians Assistants) within their scope of practice achieved comparable outcomes to care provided by physicians and sometimes yielded improved measures of care (e.g., greater patient satisfaction).²³

Chart 8

Sources of Insurance in Michigan, 2015



Source: Kaiser Family Foundation. “Health Insurance Coverage of the Total Population.” www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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Another worry prior to implementation of the Healthy Michigan Plan was that expanded coverage for a newly insured population would impair access for those who were already continuously insured (private, employer-sponsored insurance, Medicare, and traditional Medicaid beneficiaries). These fears were also not realized, and access for the continually insured was not impacted by any “negative spillover” resulting from ACA coverage gains, including Medicaid expansion.²⁴ While some analyses have found a small decline in private insurance related to Medicaid expansion—referred to as crowd-out—other analysis has found no significant decline in private insurance enrollment within expansion states.²⁵ If any crowd-out of private insurance has occurred in Michigan, it has been minimal. Moreover, since the Healthy Michigan Plan contracts with private health plans to utilize a system of capitated managed care, Healthy Michigan Plan enrollees are still able to choose from a selection of private insurances (to whom the state will pay a capitated sum in exchange for management of health care service utilization and payment).

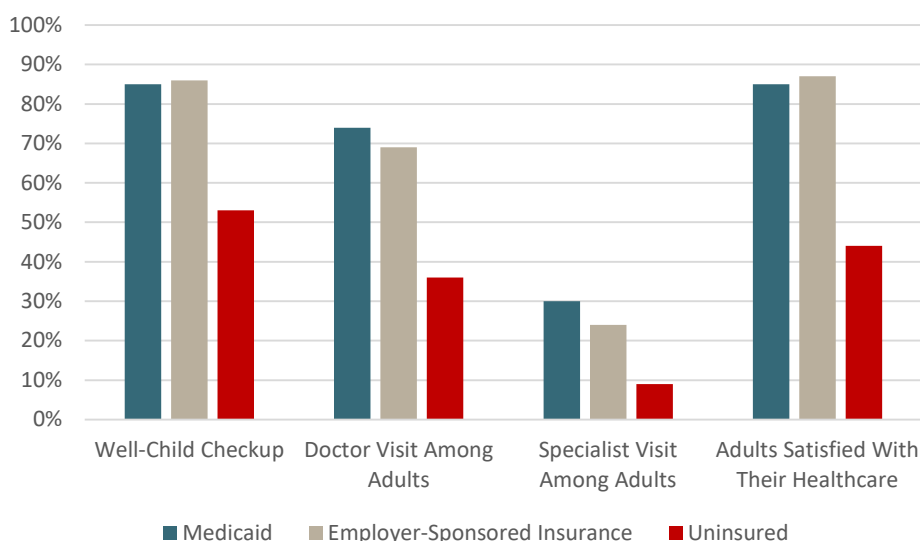
Across many measures of access (e.g., regular source of care, regular check-ups, or satisfaction with insurance), research indicates that insured patients fare better than the uninsured. (See **Chart 9**.)

Areas where adult Medicaid beneficiaries experience continuing disparities in access and utilization (relative to adults with employer-sponsored insurance) are most likely attributable to the greater health needs and lower socioeconomic position of the Medicaid population.²⁶ Further refinement and improvement of the Medicaid program is possible to address these residual disparities.

For instance, increasing payment levels to Medicaid providers appears to improve access.²⁷ Any increase to fees paid by Medicaid, however, should be predicated on consistent evidence that the increase would benefit patients’ access to quality care (and that access has been marginalized by an inadequate schedule of fees). One way to assess Medicaid fees in each state is by using fees set by Medicare as a national benchmark. The Medicaid-to-Medicare fee index in Michigan during 2016 for all services was 0.65:1. This means that health care providers were receiving only 65 cents for Medicaid services per dollar received for Medicare services. Only 12 states had a lower Medicaid-to-Medicare fee index during that year.²⁸ Michigan has also ranked among the bottom states in Medicaid reimbursement for hospital services.²⁹ The adequacy of Medicaid reimbursement in Michigan should be examined further to identify the level that maximizes access.

Chart 9

Medicaid and Privately Insured Patients Fare Better Nationally than the Uninsured on Metrics of Access and Satisfaction, 2016



Source: Kaiser Family Foundation. (2017). “Medicaid in Michigan.” *State Fact Sheets*. files.kff.org/attachment/fact-sheet-medicaid-state-mi

Another particular challenge for Medicaid programs is “churning,” meaning that, due to factors like fluctuating income, individuals “churn” on and off Medicaid. Interruptions of coverage by churning may diminish the benefits of the Medicaid program. This ongoing challenge should be monitored and addressed by the state.³⁰

Finance and Economic Impact

The Healthy Michigan Plan has added a new layer of complexity and fiscal obligation to Michigan’s array of Medicaid programs since its implementation in 2014. Spending on the Healthy Michigan Plan was approximately \$3.6 billion in FY2016, before the state had borne any costs for the Healthy Michigan Plan (the federal government covered the

Churning

Churning is a fluid metaphor that is applied broadly from financial markets to health insurance to connote a series of rapid shifts and changes or a general state of instability.

As it relates to Medicaid (and health insurance more broadly), churning refers to the process by which people cycle rapidly between different types of insurance/insurance plans or in and out of health insurance coverage. In Medicaid, this is typically due to fluctuations in income/employment (sometimes seasonally) that move people over and under the threshold for Medicaid eligibility, changes in job status affecting employer-sponsored insurance coverage, and/or changes in family composition.

An analysis by the Center for Healthcare Research and Transformation (CHRT) found that, among groups with various sources of insurance, Medicaid recipients in Michigan had the greatest instability in their coverage and were seven times as likely to experience a temporary period without insurance relative to beneficiaries of employer-sponsored health insurance. Across all types of insurance, younger enrollees experience the greatest churning.ⁱ

Churning creates instability in insurance coverage, affecting cost, quality, and continuity of care. This creates administrative burdens for the state and for Medicaid MCOs. From a patient standpoint, moving between different types of insurance coverage could mean loss of access to certain providers, differences in premiums and/or cost sharing, and discrepancies in covered benefits. Each of these factors may threaten continuity of care and treatment adherence and negatively affect health outcomes as a result. Churning also creates stress and financial risk for patients.

Research published in *Health Affairs* and by the Commonwealth Fund suggests that extending Medicaid eligibility by the calendar year can reduce churning by around 78 percent and virtually eliminate the related administrative burden on states and MCOs, thereby minimizing the negative effects of churning. Necessarily, this would increase state health care expenditures by extending coverage to those whose incomes may exceed Medicaid eligibility in a given month.ⁱⁱ

The Montana Health and Economic Livelihood Partnership (HELP)—Montana’s expansion of Medicaid with a section 1115 demonstration waiver—includes 12-month continuous eligibility.ⁱⁱⁱ Montana’s expansion of Medicaid is even more recent than Michigan’s, but may provide a future test case to evaluate the costs and benefits of 12-month continuous Medicaid eligibility.

It will be difficult for Michigan to balance this trade-off between containing state health care expenditures and fostering continuity of care for Medicaid beneficiaries if the state decides to address the problem of churning in the Healthy Michigan Plan. Extending continuous benefits to those Medicaid beneficiaries affected by churning would undoubtedly increase state Medicaid expenditures, however this might be partially offset by administrative savings in costs related to churning (estimated \$400-\$600 per enrollee). On the other hand, state programs should always work to guarantee optimal service; in the case of Medicaid, this means access and quality in health care, both of which are undermined by the churning phenomenon.

ⁱ Austic, E., Lawton, E., Riba, M., & Udow-Phillips, M. (2016). “Insurance Churning.” Ann Arbor, MI: Center for Healthcare Research and Transformation (CHRT). <http://www.chrt.org/publication/insurance-churning>

ⁱⁱ K. Swartz, P. F. Short, D. R. Graefe et al., “Reducing Medicaid Churning: Extending Eligibility for Twelve Months or to End of Calendar Year Are Most Effective,” *Health Affairs*, July 2015 34(7):1180–87.

ⁱⁱⁱ Montana Department of Public Health and Human Services, *Section 1115 Demonstration Waiver Application*. <https://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/MontanaSection1115and1915b4Waivers.pdf>

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total cost of the program until the start of FY2017). The Affordable Care Act established that the federal government would fully fund the cost of Medicaid expansions (like the Healthy Michigan Plan) through FY2016, and then would require states to begin to contribute greater shares of the cost over time. State liability began at five percent of the cost in FY2017, and will increase each year until the state contribution reaches ten percent in FY2020 (the remaining 90 percent to be paid by the federal government is still a much higher federal share of funding than is the state's unenhanced FMAP for other Medicaid enrollment).

