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The Consumer Connection

... linking consumers with health care news and information

Michigan Consumer Health Care Coalition
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The Consumer Connection is a publication of the Michigan Consumer Health Care Coalition with the Michigan League for Human Services

Reform Debate Continues— At Both Federal and State Levels

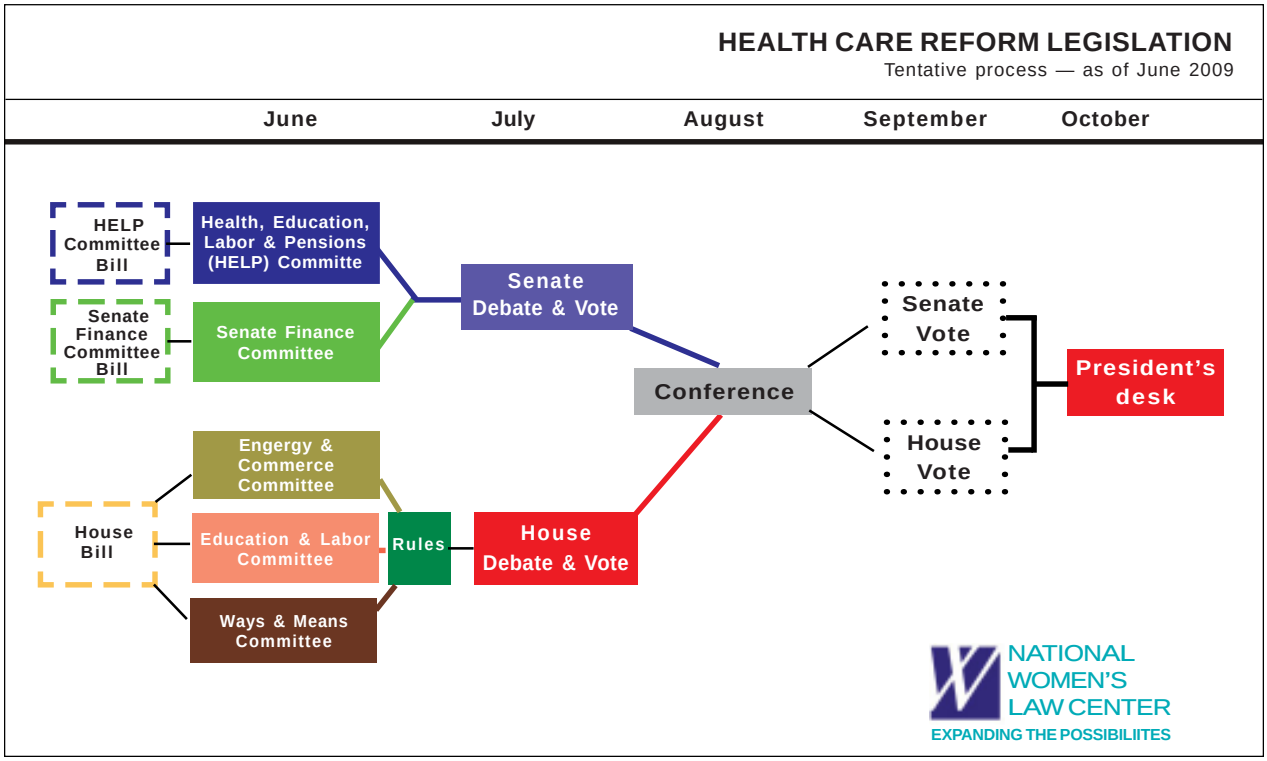
The last edition of the Consumer Connection focused on health care reform from the national perspective, articulating the need for reform, the process to date (including the Congressional committees involved), and the President's proposal to set aside a down payment for the reform efforts while specific proposals and details are being developed. Proposals are expected to be released in the next couple of months. Current projections are that committee votes will take place in June and floor debates in July before Congress adjourns for its August recess. *See chart below for projected timeline*. The conference committee called to iron out the differences in the House and Senate versions will take place during the recess, with a final vote of both Houses scheduled for September.

There are two "sticking" points in the design of a new coverage system: Will reform carry a public insurance plan option? Will employers be required to offer coverage to their employees or pay an assessment into a general fund? The question of whether individuals will be required to carry insurance appears to be a settled issue—they will, with a means tested, sliding scale subsidy if they cannot afford to purchase coverage.

But the major sticking point remains: how reform will be financed, given that many currently uninsured individuals will need a subsidy if mandatory coverage is required of them.

