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Health Policy for Low-Income People in Michigan

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health policy in Michigan has been characterized recently by incremental modifications of long-standing policies. Relative to many states, Michigan is well-situated to respond to the changes taking place in both the public and private health care sectors. Michigan has a strong base of well-funded employer-sponsored insurance, reflecting the strong union presence, and fairly extensive Medicaid coverage. Blue Cross/Blue Shield's dominance in the insurance market and its policies of open enrollment and community rating have generally provided access to health insurance for individuals with higher health risks. As a result, the state has relatively few uninsured residents (10.4 percent of the nonelderly population versus the national average of 15.5 percent). Further, the state's health care system is not faced with the intense cost-cutting competition seen elsewhere. Because all acute care hospitals are not-for-profit and marketplace competition is less intense, hospitals are under less financial pressure and there is less of a threat to their ability to provide care for the uninsured than in many other states.

State Characteristics

In 1995, Michigan's population was 9.6 million, growing at half the rate of the United States population. The majority of the state's population resides in southeast Michigan, which includes Detroit. Compared with the United States as a whole, Michigan has a higher proportion of black and white (non-Hispanic) residents and significantly fewer Hispanic residents (table 1).

Michigan's economy has diversified over the past two decades, but it still depends on the "Big Three" auto makers and their suppliers. Michigan's economy is strong according to a number of indicators. Its unemployment rate is lower than that of the United States (4.9 percent versus 5.4 percent in 1995). Per capita income (\$23,915) is somewhat higher than the national average (\$23,208) and has grown more over the past several years than that of the nation overall (27.8 percent versus 21.2 percent). Aid to Families with Dependent Children (AFDC) rolls declined from about 225,000 families in early 1995 to some 170,000 in late 1996. One in seven people (13.9 percent) in the state has an income below the federal poverty level, which is slightly lower than the national rate (14.3 percent) (table 1).

Relative to many states, Michigan is well-situated to respond to the changes taking place in both the public and private health care sectors.

Table 1
State Characteristics

Sociodemographic	Michigan	U. S.
Population (1994–95) (in thousands)	9,559	260,202
Percent under 18 (1994–95)	27.6%	26.8%
Percent 65+ (1994–95)	12.4%	12.1%
Percent Hispanic (1994–95)	1.7%	10.7%
Percent Non-Hispanic Black (1994–95)	13.7%	12.5%
Percent Non-Hispanic White (1994–95)	81.8%	72.6%
Percent Non-Hispanic Other (1994–95)	2.7%	4.2%
Percent Noncitizen Immigrant (1996)*	2.3%	6.4%
Percent Nonmetropolitan (1994–95)	16.1%	21.8%
Population Growth (1990–95)	2.7%	5.6%
Economic		
Per Capita Income (1995)	\$ 23,915	\$ 23,208
Percent Change in Per Capita Personal Income (1990–95)	27.8%	21.2%
Unemployment Rate (1996)	4.9%	5.4%
Percent below Poverty (1994)	13.9%	14.3%
Percent Children below Poverty (1994)	22.0%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	10.4%	15.5%
Percent Medicaid—Nonelderly (1994–95)	11.5%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	74.4%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	3.7%	6.2%
Smokers among Adult Population (1993)	25.1%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	7.8%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	8.5	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	54.5	54.4
Violent Crimes per 100,000 (1995)	687.8	684.6
AIDS Cases Reported per 100,000 (1995)	12.6	27.8
<p><i>Source:</i> Complete list of sources is available in <i>Health Policy for Low-Income People in Michigan</i> (The Urban Institute, 1997).</p> <p>* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.</p>		

Measures of health status are somewhat less favorable. Michigan's rates of low birth-weight, infant mortality, and violent crimes exceed those of the nation. The state's rate of reported AIDS cases, however, is much lower than the national rate (table 1).

Politics and Fiscal Policy

While Michigan has a long Democratic tradition, this has changed in the past several years. Republican Governor John Engler was elected in 1990, and his popularity grew as he championed tax cuts and devolution of power to local communities. He

was reelected to his second term in 1994 by a substantial majority. As of the 1996 elections, Republicans also control the Senate (22 Republicans to 16 Democrats), while Democrats have a slight majority in the House (57 Democrats to 52 Republicans).