Once this state contribution has been fully phased in, the House Fiscal Agency (HFA) estimates that the cost will be around \$400 million per year. Because Medicaid costs are partially funded through provider assessments and state retainers, about \$222 million per year will need to come from the General Fund in FY2021.³¹ Absent a proactive mechanism or plan to meet this funding obligation, the Healthy Michigan Plan will eventually join a host of other state spending priorities as a source of long-term fiscal stress.^e

The Healthy Michigan Plan is not solely a source of cost, but also a source of savings and benefits to the state. The HFA estimates that the Healthy Michigan Plan has saved the state about \$235 million per year in costs outside of Medicaid, such as in non-Medicaid mental health (\$168 million), Adult Benefits Waiver program (\$47 million), state prisoner health care costs (\$19 million), and the Plan First! waiver program (\$1 million).³² By transitioning enrollees in state funded programs (e.g. behavioral health services for the severely mentally ill) into expanded Medicaid, the state eliminated general fund expenditures and replaced them with enhanced federal matching funds. Similarly, the Adult Benefits Waiver program that previously allowed Michigan to offer limited health benefits to some childless adults with very low incomes

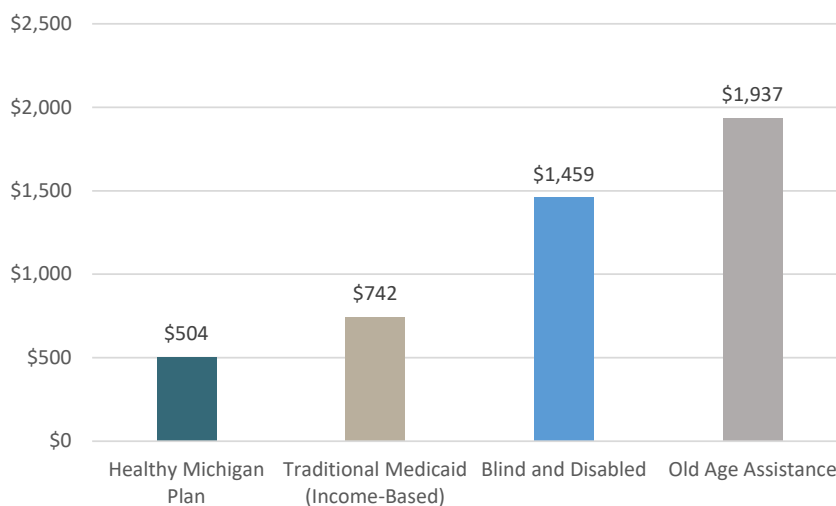
was reformed into the Healthy Michigan Plan, allowing the state to access enhanced federal dollars for these Medicaid enrollees.

Cost per Enrollee. The Healthy Michigan Plan has been effective at providing health insurance at a relatively low cost. **Chart 10** shows that the Healthy Michigan Plan provides care at an expense of around \$500 per person each month. The 2014 cost was \$505.94 per person. In 2015, the cost per member per month dropped by one half percent to \$503.38 per person.

The cost of Healthy Michigan Plan coverage falls in the middle when compared to private health plans. In Michigan, 2017 marketplace silver plans range from a high of \$1,133 per person per month for a 55+ year old smoker in rating area 7 (Ingham, Eaton, Clinton, Jackson, and Hillsdale Counties) to a low of \$183 per person per month for a 25 year old non-smoker in rating area 2 (Oakland and Macomb Counties).³³ While the ACA prevents differences in pricing based on certain characteristics like health status or gender and limits rating differences on others (age), individual marketplace plans have substantial variability in cost, based

Chart 10

Average Cost per Enrollee by Medicaid Group, FY2016



Source: Michigan Department of Health and Human Services

^e For further discussion of looming budgetary pressures created by Medicaid and other programs, see Citizens Research Council Report 397, *Challenges Ahead in Balancing the State Budget, August 2017*, <http://crcmich.org/challenges-ahead-in-balancing-the-state-budget/>.

on the combination of geography, age, and tobacco use, as well as plan tier and specific coverages.

Any comparison between managed care plans through Medicaid and those in the non-group marketplace, however, will be an apples-to-oranges comparison for two major reasons: 1) federal rules create additional requirements for Medicaid that may not be included in all private plans, and 2) the Medicaid population is poorer, tends to be less healthy, and is therefore more expensive to insure. In terms of absolute value, the Healthy Michigan Plan provides health insurance for the working poor and other low-income individuals at a lower cost than and comparable quality to many privately available health insurance plans (when considering the age, income, and health status of enrollees).

Within the Medicaid program as a whole, spending for Healthy Michigan Plan enrollees is comparatively low. Medicaid coverage for the elderly is provided at an average cost per person of nearly \$2,000/month or \$23,244/year—this is quadruple the cost of Healthy Michigan Plan enrollees. The elderly and disabled account for around one-fifth of the total population of all Medicaid beneficiaries, but are responsible for nearly two-thirds of the costs of the program as a whole.³⁴ Yet again, this is an apples-to-oranges comparison due to the differing health needs of the elderly.

While the Healthy Michigan Plan's costs per enrollee have remained very stable for the first three years of the program, it is more difficult to predict potential long-term growth. Among traditional Medicaid beneficiaries, the average annual cost per enrollee increased by around 50 percent from FY2001 through FY2016 (\$4,900 to \$7,500).³⁵ During the same period, however, the cost of insurance for a family of four with employer sponsored health insurance has grown by 300 percent (\$8,414 to \$25,826).³⁶ Using data from 2003-2009, one analysis found that spending for adult Medicaid beneficiaries was 25 percent less than it would be per enrollee with private, employer-sponsored insurance.³⁷ With its large risk pool and use of managed care, it is reasonable to assume that the Healthy Michigan Plan will continue to constrain long-term growth in cost.

Economic Impact. Beyond health, the economic benefits to individuals and to the State of Michigan from expanding Medicaid have been immense. A review of 29 different studies by the Kaiser Family Foundation has found con-

sistent and substantial economic benefit from Medicaid expansion in all states that adopted the expansion.³⁸

According to a study by University of Michigan researchers published in the *New England Journal of Medicine*, Michigan has enjoyed numerous economic benefits attributable to Medicaid expansion.³⁹ In 2016, 39,329 jobs were attributable to the Healthy Michigan Plan's expansion of Medicaid. About two thirds of these jobs were outside the health sector (due to the multiplier effect of Medicaid spending, as well as federal Medicaid dollars covering costs that had previously been borne by employers, individuals, and the state). During the period from 2016 to 2021, the Healthy Michigan Plan is expected to generate an increase in personal income of between \$2.2 and 2.4 billion per year and new state tax revenue in the range of \$145 to 153 million per year.

Workforce Impact. Some have expressed concerns about Medicaid's potential negative effect on the labor market (that Medicaid will cause people to choose to work less—or not work at all—in order to qualify for or maintain Medicaid benefits). It is possible that Medicaid may cause some people to work less (without the need for employer-sponsored health insurance). On the other hand, healthier people may seek new/additional employment or work longer hours and generate more workplace productivity. Businesses may have a vested interest in maintaining a physically and mentally healthy workforce, and expanded Medicaid supports this goal.

At present, it does not appear that Medicaid expansion has had any effect on labor supply.⁴⁰ Estimates of the effects of Medicaid expansion on labor supply among low-educated (high school or less) and low-income persons are small, not statistically significant, and generally positive (meaning no discernable effect has been observed, but if anything, Medicaid may actually increase the supply of labor).⁴¹ Whether or not the Healthy Michigan Plan has affected labor supply in either direction, Michigan has enjoyed steady growth in labor supply and employment since the state began implementation of the Healthy Michigan Plan.⁴²

Beneficiaries of the Healthy Michigan Plan have also continued working or sought work. Among non-elderly, non-disabled adult beneficiaries of Medicaid in Michigan (the primary recipients of Healthy Michigan Plan ben-

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efits), seven of ten are in working families and more than half work themselves.^f Healthy Michigan Plan beneficiaries typically work in small businesses or in industries that don't offer employer-sponsored health insurance. By definition, full-time workers who meet Medicaid eligibility requirements are employed in low-wage jobs. One in ten Medicaid beneficiaries works in food service. Other industries employing substantial numbers of Medicaid beneficiaries include construction, retail service, custodial/building services, child daycare, and nursing care facilities. Low-income employees of hospitals and schools also benefit from the program.⁴³

Uncompensated Care. Uncompensated care has been an ongoing problem for Michigan's hospitals. Uncompensated care refers to any services provided for which the recipient of the care is unable or unwilling to pay—typically separated into charity care and bad debt. Uncompensated care affects providers' margins and the associated costs of this uncompensated care are shared by all, whether through higher insurance rates, diminished service capacity/quality of hospital care, or more often both.