State Reforms Also Underway

In mid May, both the state House and the state Senate introduced health care reform legislation. The House bills (HB 4934–4943) were introduced by Representative Marc R. Corriveau, D–Northville on May 11, and the Senate bills (SB 579–582) were introduced



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by Senator Tom George, R–Kalamazoo on May 14. The intent of both sets of bills is to make affordable coverage available to residents who are uninsured, relieve the health care industry of the increasing burden of uncompensated care, and dramatically increase the number of people who have access to affordable coverage, and therefore, health care services.

The following summary of health care reform efforts at the state level is taken from a report published by the Michigan League for Human Services.

When the Legislature was unable to arrive at a compromise in the last legislative session on changes related to individual insurance market reform, a task force was established to review and consider ways to provide a more comprehensive solution including making insurance more affordable and accessible for individuals, small businesses, and others struggling with the high and rising cost of health care coverage.

Highlights of the House and Senate packages of bills follow. The Senate Fiscal Agency analysis of the individual Senate bills can be found at http://www.legislature.mi.gov/documents/2009-010/billanalysis/Senate/pdf/2009-SFA-0579-S.pdf. House Fiscal Agency analysis of the House bills has not yet been posted, as of this writing.

Public and Private Solutions — Both plans propose a combination of public and private solutions. The House plan calls for an expansion of MIChild, the state's children's health coverage program for those who are low income and not eligible for Medicaid, from its current eligibility level of 200 percent of the federal poverty level to 300 percent of the federal poverty level ($66,200 for a family of four). The House plan calls for the development of ''basic and basic enhanced'' plans by insurance carriers, with subsidies being provided for the basic plan to those with incomes up to 300 percent of the federal poverty level. The services included in each type of plan would be determined by the newly-created administrative board. The House proposal also includes subsidies for senior citizens with incomes up to 300 percent of the federal poverty level to assist with their costs for Medigap policies.

The Senate plan calls for a Medicaid waiver to expand coverage for adults with incomes up to 200 percent of the federal poverty level (children would already be eligible under Medicaid or MIChild at this income level). For those with incomes between 200 and 300 percent of the federal poverty level, individuals would be eligible for a sliding scale subsidy to allow them to purchase an insurance product in the private market through the newly created entity called MI-Health. The benefit would be limited and could include cost sharing (deductibles and/or copays), with specific services determined by an administrative board.

Benefits Package — Neither package of bills specifies the exact benefits that would be included in the new products to be offered, deferring instead to the newly created governance/administrative boards.

Catastrophic Fund — Both proposals include the creation of a catastrophic fund from which insurance companies would be reimbursed for an individual's claims that exceed $25,000 in a year.

Governance Structures — The House proposal creates a new board to administer the catastrophic fund. The Senate proposal includes the creation of two new boards—the ''Cover Michigan Board'' which would determine the benefits to be included in the insurance products and the ''Michigan Claims Board'' which would determine the amount of assessments the private health insurers would be required to pay.

Financing — Both proposals rely on financing that does not come from the state's general fund. Funding for the House proposal to cover expanded populations would come from: Blue Cross Blue Shield in an amount equal to the value of their tax exempt status (House estimate—about $100 million), the tax-exempt value from other nonprofits (about $60 million), while funding for the catastrophic fund would come from assessments based on the market share of insurance companies. The House proposal assumes that the $160 million would be used to match federal Medicaid funds, increasing the available health care dollars to $450 million.

The Senate proposal also assumes an assessment on Blue Cross Blue Shield up to the value of their tax exempt status (Senate estimate—about $120 million), as well as an increase in the Medicaid hospital provider tax (about $180 million), and up to a 1.8 percent assessment on all private paid claims, providing an estimated $329 million per year. The combi-

nation of these funds, just over $600 million, would be used to the degree possible to match federal Medicaid funds to provide the expanded coverage and subsidies included in the Senate proposal. The catastrophic fund would be financed from surcharges on the plans offered through MI-Health.

Insurance reforms — Numerous reforms are proposed in the two packages of bills which are intended to provide consumer access and protections in the individual and small insurance markets. Both packages of bills limit pre-existing condition exclusions to six months, as well as limiting policy cancellations for technical reasons. In addition, the catastrophic fund is intended to level the playing field among Blue Cross and other carriers, as other carriers will no longer be allowed to insure only "healthy" applicants.

Among other reforms in the House proposal are: a guaranteed access to coverage requirement that insurance companies must cover people with pre-existing conditions (insurance companies can no longer select only healthy people to cover), a requirement that insurance companies cannot raise rates on people who become ill, an end to gender discrimination against women, a reduction in dramatic renewal increases for small businesses by ending experience rating, and a requirement that discounts for good health and adherence to healthy lifestyles be offered.