Governor Engler's priorities and interests have focused on welfare, job growth, tax cuts, and corrections. He has been one of the leading governors on national welfare reform, pushing for changes in federal law, and he has also made implementing welfare reform in Michigan a priority. In contrast, health policy issues have not been a priority of the governor or the legislature, with the exception of Medicaid cost-control

efforts. Medicaid accounts for about one-tenth of state general-fund expenditures, making it the third-largest budget item, after K–12 education and higher education. Medicaid has also been one of the state's fastest-growing programs when federal and state funds are taken into account. From 1990 to 1992, annual growth in total Medicaid expenditures averaged 19.5 percent. This growth rate declined by half between 1992 and 1995 (table 2). However, Medicaid spending per enrollee remains above the national average for every category of beneficiary except the blind and disabled (table 3), and between 1992 and 1995 average spending per enrollee grew at a rate twice the national average (11.5 percent versus 5.2 percent). Rapid budget growth in the Medicaid program has created pressure for significant Medicaid cost containment efforts. In response, the Engler administration has established a 3-percent annual growth target for Medicaid.

Detailed Medicaid Trends

The high rate of Medicaid expenditure growth in Michigan has been driven by increased spending in nearly all categories of enrollees—namely, the elderly, children, and the blind and disabled. From 1992 to 1995, the state's average annual growth in spending on the elderly was 14.3 percent, compared with 8.1 percent nationally (table 2). Michigan's enrollment growth for the elderly during the same period was only 0.2 percent, while the United States average was 3.0 percent. Thus, the growth in spending was largely a result of increases in spending per enrollee. The average spending for an elderly beneficiary in the state in 1995 was \$12,326 versus the national average of \$9,738 (table 3).

The growth of Medicaid expenditures for children has outpaced that of Michigan's elderly enrollees as well as the national average for children: In the aggregate and on a per enrollee basis, spending increased an average of 16.7 percent per year between 1992 and 1995. Spending per child is a fraction of that spent per elderly enrollee, but there were 719,900 children enrolled in Medi-

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
Michigan and United States
 (Expenditures in Millions)

	Michigan			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990-92	1992-95	1995	1990-92	1992-95
Total	\$5,338.6	19.5%	10.5%	\$157,872.5	27.1%	9.9%
Benefits						
Benefits by Service	\$4,676.4	12.5%	13.0%	\$133,434.6	18.8%	11.0%
Acute Care	2,942.1	15.1%	11.0%	79,438.5	22.1%	13.0%
Long-Term Care	1,734.3	7.8%	16.7%	53,996.1	14.8%	8.3%
Benefits by Group	\$4,676.4	12.5%	13.0%	\$133,434.6	18.8%	11.0%
Elderly	\$1,131.5	17.6%	14.3%	\$40,087.4	16.7%	8.1%
Acute Care	196.5	29.5%	1.9%	9,673.7	18.5%	11.9%
Long-Term Care	935.0	14.4%	17.8%	30,413.7	16.2%	7.0%
Blind and Disabled	\$1,939.0	14.1%	13.0%	\$51,379.4	17.7%	12.9%
Acute Care	1,256.3	19.4%	12.4%	29,760.7	22.8%	15.2%
Long-Term Care	682.7	5.7%	14.1%	21,618.7	12.3%	10.1%
Adults	\$622.6	10.6%	6.0%	\$16,556.9	20.4%	9.2%
Children	\$983.3	5.5%	16.7%	\$25,410.9	24.3%	13.3%
Disproportionate Share	\$438.0	216.3%	-7.0%	\$18,988.4	261.5%	2.7%
Hospital Administration	\$224.1	5.4%	10.5%	\$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

caid in 1995 versus 91,800 elderly (table 3). As a result, spending on children accounts for nearly the same proportion of program benefits (21 percent) as spending on the elderly (24 percent) (table 2).

Consistent with national trends, spending on the blind and disabled comprises the largest share of Michigan's Medicaid program—41 percent of benefits spending. Spending on the blind and disabled grew 13.0 percent annually from 1992 to 1995 and averaged \$7,841 per enrollee in 1995. Numbering 247,300 in 1995, blind and disabled enrollees have increased more rapidly than any other group in recent years. Between 1992 and 1995, annual enrollment increases were 10.5 percent on average, mirroring national trends (table 3).