Medicaid expansion sharply and substantially reduced the burden of uncompensated care on hospitals in expansion states.⁴⁴ In 2014, uncompensated care fell by 35 percent in expansion states, versus one percent in non-expansion states, representing around a \$6 billion reduction in bad debt and charity care among states with expanded Medicaid.⁴⁵

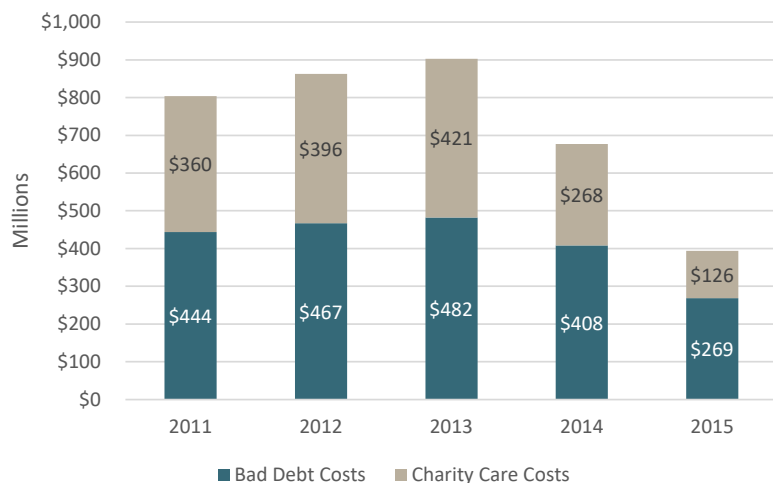
Research from the Center for Healthcare Research and Transformation (CHRT) found that Michigan's uncompensated care fell from \$903 million in 2013 to \$394 million in 2015—a decrease of 56 percent from levels prior to Medicaid expansion (see **Chart 11**).⁴⁶

^f Those who do not work may be attending school or have domestic/caregiver responsibilities, health issues, or other impediments to employment.

Relative to peer states, Michigan has been effective at getting people insured through the Healthy Michigan Plan and through non-group private insurance plans under the ACA. This expansion of health insurance access explains Michigan's enormous reduction in uncompensated care. The reduction was directly associated with changing inpatient payer groups. For instance, as more people gained access to Medicaid, fewer needed to rely on charity care (see **Chart 12**).

Sunset Mechanism. In an ostensible attempt to prevent the Healthy Michigan Plan (and the Affordable Care Act, by extension) from using any new state resources, Michigan's expansion of Medicaid contains a "kill switch" of sorts: the Healthy Michigan Plan is statutorily scheduled to expire when the costs of the program exceed the savings. Whether legislators at the time the program was adopted were worried about the long-term costs to the state that the program might represent, or, alternatively, simply did not want to appear to endorse the Affordable Care Act (amid political contention) by implementing one of its key provisions, Michigan now has a program that is predicated on a truly unique benchmark: generating savings in excess of cost (without regard to any program benefits beyond the state ledger).

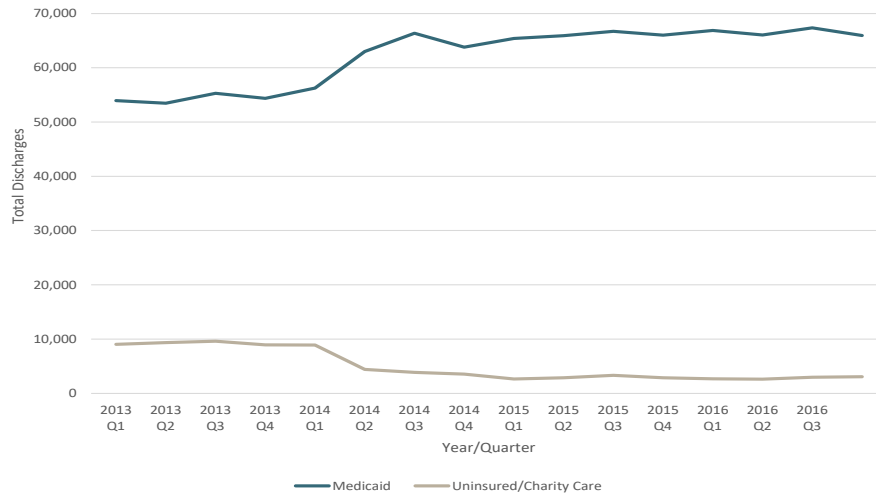
Chart 11
Uncompensated Care Costs in Michigan Hospitals
Separated by Bad Debt and Charity Care, 2011-2015



Source: Center for Healthcare Research and Transformation. (2017). "Decrease in Hospital Uncompensated Care in Michigan." www.chrt.org/publication/decrease-hospital-uncompensated-care-michigan-2015/#accordion-section-0

Chart 12

Changing Inpatient Payer Groups in Michigan Hospitals, 2013-2016



Source: Citizens Research Council analysis of data from the Michigan Health and Hospital Association.

How exactly to calculate state costs versus state savings remains somewhat ambiguous. The law—Public Act 107 of 2013, Section 105d(27)—states that the Healthy Michigan Plan will be eliminated if “federal government matching funds for the program...are reduced below 100% and annual state savings and other non-federal net savings associated with the implementation of that program are not sufficient to cover the reduced federal match.” To determine these state savings the law instructs that the Michigan Department of Health and Human Services “...shall determine and the state budget office shall approve how annual state savings and other nonfederal net savings shall be calculated...”

The methodology reported by the Department of Health and Human Services to the legislature includes consideration of various budget items relative to “base year” (2013) considerations, including: the Adult Benefits Waiver, Community Mental Health non-Medicaid Services, and Prisoner Health Care Services, as well as Plan First!, the Medicaid Benefits Trust Fund for Adult Benefits Waiver, the Health Insurance Claims As-

essment (HICA), the County Match for Indigent Care Disproportionate Share Hospital payments, and the Community Mental Health Services Programs match for non-Medicaid mental health services. Savings in other state fund accounts may be proposed to legislative appropriations committees for consideration.

The federal matching funds were reduced below 100 percent (to 95 percent) in FY2017. Annual reductions will continue down to a base of 90 percent in FY2020 and subsequent years. As the share of federal contribution begins to decrease, increasing costs from the Healthy Michigan Plan may begin to exacerbate overall stress and looming pressures on the state’s general fund.⁴⁷ This also means that the requirement to determine non-federal net savings has been activated.

The House Fiscal Agency projects that the Healthy Michigan Plan will still save the state more money than it costs through at least FY2021. Despite an increase of General Fund/General Purpose costs of about \$200 million yearly by FY2021, it is projected that the Healthy

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Michigan Plan will still yield a net savings of \$13 million (a narrow margin for such a large program). **Chart 13** outlines the projected costs and savings of the program. In 2021 and beyond, the vast majority of the program would continue to be federally funded. The split of federal and state funding for the Healthy Michigan Plan is shown in **Chart 14**.

While cost-benefit analysis is a classic tool of policy analysis and program evaluation, the type of narrow framework for the Healthy Michigan Plan that is based on state net-savings ignores numerous dimensions of program benefits. For instance, fiscal savings from the program might also appropriately consider factors like the dramatic reduction of uncompensated care in Michigan hospitals directly, rather than solely including reductions in Disproportionate Share Hospital (DSH) payments resulting from the aforementioned reduction in uncompensated care. Lower private marketplace insurance premiums attributable to Medicaid expansion might also be considered as a fiscal benefit to citizens of the state. Moreover, cost-benefit evaluations might consider that Medicaid spending (like other public investments) has a multiplier effect, and program investment generates macroeconomic stimuli, leading to increases in employment, personal income, and state revenue.⁴⁸ The benefits of the state investment in Medicaid are especially intensified due to the accompanying federal matching dollars. With the Healthy Michigan Plan's relatively high FMAP, every dollar of state investment in the program generates a significant impact. A purely economic analysis also entirely ignores the tremendous social and practical impacts of the program (that might be judged as worthy of some degree of expenditure). An unhealthy and financially insecure population (due to lack of insurance) poses many kinds of costs on society.