The Senate bills, while not guaranteeing issuance, do guarantee renewal, and insurers are prohibited from raising rates at renewal for those who become ill. In addition, Blue Cross Blue Shield is allowed to charge rate differentials based on body mass index (BMI), tobacco use and adherence to health screenings and participation in covered wellness programs.

Initiatives — The House bills include a number of initiatives, among them: a mandate that prescriptions be electronically transmitted, the creation of a bulk prescription drug purchasing cooperative and drug program for the uninsured and underinsured, the mandated creation of a health assessment Website to promote healthy behaviors, and the requirement that a statewide advance health care directive registry be developed by the Secretary of State.

It is important to note that neither proposal represents universal, comprehensive coverage.

We want to hear from you— suggestions for improvements and topics, questions, even encouragement!

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Two New Reports on Health Care Issues

Families USA (FUSA), the D.C.-based consumer advocacy organization, recently released two reports with significant implications for the current health care debate in the halls of Congress. The first, "Americans At Risk: One in Three Uninsured," takes a closer look at the profile of uninsured Americans, and the second, "Too Great a Burden: Americans Face Rising Health Care Costs," provides perspective and brings urgency to the policy debate.

Children Comprise One-Third of Nation's Uninsured

The first FUSA report focuses on the 86.7 million people who were without health insurance coverage at some point during 2007 and 2008—one in three Americans under age 65. Almost twenty-seven million children aged 0 to 18 years were among the uninsured at some point during the study period, making up almost one-third of all the uninsured (30.7%).

Twenty-two million of the uninsured people profiled in the report were without coverage for the full 24 months of the 2007–2008 period, and sixty-five million were without coverage for six months or more. The highest rate of the uncovered by age was among the 19 to 24 year-old group whose uninsured rate was 49.5 percent—fully half.

The profile of the 87 million uninsured Americans is revealing and does not lend itself to stereotyping:

- One in four were uninsured the full 24 months (25.3%)
- Four in five were from working families (79.2%)
- Seven in ten were from families with a fulltime worker (69.7%)
- Three in five had family income below the poverty level* (58.7%)
- More than half were in near poor families** (52.0%)

People of all backgrounds suffered from the lack of coverage:

- More than half of all Hispanics (55.1%)
- Two of five African Americans (40.3%)
- One in four non-Hispanic whites (25.8%)

* Poverty level in 2008 was $21,200 for a family of four, considered the "basic needs" level.

** "Near poor" income: 100 - 199% of the poverty level.

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Some age groups were disproportionately without coverage:

- One in three children and youth (33.8%)
- One in two 19–24 year-olds (49.5%)

Data sources: Three federal reports: March Current Population Survey (CPS), Medical Expenditures Panel Survey (MEPS), Survey of Income and Program Participation (SIPP)

Health Care Costs Increasingly Burdensome

The second FUSA report deals with the costs of health care, which have become overwhelming for many Americans. The report includes the cost of insurance premiums, copayments, deductibles, prescription drugs, medical supplies and over-the-counter medication.

The most significant finding is the degree to which health care costs control individual and family spending: in 2009, almost 19 million Americans under the age of 65 will spend more that one-quarter of their pre-tax income on health care costs, a 61 percent increase over the number that were in this situation in 2000. Of these 19 million Americans with high health care costs, 562,000 reside in Michigan, and 449,000 of them *have insurance* which does not protect them from these very high out-of-pocket costs. (See the May issue of the Connection for Michigan detail on the numbers.)

The report also provides detail on persons and families spending more than 10 percent of their pre-tax income on health care—64.3 million or one in every four Americans. This number for Michigan is 2,085,000; 1.8 million *insured* Michiganders find themselves in this position.

A discussion of the reasons for this high health care costs affecting millions of Americans addresses:

1. the rising health care spending which is driving up premiums—prescription drug spending doubled between 2000 and 2009 and hospital services increased from $417 billion in 2000 to $789 billion in 2009, with overall personal health care expenditures projected to rise by nearly 70 percent over the period, from $4,032 to $6,826;
2. an unregulated, monopolistic insurance market: in 44 percent of major metropolitan areas, a single insurance company controls half or more of the market;
3. that employers are ''thinning'' out their coverage—providing fewer benefits, covering workers only and not their dependents, increasing cost sharing by employees.

The major point made by the report is that high medical costs and medical debt compromise a family's access to health care and undermines its economic security. Even among *insured* adults with medical bill problems or medical debt, 33 percent used up all of their savings to pay the bills, 30 percent took on credit card debt, and 10 percent took out a second mortgage or personal loan.

For the full reports, visit Families USA at <www.familiesusa.org>