Long-term care costs for both the elderly and disabled rose faster than acute care costs from 1992 to 1995; the reverse was true for the United States as a whole. In 1995, long-term care services comprised 37 percent of Michigan's spending on all services, up from 34 percent in 1992 (table 2). The majority of long-term care spending is for nursing homes, although

home health care is an expanding segment.

Health Care Initiatives

Michigan has adopted a fairly standard mix of policies designed to address the costs and accessibility of health care services for the low-income population. The four primary features of the Michigan approach are greater use of managed care in Medicaid, significant efforts to maximize receipt of federal funds, reorganization of state agencies, and use of limited state and local programs to provide insurance for low-income persons who do not qualify for Medicaid.

Medicaid Managed Care. One of the first states to implement a primary care case management program for its Medicaid population, Michigan introduced the Physician Sponsor Plan (PSP) in the Detroit area in 1982. A decade later, the state received federal approval to mandate statewide enrollment in either the PSP or a capitated program for most Medicaid beneficiaries. More recently, in April 1996, the state announced plans to move nearly all Medicaid beneficia-

ries into capitated managed care plans, phasing out the PSP. The state's plan to increase its reliance on capitated managed care in Medicaid is fairly typical. However, the plan reaches further than those of many states in its use of managed care for disabled populations and long-term care services and in the fairly rapid pace of expected implementation. The plan consists of five separate components, the largest of which is the "comprehensive plan," covering all AFDC/Temporary Assistance for Needy Families and Supplemental Security Income clients. Starting in 1997 in southeast Michigan, clients enrolled in the PSP will be expected to enroll in health maintenance organizations or other capitated plans. Enrollment for the four remaining components—care for children with special health care needs, long-term care services, behavioral health services, and services for people with developmental disabilities—is scheduled to commence in 1998.

Medicaid Maximization. Michigan has been aggressive in its efforts to earn federal matching funds through the Medicaid program. The primary

Table 3
Medicaid Enrollment and Expenditures
per Enrollee: Contributions to Total Expenditure Growth

	Michigan			United States		
	1995	Average		1995	Average	
		1990-92	1992-95		1990-92	1992-95
Elderly						
Total expenditures on benefits (millions)	\$1,131.5	17.6%	14.3%	\$40,087.4	16.7%	8.1%
Enrollment (thousands)	91.8	4.4%	0.2%	4,116.6	5.1%	3.0%
Expenditures per enrollee	\$12,326	12.7%	14.1%	\$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	\$1,939.0	14.1%	13.0%	\$51,379.4	17.7%	12.9%
Enrollment (thousands)	247.3	14.0%	10.5%	6,405.2	9.8%	9.5%
Expenditures per enrollee	\$7,841	0.1%	2.2%	\$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	\$622.6	10.6%	6.0%	\$16,556.9	20.4%	9.2%
Enrollment (thousands)	357.0	6.6%	-0.9%	9,584.2	11.5%	4.6%
Expenditures per enrollee	\$1,744	3.7%	7.0%	\$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	\$983.3	5.5%	16.7%	\$25,410.9	24.3%	13.3%
Enrollment (thousands)	719.9	7.2%	0.0%	21,566.0	13.1%	4.8%
Expenditures per enrollee	\$1,366	-1.6%	16.7%	\$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

vehicle for these efforts has been use of the disproportionate share hospital (DSH) program and provider payment adjustments, with the state share financed with intergovernmental transfers. An indication of the scope of Michigan's effort is that, in 1996, more than one-third of the state appropriation for Medicaid consisted of intergovernmental transfers, rather than general-fund monies. Through extensive use of DSH and related payment systems, the state has increased federal revenues for the state government and increased payments to health care providers.

Reorganization of State Health Agencies. In 1996, Michigan combined the three state agencies responsible for most health programs. The Medicaid program, the public health agency, and programs for developmental disabilities and mental health were placed in a single agency, the Department of Community Health. The consolidation was meant to help the state become a better purchaser—one that could command better quality and lower prices—for the popula-

tions it serves. The three former agencies retain their status as separate divisions within the new department. It appears that it will take some time for the new agency to overcome the historical separation of its various functions.

The reorganization of state health-related agencies has accompanied changes in the state's public health activities. The state has made a significant investment in public health, largely with new revenues derived from an increased tobacco tax. New public health funding has been targeted toward population-based services and an incentive system that provides matching payments to counties for certain services, such as well-child visits and immunizations.