It also merits consideration that, whether or not the nominal program costs for the Healthy Michigan Plan exceed state savings, a negative budgetary impact would result from the program's termination. If the program were to be eliminated today, it would create a sig-

nificant need to increase spending for other programs in the state budget to restore them to the 2013 pre-expansion baseline, and could create additional costs in the private sector and for local governments (in the realm of public health and community mental health services). Because state-level Medicaid spending brings in federal matching dollars, if the state chose to reduce that spending it would lose Medicaid funding at more than the dollar-to-dollar rate at which it was cut, quickly escalating to the magnitude of hundreds of millions (if not billions) of dollars. The state would either need to appropriate new funding sources for state programs that have been absorbed into the Healthy Michigan Plan, or else face a decline in services (in areas like mental health or health care for adults in extreme poverty that previously received insurance through the adult benefits waiver) to levels lower than the state had prior to its expansion of Medicaid.

Unique Characteristics

As discussed previously, the Healthy Michigan Plan is an alternate expansion of Medicaid authorized by a section 1115 demonstration waiver from the federal Centers for Medicare & Medicaid Services (CMS). Six other states (Arizona, Arkansas, Indiana, Iowa, Montana, and New Hampshire) have also implemented Medicaid

Chart 13

Healthy Michigan Plan Net Savings



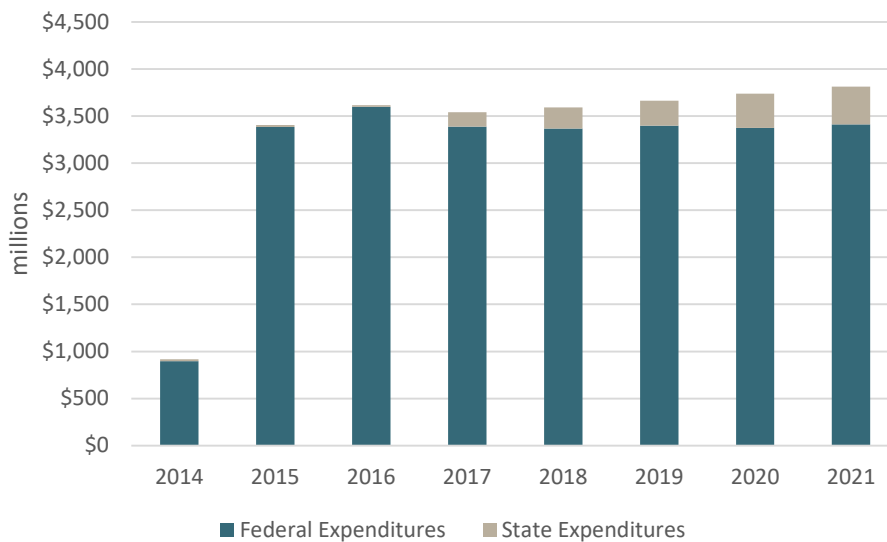
Source: House Fiscal Agency. (2016). "Healthy Michigan Plan Saving and Cost Estimates." www.house.mi.gov/hfa/PDF/HealthandHumanServices/HMP_Savings_and_Cost_Estimates.pdf

expansion through section 1115 waivers. Waivers are used to allow states to expand coverages, innovate, or otherwise implement state Medicaid in some way that deviates from the usual federal guidelines. In the case of the Healthy Michigan Plan, waiver applications allowed the state to implement various market-based components, such as healthy behavior incentives and Medicaid premiums/cost sharing.

Michigan Plan beneficiaries also contribute copayment amounts into their MI Health Accounts each month based on average service utilization and cost. Copayments range from \$1-3 for outpatient services and \$50 for non-emergency inpatient hospitalization. Total cost sharing may not exceed five percent of an individual's annual income.

Chart 14

State and Federal Shares of Medicaid Expansion in Michigan



Source: House Fiscal Agency. (2016). "Healthy Michigan Plan Saving and Cost Estimates." www.house.mi.gov/hfa/PDF/HealthandHumanServices/HMP_Savings_and_Cost_Estimates.pdf

Michigan has utilized two section 1115 waivers to create the Healthy Michigan Plan.⁹ The first waiver incorporated Michigan's already existing delivery system of capitated managed care into Medicaid expansion. The waiver also created premiums (two percent of income, monthly) for adult enrollees with incomes at 100 percent FPL and above to be paid into a MI Health Account (a kind of Medicaid health savings accounts).^h Healthy

The Healthy Michigan Plan also encourages compliance with specified healthy behaviors as determined by an annual health risk assessment and recommendations; adherence results in a 50 percent future premium reduction for those who pay premiums (100-133 percent FPL) or a \$50 gift card (for those below poverty). Healthy behaviors are coordinated through the various health plans that receive capitated payments from the state for each Medicaid beneficiary. This delivery model of capitated managed care existed prior to expansion and was readily adaptable for the Healthy Michigan Plan.

The second 1115 demonstration waiver originally sought to provide a choice to Healthy Michigan Plan beneficiaries with 48 cumulative months of coverage between remaining in the Healthy Michigan Plan with a higher premium cost share (seven percent of an enrollee's income) or receiving premium assistance from the

state to enroll in an ACA non-group marketplace plan. CMS and the state eventually reached an alternative agreement, and beginning April 1, 2018, all Healthy Michigan Plan beneficiaries with incomes from 100 percent to 133 percent of the FPL must complete the Healthy Behavior requirement to remain enrolled in the Healthy Michigan Plan by working with their physicians on health improvement strategies. Alternately, enrollees may choose to receive premium assistance to enroll in a marketplace plan. The medically frail are exempt from enrollment in marketplace plans.

Healthy Behavior Incentives. The Healthy Michigan Plan includes a Health Risk Assessment (HRA) that is a multi-step process designed to encourage Healthy Michigan Plan beneficiaries to address health issues (e.g., physical activity, nutrition, tobacco/alcohol/sub-

⁹ The Adult Benefits Waiver (ABW) program was a previous section 1115 demonstration that Michigan used to provide limited coverage to some childless adults. The ABW program was amended and expanded into the Healthy Michigan Plan.
^h Failure to pay premiums does not result in elimination of Healthy Michigan Plan coverage or eligibility, however past due balances may be recouped by the state from either income tax refunds or lottery winnings when applicable.

stance use, mental health, flu vaccination) through prescribed healthy behaviors. Initial HRA questions are completed with an enrollment broker before enrolling in a plan (this process has a 95 percent completion rate). Following this initial step, beneficiaries must schedule an annual appointment and work with their primary care provider to select a healthy behavior. The primary care provider must assess the beneficiary's results with the behavior and provide the completed HRA to the beneficiary's Medicaid Health Plan.

While the HRA process carries the laudable goal of improving enrollee health, this process could break down at several junctures, creating barriers to completion beyond the five percent rate of initial refusal. At present, between a quarter to a third of Healthy Michigan Plan beneficiaries fail to make a health plan selection and are auto assigned into a plan. Consequently, these enrollees are not surveyed and may not be aware of how to proceed with the HRA to pursue healthy behavior incentives. Moreover, while most Healthy Michigan Plan enrollees have been able to access primary care and preventative health services, any enrollees that are unable or choose not to establish ongoing primary care will also be unlikely to complete the HRA.

It is still unclear how effective the system of HRAs and incentives for healthy behavior compliance will be in Michigan, but so far the results are not promising. Of the 348,236 individuals who were on the Healthy Michigan Plan for at least 11 of the 12 months in FY2016, just 66,467 (fewer than one in five) submitted a Health Risk Assessment with an attestation date and were eligible for a gift card or premium assistance.

Improved communication or better coordination of the currently diffuse HRA responsibilities may offer areas for improvement. Previous research has shown that even low-cost interventions intended to "nudge" people into program utilization and/or compliance were very successful.⁴⁹ Lack of compliance with and understanding of Healthy Behaviors may pose a great problem for enrollees in the Healthy Michigan Plan when the healthy behavior requirements become mandatory in 2018. The state should continue to work with health plans to improve and coordinate communication strategies.

Finally, while the Health Risk Assessment may laudably be geared towards improving the health of enrollees, good intentions do not guarantee good policy imple-

mentation. Programs constructed with the intention of coercing "responsible behavior" may be inherently doomed to fail if they take a "one-size-fits-all" approach that does not acknowledge the underlying reasons behaviors may differ between populations. The population that most benefits from Medicaid has higher rates of tobacco and alcohol use, substance abuse, obesity, poor nutrition, and chronic comorbidities. The presumption of individual irresponsibility, therefore, falls short in explanatory power relative to an analysis of the social determinants of health that would consider the measurable association between behavioral or environmental health risks and socioeconomic position. A small financial incentive may be unable to overcome strong social, cultural, and environmental pressures without a more direct intervention and case management strategy.

Medicaid Premiums and Cost Sharing. Medicaid has traditionally imposed no cost sharing, as its beneficiaries were, by definition, poorer and sicker than the population receiving private insurance. As higher income groups have been added to both the Children's Health Insurance Program (CHIP) and the ACA's Medicaid expansion, a few states (including Michigan) have included cost sharing provisions in an attempt to create parity between public and private insurances. Some have also conceptually endorsed various forms of cost sharing under the presumption that it is best for recipients of public benefits to have some "skin in the game."

Co-payments, coinsurance, and other cost sharing mechanisms have been the subject of decades of study and debate. Some have argued that cost sharing works to constrain costs and improve care by leading health care consumers to assess the relative value of the care they receive. Absent a shared cost, some may not value the care they receive, or may (in a classic example of moral hazard) expose themselves to greater risk by overconsuming unnecessary or low-value health care services. This makes cost sharing a valuable economic tool to constrain or modify individual consumer behavior in the health care marketplace.

Others argue that an ideal co-pay can encourage high-value procedures (and discourage low value ones), but should avoid restricting access to preventative care and screenings. Co-pays should be utilized strategically to improve health care consumption and behaviors; they

Iowa Medicaid Waiver

Iowa’s expansion of Medicaid, like in Michigan and Indiana, was done with a waiver to enable inclusion of market-based principles, such as patient cost sharing and financial incentives to modify behavior.ⁱ Iowa’s expansion also included an incentive structure that waived monthly premiums in exchange for adherence to healthy behaviors. An analysis of the first year showed that healthy activity completion rates in Iowa did not exceed 17 percent. One likely cause for low levels of participation was lack of knowledge and understanding of the program design and implementation. Participation was also lower among individuals from racial/ethnic minorities and individuals who live in rural areas—two traditional populations that already face greater health disparities. The results suggest that “efforts by federal and state governments to reform Medicaid by shifting responsibility onto program members for healthy behaviors are unlikely to succeed, especially without careful thought and design of premiums, penalties, and incentives for participants.”ⁱⁱ Iowa’s experience may offer a cautionary tale for Michigan as the state continues to pursue Healthy Behavior Incentives as part of the Healthy Michigan Plan.

ⁱ Seema Verma, current CMS administrator in the Trump administration, was the architect of Healthy Indiana, and influenced the structure of Medicaid expansion in Iowa and Michigan.

ⁱⁱ Askelson, N. M., Wright, B., Bentler, S., Momany, E. T., & Damiano, P. (2017). “Iowa’s Medicaid Expansion Promoted Healthy Behaviors But Was Challenging To Implement And Attracted Few Participants.” *Health Affairs*, 36(5), 799-807.

should not be blunt instruments. While a high co-pay may be appropriate for certain medically unnecessary procedures, or for procedures with lower-cost alternatives, copays should be very low (or non-existent) for high-value drugs and services.⁵⁰

Still others may argue that health care is a right, not a commodity, and that any cost barriers to health care services are unjust. The fact that co-payments affect individuals differently based on health status, age, socioeconomic position, race, or gender should be considered.

Research has shown that, while cost sharing may be an important tool for guiding health service utilization, it is an imprecise tool and can function as a double-edged sword when it cuts away needed health services (leading to long-term health detriments and cost).^{51 52} The impact of co-payments also varies between types of health care products and services (e.g. medical procedures versus prescription drugs), creating further complications. When needed health services are forgone, the economic cost alone can far exceed any attributable savings from deductibles, co-payments, or co-insurances. Research following cholesterol patients found that reducing prescription co-pays could increase adherence to treatment and reduce the chance of hospitalization, potentially saving more than \$1 billion annually—far in excess of the cost of lowering

co-payment amounts.⁵³

Cost-sharing is much more effective when used as a surgical instrument intended to modify individual behavior and consumption, rather than as a hammer used on every insurance enrollee (with every procedure or service thereby treated as a uniform box of nails). Economic incentives alone do not lead to clinically sensible reductions in utilization of care nor improve the appropriateness of that care.⁵⁴ In fact, cost-sharing tends to restrict access to care, especially for the sick-est and poorest individuals.⁵⁵

Indeed, the majority of state savings observed from cost sharing have come from foregone (and potentially needed) health services and decreased enrollment. A report from the Lewin Group on Indiana’s Medicaid expansion, Healthy Indiana, revealed that individuals who failed to make Personal Wellness and Responsibility (POWER) Account Contributions (PACs) or never enrolled due to the cost of these contributions accounted for 29 percent of eligible individuals. A majority of beneficiaries reported not worrying about contributions, but among those who left the plan or never enrolled, cost was much more likely to be reported as a concern. Not surprisingly, those who left the plan have a more difficult time accessing routine care and filling prescriptions relative to those who remain in the plan.⁵⁶

Social Determinants of Health

According to the U.S. Office of Disease Prevention and Health Promotion: social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.ⁱ Examples of social determinants of health include:

- Essential Resources (Safe Housing, Available Food)
- Economic Conditions (Poverty and the Stresses that Accompany Poverty)
- Quality of Education and Job Training
- Public Safety/Exposure to Violence/Crime
- Availability of Social Support and Community Resources (Family, Church, Public Spaces)
- Social Norms (Discrimination, Racism, Attitudes on Education, Distrust of Government)
- Access to Health Care Services
- Language/Literacy
- Culture

Each of these factors has significant explanatory power and value when addressing the health of individuals or communities. Social factors, such as education level, physical environment, presence or lack of social supports, and poverty account for around one-third of total annual deaths nationally—social factors are as linked to mortality as are behavioral and pathophysiological factors.ⁱⁱ Moreover, the social determinants of health are often inextricably linked with behavioral factors, with exposure to environmental hazards, and with greater susceptibility to pathophysiological risks.

Socioeconomic position—the combination of a person’s education level, income, and occupation—is a powerful predictor of health status. Poverty is almost inevitably accompanied by poorer health (and is often intimately and inexorably linked to stress, poor education, environmental hazards, and risky behaviors). Socioeconomic position is often generational and affects whole families and communities in ways often beyond individual control. Children born into low-income/low-education families are more likely to face environmental and social threats to good health and to experience adverse childhood experiences (ACEs) that contribute to greater lifelong health risks.

Low education and low income levels are correlated with one another, and both are positively associated with shorter life expectancy, higher rates of smoking, greater prevalence of obesity, and poorer nutrition. Research has confirmed this inverse relationship between social position and morbidity/mortality.ⁱⁱⁱ Whether a causal relationship exists between low socioeconomic position and observed health disparities or whether there is some intermediary factor responsible for this covariance (such as social anomie or low self-efficacy), the relationship between income/education and health is undeniable. As some have quipped with no intentions of humor, “they call it ‘poor health’ for a reason.”^{iv}

ⁱ United States Office of Disease Prevention and Health Promotion. “Healthy People 2020: Social Determinants of Health.” <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

ⁱⁱ Galea, S., Tracy, M., Hoggatt, K. J., DiMaggio, C., & Karpati, A. (2011, August). “Estimated Deaths Attributable to Social Factors in the United States.” *American Journal of Public Health*, 101(8), 1456–1465.

ⁱⁱⁱ Marmot, M.G. et al. (1991) “Health inequalities among British civil servants: the Whitehall II study.” *The Lancet*, Volume 337, Issue 8754, 1387 - 1393.

^{iv} Barr, D. A. (2014). *Health Disparities in the United States: Social Class, Race, Ethnicity, & Health* (2nd ed.). Baltimore, Maryland: Johns Hopkins University Press.

Research in Michigan has revealed that health accounts remain confusing to many beneficiaries, and complex enrollment policies combined with costs can prevent or dissuade eligible individuals from enrollment.⁵⁷ The complexity of Michigan's system, with different rules for different beneficiaries, also requires added resources and time to track. The added burden of costs and time on the state and health plans should be part of the evaluation to determine if any benefits identified from cost sharing provisions justify associated costs of implementation and continued evaluation.

Most spending in low-income households is used for food, housing, and transportation, and, because spending can easily exceed average income, many low-income households accrue debt for basic living expenses. Additionally, low-income households with Medicaid spend less on health care in total dollars or as a portion of household budget (a difference likely attributable to the presence of premiums and higher co-payments in private insurance plans). Even small amounts of health spending can either increase debt burdens or supplant other basic necessities in the household's spending hierarchy, and an analysis of low-income household budgets suggests that health care spending may be crowding out what low-income (non-Medicaid) households are able to allocate to other necessities like food or housing.⁵⁸

How effectively the change in benefit structure of the Healthy Michigan Plan achieves the goal of improved health still remains to be seen and requires further analysis. Collection issues surrounding premiums and co-payments should also be considered in future evaluations of the Healthy Michigan Plan's relative success in this regard.