Programs for the Uninsured. In addition to Medicaid, Michigan has several programs to address the health insurance needs of the low-income population, but they are quite limited in scope. The state-administered State Medical Program, which has its origins in the former General Assistance medical program, covers fewer than

12,000 people. Like some other states, Michigan has a Blue Cross/Blue Shield Caring Program for Children, which provides limited health benefits to 4,500 low-income children. Wayne County, the largest county in Michigan (it includes the city of Detroit), has developed two programs: PlusCare, which serves about 40,000 people, and HealthChoice, which covers 4,000 of the working poor using funding from employers, employees, and the county. Together, these programs reflect a modest effort to address the needs of a portion of the uninsured population.

The Health Care Market

Two characteristics of the health care market set Michigan apart from most of the rest of the country. First, all acute care hospitals in the state are not-for-profit, and competition among hospitals seems less aggressive than in other states. Second, Michigan is one of relatively few states that have not adopted significant reforms in the small-employer insurance market.

This is likely related to the dominance of Blue Cross/Blue Shield in the private health insurance market. Blue Cross/Blue Shield employs open enrollment periods and uses community-rated policies in the small-group and individual markets. Its dominance of the market means that certain reforms adopted by other states to reduce risk-skimming behavior have limited relevance in Michigan.

Long-Term Care

Michigan has forged a long-term care strategy for its elderly and disabled populations that emphasizes managed care and home and community-based care, with the objective of reducing dependence on costly residential facilities. Michigan has been especially aggressive in deinstitutionalizing its developmentally disabled and severely mentally ill populations. The census for state-operated intermediate care facilities for the mentally retarded has declined from its peak of 12,694 in 1967 to 392 in 1996. Similarly, the census in state psychiatric hospitals has fallen from 19,059 in 1960 to 1,650 in 1995.

The state has been more cautious in the use of home and community-based waivers to provide alternatives to institutional care for the elderly. In 1996, more than 10 times as many Medicaid elders were in nursing homes as were served through the state's waiver program. The state plans to expand this program in the near future. In addition, the state's certificate-of-need program, which authorizes new nursing home facilities or beds, appears to be slowing growth in the nursing home bed supply; bed supply expanded only 10.1 percent from 1980 to 1995 versus 33.5 percent nationwide. The continued expansion of residential alternatives, such as homes for the aged, is also expected to decrease reliance on nursing homes to meet long-term care needs.

Challenges for the Future

Michigan faces several challenges in financing and providing health care services to its low-income population in the coming years. First, there is some

question as to whether the state will be able to realize its quality and cost objectives in Medicaid by using managed care. The state has established fairly optimistic assumptions about the savings that are likely to accrue from managed care competitive bidding. Additionally, Michigan may face difficulties related to the proposed rapid enrollment of the Medicaid population into managed care. In particular, the state will likely face barriers that other states have experienced in its efforts to enroll people with disabilities in managed care. Given a 3-percent annual cost growth target, how will the state respond if any of these barriers prevent that target from being met? And how will safety net providers adjust to the changes brought by Medicaid managed care? At this point it is unclear whether managed care will reduce or increase the financial burden on safety net providers and access to care for the uninsured.

A second challenge is that changes in federal Medicaid law may affect Michigan's heavy reliance on federal funds. The recent reductions made to the DSH program by federal law may force the state to allocate new state funds to the Medicaid program or adopt even greater cost containment measures to meet its budget targets.

Finally, there are some uncertainties about health insurance coverage. Many people in Michigan are concerned about the effects of changes driven by welfare reform. Medicaid rolls have fallen recently and could decline more as further reforms are implemented. In addition, when the state eliminated its General Assistance cash program, it replaced the adjunct medical assistance program with the far more limited State Medical Program. There are also reports that insurance coverage offered by small employers is declining. These factors may lead to an increase in the number of uninsured. At the same time, as part of its welfare reform plans, the Engler administration and many legislators support a proposal to extend Medicaid benefits on a buy-in basis to former welfare recipients who have exhausted their transitional benefits. It is not yet clear how the sum of these various changes will affect access to health insurance for low-income Michigan residents.

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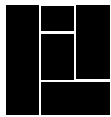
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