Health Outcomes

The Healthy Michigan Plan began mid-year in 2014 and is simply too new for viable measures of health outcomes to be directly and reliably assessed; it may be unreasonable to expect Medicaid (or any insurance) to markedly improve health in just a few years. Moreover, Medicaid enrollees (and dual-enrollees between Medicaid and Medicare) tend to be poorer, less educated, and face more health risks (like improper nutrition and lack of resources or social supports). This will necessarily confound any data on patient

outcomes comparing populations (even if matched upon approximate socioeconomic strata). Moreover, the sickest and neediest patients are often enrolled in Medicaid with the help of social service agencies or medical providers, leading to even greater selection bias when these populations are studied.

The evidence on direct health improvement from Medicaid is still unclear. Nonetheless, most research has consistently shown that Medicaid increases utilization of preventative health services, improves rates of disease detection and diagnosis, reduces depression and anxiety, reduces mortality, and improves financial security. Preliminary data from the Healthy Michigan Plan combined with studies of other insurance expansions may provide the tools for plausible assumptions and inferences to determine general outcomes for health from obtaining insurance through expanded Medicaid.

Health Screenings and Prevention. Acquisition of insurance coverage may facilitate better use of health screenings and preventative health services, leading to early treatment and providing important long-term health benefits. Beyond screenings for diabetes, hypertension, and high cholesterol, Healthy Michigan Plan beneficiaries may also access mammography, cancer screenings, mental health assessments, and other services to prevent or detect and treat (sometimes asymptomatic) chronic conditions. The increased detection of chronic health conditions under Medicaid expansion could have important implications for both population health and state and national health care spending if it leads to improved early management and control of these conditions. Some evidence shows that Medicaid expansion improves beneficiaries' awareness and management of high blood pressure, as well as obesity awareness.⁵⁹ In another study, respondents reported significant increases in diagnoses of diabetes and high cholesterol associated with Medicaid expansion.⁶⁰

Mental Health. Ample evidence is found for improvements in mental health and reductions in depression among Medicaid beneficiaries gaining insurance through expansion.^{61 62} Depression, a leading cause of disability in the U.S.,⁶³ is also associated with the development of a variety of physical illnesses and conditions over time, ranging from psoriasis and osteoarthritis to diabetes and stroke. Managing depression has

important implications for the health and well-being of individual patients. Depression management may also affect long-term health care utilization and spending, prevalence of substance abuse and addiction, crime, and workforce participation and productivity.

Chronic Condition Management. Medicaid's impact on managing and treating chronic physical conditions is not straightforward, and variance may exist among diseases, populations, and delivery systems.⁶⁴ More research and more time are needed to fully assess Medicaid expansion's full impact on enrollees' health. Preliminary data suggest, however, that Medicaid expansion is improving health, even as the degree and scope of this improvement are not yet entirely clear after only a few years.

Self-Reported Health Status. Self-reported health is another reliable measure of general health that is widely accepted by researchers and scholars.⁶⁵ Self-reported health status forms a proxy measure for objective measures of health (that are sometimes impractical or impossible to collect) and offers a metric with meaningful predictive uses. For instance, those who self-report poor health have significantly higher mortality rates than those who report good health.⁶⁶

In addition to much improved self-reported health status, low-income adults in Michigan and other expansion states have reported better quality insurance coverage after expansion relative to before.⁶⁷ The steady increase of cost sharing in private plans, and the particular barriers to care created by cost sharing for low-income adults, are important considerations; perception of high quality in the Medicaid program may indicate that expanded Medicaid is a superior insurance option for this population.

Mortality. One frequent point of inquiry surrounds the impact of expanded Medicaid and other insurances on mortality. In other words: are people at an increased risk of dying without health insurance? The answer to that question is a clear and simple "yes" (although measuring the exact magnitude of increased mortality among the uninsured and those with varying types of insurances is not so simple nor so clear). One robust estimation of the excess mortality in the United States due to uninsurance between 2000 and 2006 found 165,000 attributable deaths; this estimate only con-

sidered excess deaths among the uninsured relative to matched populations with insurance, and does not fully encompass the increased mortality and loss of life-years from lack of medical treatment that would have been enabled by insurance.⁶⁸

Some have argued that insurance (even employer-sponsored private insurance) has no impact on mortality, and, indeed, a handful of studies have not detected any statistical difference in risk between insured and uninsured populations relative to mortality.⁷² Even prior to the Affordable Care Act's Medicaid expansion, however, state level expansions of the program in New York, Maine, and Arizona were associated with significantly reduced mortality, as well as improved access and self-reported health status.⁷⁰ Health care expansion in Massachusetts yielded improvements in access to care, self-reported physical and mental health, use of preventative services, and functional status. Additionally, even starting from a higher baseline of coverage and health status, Massachusetts saw a mortality reduction (particularly in lower-income counties with lower rates of pre-reform insurance coverage).⁷¹

Historically, expansions of insurance status have led to reduced mortality. For instance, changes in Medicaid eligibility for pregnant women during the 1980s and early 1990s led to better birth outcomes, quantified by a corresponding 8.5 percent decrease in infant mortality.⁷² In a more recent study of insurance status and cancer-specific outcomes among young adults (a group at greatest risk for being uninsured), cancer-cause mortality decreased substantially among the insured group relative to the uninsured, as did the likelihood of presenting with metastatic disease.⁷³ Other research has concluded that Medicaid expansion holds the potential for saving many lives – particularly if coverage for certain drug treatments were not restricted to late-term disease.⁷⁴

Analysis in recent years is perhaps even more compelling. Estimates in the first year of Medicaid expansion under the ACA showed that 7,000-17,000 deaths could be attributed to states opting out of Medicaid expansion.⁷⁵ In another multi-state study, overall rates of death decreased due to Medicaid expansion, and this decrease was driven primarily by causes of death that may be prevented (or at least forestalled) by timely and effective health care.⁷⁶ It is both difficult and perhaps distasteful to put a price on life, however an

analysis of mortality changes due to Medicaid expansion suggests that the program saves lives at a public cost of \$327,000-\$867,000 per life saved, whereas other policies aimed at reducing mortality averaged a cost of \$7.6 million per life, suggesting that Medicaid's expansion of public insurance is a cost-effective public investment for saving lives.⁷⁷

Healthy Michigan Plan and the Social Determinants of Health

Michigan's contract for Medicaid MCOs now includes support for population health management and emphasizes collection and use of data on social determinants of health, stating that "population health management also includes an overarching emphasis on health promotion and disease prevention and will incorporate community-based health and wellness strategies with a strong focus on the social determinants of health, creating health equity, and supporting efforts to build more resilient communities."⁷⁸ MCOs contracting with the state must submit a multi-year plan to incorporate 1) social determinants of health into their data analytics process in an effort to improve population health by addressing the social determinants thereof, and 2) to reduce disparities in health experienced by various subpopulations. The goal of this plan is to ultimately achieve health equity, improve health status of plan beneficiaries, and reduce the need for costly interventions due to poor long-term health status.

Incorporating the social determinants of health together with physical and biological determinants paints a clearer picture of total health and is beneficial for policies and programs (like Medicaid) that seek

to create a healthier Michigan. Policies that address the social determinants of health may reduce some demand for health services and improve the health of the population.⁷⁹ Similarly, private health plans and providers may also improve quality and reduce costs by focusing more on social determinants as a component of prevention rather than relying on later, more costly acute clinical interventions once diseases have developed. This model of health care payment and delivery, while nascent and limited in scope in Michigan, has led to lower costs and better health outcomes in other states.⁸⁰

The Medicaid population in Michigan faces disparities in health care and outcomes due to a variety of factors. Worse health outcomes are observed among populations that are poorer, less educated, live in rural areas, or belong to racial/ethnic minority groups; these characteristics disproportionately describe Michigan's Medicaid population relative to the whole state population.

Because Medicaid serves a population with complex social, behavioral, and clinical needs, the Michigan Department of Health and Human Services (as Michigan's Medicaid agency) is in a unique position to identify and address social determinants of health within this population. The state might consider expanding these endeavors and utilizing Medicaid as a bridge between the traditionally separated spheres of health care delivery and other disparate sectors like nutrition, employment, housing, and transportation; this broader view of Medicaid could allow the state to simultaneously reduce Medicaid expenditures and improve health outcomes for Medicaid beneficiaries.⁸¹

Oregon Health Insurance Experiment

Many studies in health and the social sciences rely on a variety of observational study designs, rather than true empirical experiments. After all, serious legal and moral issues are raised by withholding beneficial treatment to people or subjecting others to potentially harmful pathogens, just to see what happens. Sometimes it is either unethical or logistically impractical for researchers to have full control over an independent variable. Instead, researchers design studies that look at what happened and attempt to isolate relational or causal factors to draw conclusions through statistical inference. From education to epidemiology, this is the reality when it comes to studying humans. While sometimes scientifically messy, observational study designs (cohort studies, case-control studies, longitudinal studies, ecological studies, or cross-sectional analyses) have yielded strong evidence and findings over time (e.g. the association between tobacco use and various forms of cancer and cardiovascular disease).

In 2008, researchers were given a rare opportunity for an experimental study on the effects of expanded Medicaid coverage. Oregon allocated a limited number of Medicaid spots to low-income adults through a lottery. In total, about 30,000 people were selected out of about 90,000 lottery participants on the waiting list. Approximately 10,000* beneficiaries ended up enrolled in Medicaid.ⁱ

The Oregon Experiment's findings were mixed. Researchers found that, in the first two years, Medicaid significantly decreased the probability of a positive depression screening, increased the utilization of many preventative services, and virtually eliminated out-of-pocket catastrophic medical expenses. No effect on diagnosis of hypertension or high cholesterol were observed, but researchers did find an increase in detection and treatment of diabetes. Despite more treatment of diabetes, no effect was observed on average glycated hemoglobin levels.** Increased detection and treatment of diabetes and reductions in depression are certainly meaningful outcomes after only two years of a program, even if no change in health status was observed.

Researchers acknowledged several limitations of the Oregon Experiment. Oregon's low-income population has different racial, social, and environmental characteristics relative to the U.S. as a whole. Additionally, the study used exclusively a subgroup who actively signed up for the Medicaid lottery, suggesting a degree of selection bias (though take-up rates for Medicaid and other public programs may all be susceptible to selectivity and imperfections). The outcomes that were observed reflected only 17 months, and longer-term impacts may differ. Additionally, because those eventually given Medicaid through Oregon's lottery were a small fraction of the uninsured population at the time, it is difficult to assess potential systemic effects the program would have had were it extended to the total population (such as provider strain).

The Oregon Health Insurance Experiment was limited in time and scope. Other observational studies that have followed hundreds of thousands of people over four to five years or more have found positive health outcomes that were not observed in the Oregon Experiment. While study design may explain differences in findings, it is also important to consider that coverage and health impacts of insurance may take many years to manifest in improved health status or reduced mortality.ⁱⁱ

* Many of those selected by lottery did not successfully complete the required application or meet the final eligibility criteria.

** Glycated Hemoglobin is measured to ascertain the three-month average plasma glucose concentration, or blood sugar level.

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State Comparisons of Medicaid Expansion

The Medicaid expansion was adopted to avoid coverage gaps in the ACA by providing coverage when the system of employer-based health insurance breaks down due to costs (typically among low-wage workers). As one might expect, states that expanded Medicaid have largely eliminated gaps in coverage by implementing a system of eligibility from expanded Medicaid to employer-sponsored plans (with subsidized non-group plans filling in the gaps), whereas the states that chose not to expand their Medicaid programs still have large numbers of uninsured who lack insurance options and may not qualify either for Medicaid or marketplace subsidies.

The rates of uninsured citizens fell substantially more in states participating in Medicaid expansion (like Michigan) than in non-expansion states, and states that expanded Medicaid also more effectively improved access and quality of health care for program participants.⁸² Around eight million people nationally remained uninsured due to decisions made in the 19 states that opted not to expand Medicaid.⁸³ In 2012, prior to enactment of the Healthy Michigan Plan, 14 percent of Michigan's population lacked insurance. Since expanding Medicaid and implementing other provisions of the ACA, that number has fallen below six percent. In comparison, the uninsured rate in Texas remains above 17 percent.

Private health plans are also more expensive in these non-expansion states due to multiple factors. Namely, private risk pools for the health insurance marketplaces in expansion states typically consist of individuals with incomes of 138 percent FPL and above, whereas comparable markets in non-expansion states extend coverage to individuals down to incomes at 100 percent FPL. In states that did not expand Medicaid, individuals with incomes between 100–138 percent FPL make up about 40 percent of the marketplace population (versus six percent in expansion states). Because lower-income is correlated with poorer health status, risk pools in non-expansion states tend to be sicker and present greater risk to insurers, leading in turn to higher premiums. In essence, Medicaid expansion

has acted as a kind of public *high-risk pool* for poorer, sicker individuals. Controlling for various differences across states, private health plans tend to be around seven percent less expensive in states that expanded Medicaid.⁸⁴

Expanding Medicaid coverage and access necessarily means expanding Medicaid spending. Analysis of state budgets from FY2010 to FY2015 show that Medicaid Expansion led to much greater (11.7 percent on average) total state spending on Medicaid; however, this was done almost entirely with federal funds, with no substantial use of state resources and no associated reductions in state spending for education, transportation, or other programs/priorities.⁸⁵ As a result, state budgets also fared better in states that expanded Medicaid.

Hospital systems' charity care and bad debt have decreased much more in expansion states than in states that did not expand Medicaid. Drops in uncompensated care and decreasing uninsured rates are having a positive ripple effect throughout the health system in expansion states, generating job growth in the health sector, reducing risk, and improving the bottom line of hospitals and safety net providers. This benefits all patients of health care systems, not only the direct beneficiaries of Medicaid Expansion. The Healthy Michigan Plan also greatly benefits Federally Qualified Health Centers (FQHCs) that provide essential care for underserved rural and urban communities.

Researchers from the University of Michigan identified several economic benefits to states from Medicaid expansion:

- States may experience a fiscal benefit through reduced state spending on services covered by the expanded Medicaid program, such as state mental health and correctional health programs for adults who were previously ineligible for Medicaid. Annual state spending for such programs in Michigan has been reduced by \$235 million because of the Healthy Michigan Plan.⁸⁶

- States may experience macroeconomic benefits through increased economic activity from new federal funding. Medicaid expansion does not simply shift spending by state governments or residents to the federal government, but actually increases total spending in the state without a commensurate tax increase for state residents. This increase in economic activity benefits state residents directly through increased employment in health care and a multiplier effect of related spending and employment in other sectors of the state economy, such as construction and retail services, with corresponding increases in tax revenue.⁸⁷
- Low-income adults who paid directly for health care services or private insurance premiums before the expansion can redirect this personal spending to other household needs — such as housing, transportation, and food — after they gain Medicaid coverage. This redirected economic activity can also increase state income and sales tax revenues, further offsetting the state share of Medicaid expansion costs beginning in 2017.⁸⁸

Researchers at the State Health Reform Assistance Network⁸⁹ found consistent economic benefits across 11 expansion states, including Michigan:

- While total Medicaid spending in expansion states grew substantially in 2014 due to the surge of enrollment, state spending in expansion states was half that of nonexpansion states (due to the substantial amount of federal funding tied to expansion).
- Expansion states saw more job growth in the health sector.
- In 2014 (the first year of utilization), expansion states saw an overall decrease in uncompensated care of 26 percent.
- The climbing rate of insured patients in expansion states is helping to stabilize struggling hospitals, particularly rural facilities; rural hospitals are twice as likely to face closure in states that did not expand Medicaid.

Researchers at the Georgetown University Health Policy Institute⁹⁰ found other significant differences between expansion states and non-expansion states:

- Compared to non-expansion states, expansion states have seen major reductions in uncompensated care delivered by safety net institutions, significant drops in the number of uninsured residents, and budget savings for hospitals and community health clinics.
- Health Executives in Medicaid expansion states report opening new clinics, buying new equipment, and hiring new staff—all of which allow them to begin filling gaps in the current health system and work actively to integrate and improve the care they deliver. By contrast, health executives in non-expansion states say they continue to face substantial financial pressures and are more likely to report “status quo” in their systems.

Impact on Children from State Medicaid Expansions

Most attention on beneficiaries of Medicaid expansion has been focused on newly-eligible childless adults, overshadowing the indirect impact Medicaid expansion has had on low income children and parents. The health status and health behaviors of children are linked to their parents. Parents with health coverage who engage in positive health behaviors are also more apt to pass these behaviors on to their children.

While children’s coverage and eligibility were not directly affected by the ACA’s Medicaid expansion, the impact for many parents has been pronounced. Low-income parents have far more comprehensive coverage in expansion states. In contrast, the median income limit for parents in states that have not expanded Medicaid is 44 percent FPL—\$8,985/year for a family of three—and most childless adults in poverty remain ineligible for any benefits in these states.⁹¹ Parents in states that expanded Medicaid also demonstrated mental health improvements, with significant reductions in severe psychological stress. Evidence suggests that children benefit when their parents are insured, and the mental health improvements for parents gaining coverage under the ACA could have particularly strong effects on the health and well-being of their children.⁹²

Children’s insurance rates also increase when their parents are offered coverage. Increased awareness of programs and simplified enrollment processes can lead to surges in enrollment of previously eligible populations—known as the “welcome mat” effect. Nationally, the children of parents who gained Medicaid coverage through the ACA’s expansion of Medicaid had more than twice the increase in insured status when compared to children whose parents who did not benefit from Medicaid expansion. If all states had expanded Medicaid, an estimated 200,000 more low-income children would have gained health coverage.⁹³

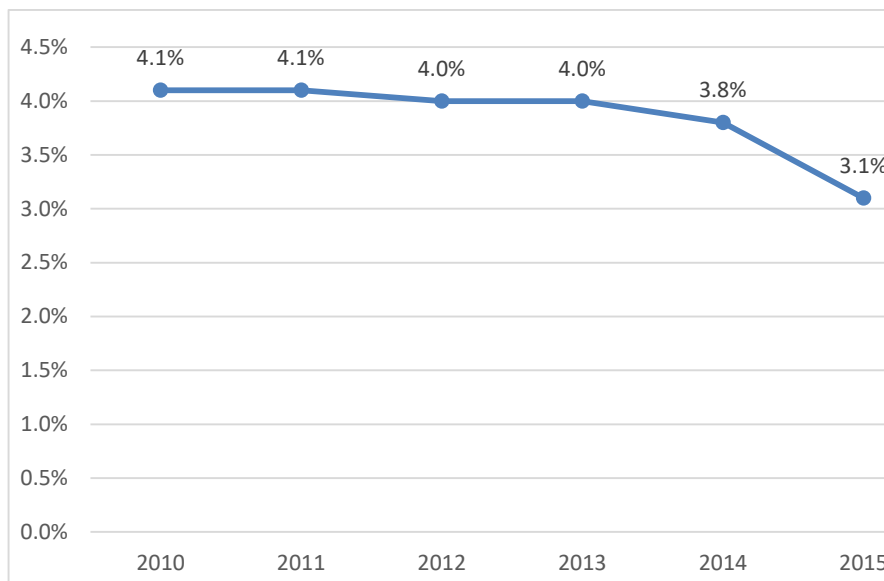
Children in Michigan were covered by Medicaid and the Children’s Health Insurance Program (CHIP) prior to any expansion of Medicaid under the ACA, and coverages extended by the Medicaid expansion do not directly impact coverage for children. Nonetheless, there appears to have been a modest welcome mat effect among Medicaid/CHIP-eligible children in Michigan. In Michigan, 96 percent of children already had insurance prior to Medicaid expansion and Michigan also previously offered more comprehensive benefits to low-income parents than many peer states, and so

resulting reductions in Michigan are necessarily small relative to states that had greater numbers of parents and children without insurance.

Chart 15 shows a small reduction in the number of uninsured children during the period following Medicaid expansion. There has not been any discernable strain on the state budget from this modest enrollment increase (especially given that children are relatively inexpensive to insure).

Better communication can lead to greater program utilization, such as developing targeted information/advertisement to populations with high need and low enrollment rates.⁹⁴ This approach could help Michigan ensure that the three percent of children remaining uninsured will receive the insurance for which they are eligible, reducing costly, long-term complications that can occur when individuals do not receive adequate health care. In general, low-cost informational interventions are a way for public programs to nudge behaviors and may be a useful policy option for any state or local government that wants to increase program enrollment among vulnerable populations.

Chart 15
Percent of Children without Health Insurance in Michigan, 2010-2015



Source: Citizens Research Council analysis using data from the American Community Survey, U.S. Census Bureau

Conclusion

Since it began in April of 2014, the Healthy Michigan Plan has enabled health insurance coverage for more than 650,000 of Michigan's citizens and has kept insurance premiums lower for others, improving the physical, mental, and financial well-being of Michigan's working poor. It also improved Michigan's economy by substantially reducing uncompensated care/bad debt among Michigan's hospitals, by supporting health sector job creation/retention, by promoting a healthier workforce, and by drawing increased federal spending into the state. The benefits of the program are manifest not only for enrollees, but for the entire population.

Enrollment in the Healthy Michigan Plan surpassed all initial expectations and benchmarks. Nonetheless, Healthy Michigan Plan enrollees have enjoyed access to quality, high-value health care services. Enrollment in the Healthy Michigan Plan was also the primary factor that enabled Michigan to more than halve the number of uninsured in the state since the federal passage of the Affordable Care Act. Moreover, since Medicaid managed care has been an effective strategy to constrain growth in insurance costs, the dramatic increase in newly insured (or re-insured) individuals has been achieved at a relatively modest cost per enrollee.

Since the program was entirely funded with federal dollars at the outset, the Healthy Michigan Plan has not created any costs to the state; on the contrary, the state has enjoyed hundreds of millions in savings attributable to the program. The Healthy Michigan Plan has also facilitated a more than 50 percent reduction in uncompensated care. The reorganization of resources under the plan fostered substantial macroeconomic benefits, such as job growth, increased personal income, and increased state revenue. Beneficiaries of Medicaid expansion have reported missing fewer days from employment, alluding to tangential economic benefits from a healthier, more productive workforce.

The Healthy Michigan Plan also improved health in the state. While the exact magnitude of impact is not yet clear, a significant body of evidence suggests that health insurance coverage through Medicaid reduces both morbidity and mortality. Having health insurance coverage also reduces stress and improves mental health—crucial for measures of total health

and wellness. Therefore, it is safe to assume that many Michigan residents who have received Healthy Michigan Plan benefits are alive now and will remain alive and healthier because of their insurance through the Healthy Michigan Plan.

As non-clinical factors are now recognized as major contributors to health and determinants of health outcomes, Michigan has an opportunity to expand the quality and consistency of data collection and measurement to study the social determinants of health in the Medicaid population. Current (and future) efforts would certainly be bolstered by greater data collection to inform policy-makers about any demonstrable linkages between individual/community health and social service agencies and programs. Current data suggest that a greater focus on social determinants of health will yield better health outcomes and lower costs for the state in the long run.

The cost versus savings criteria built into the Healthy Michigan Plan threatens the program's continuation, jeopardizing the health and well-being of current and future beneficiaries. Making continuation of the program contingent upon attributable program savings exceeding the program's costs is not only abnormal in terms of policy analysis, but also abdicates the legislature's core oversight duties. A unidimensional cost-savings criteria is bad policy; from the standpoint of efficiency, cost-benefit analysis would consider the broad impact of the program, not solely direct savings to the state budget. Efficiency (of delivery and finance), equity (of access), and effectiveness (of service) are all equally important program dimensions.

At this point, viable alternatives (of comparable cost and quality) to insure the population served by the Healthy Michigan Plan are not readily apparent. Of the 19 states that chose not to expand Medicaid, none have enacted superior private or public alternatives to give the working poor access to health insurance. Among the five states with the highest rates of people lacking health insurance (Texas, Florida, Georgia, Mississippi, and Oklahoma) none have expanded Medicaid; indeed, almost one in five Texans remains without health insurance (more than triple the rate of Michigan). Likewise, attempts to craft state-level single-payer public health

insurance systems (such as in California or Vermont) have had no success. Until viable policy alternatives have been formulated, Michigan should work to maintain coverage for the hundreds of thousands of people who rely on the Healthy Michigan Plan for insurance, health care access, and health maintenance.

Despite its many undeniable benefits, the Healthy Michigan Plan represents massive amounts of public spending (\$3.6 billion in FY2016). These costs to the public warrant both concern and strategies to reduce spending; however limiting coverage is not necessarily the wisest course. Addressing the factors that lead to high health care costs may alleviate the burden of public insurances on state budgets (by increasing the portion of the population able to afford health care, by making health care more affordable for employers that choose to offer the benefit, and by reducing the cost of health services the state does pay for). The Citizens Research Council Report 383, *Health Care Costs in Michigan: Drivers and Policy Options*, offers a discussion of various factors that lead to higher health care costs in Michigan.⁹⁵ By enacting policies that im-

prove employment, education, and public health, and by reducing poverty (a central factor in poor health), Michigan would reduce the need for public spending on health care and insurance.

Eligibility for state assistance programs like Medicaid are economically driven, rising and falling in accordance with the economic fortunes of the state. Given the well-documented economic turmoil many in Michigan have faced, it is little wonder that so many have, at one time or another, come to rely on Medicaid. Experiences in the labor market, familial responsibilities, low income and diminished job security, inadequate social supports, lost safety nets, and other social sources of stress all erode the health of individuals and communities. This erosion of health creates tremendous costs for Michigan, from higher insurance premiums, greater Medicaid spending, diminished labor market participation and productivity, and increased barriers to education and economic mobility. Every person bears a portion of these costs whether or not they are recognized, and so there is shared public interest in mitigating or eliminating them.

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