Michigan at a Crossroads

Michigan Health Policy for the Incoming 2019 Gubernatorial Administration

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Michigan's Key Health Policy Issues, 2018

Introduction

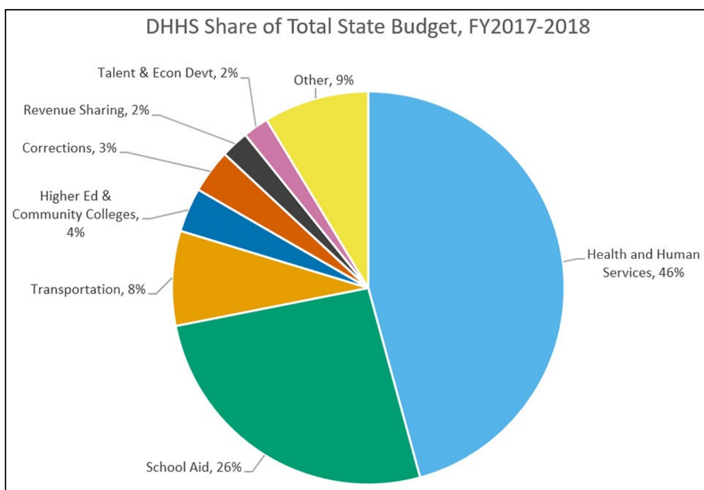
The Michigan government has jurisdiction over a wide array of health policy issues. From the regulation of insurance products, to oversight of the state's Medicaid program, to investing in local public health efforts, Michigan policymakers craft policies and budgets that impact the health of millions of Michiganders.

This brief will provide an overview of four key and timely health policy topics: Medicaid and the Healthy Michigan Plan; the individual health insurance market and the Health Insurance Marketplace; the opioid epidemic; and integration of services to address social determinants of health. It will explore some of the forces influencing our state's health and discuss policy approaches to today's health and health care issues.

Overview: Health Spending and Health Outcomes in Michigan

Spending

Nationally, health care spending accounted for nearly 18% of gross domestic product in 2016 – growing 4.3% over the previous year to $3.3 trillion, or an average of $10,348 per person.[1] Health care spending comprises 18% of Michigan's gross state product, as well.[2] In 2014 (the most recent data available), health spending in Michigan was $79.9 billion, or an average of $8,055 per person.[3,4] Health care and public health account for a substantial portion of Michigan's state budget.



Source: Michigan House Fiscal Agency

In FY2017-2018, the Michigan Department of Health and Human Services (MDHHS) accounted for 46% of Michigan's $55.8 billion state budget and 43% of the state's $10.1 billion General Fund/General Purpose (GF/GP) budget. Funding for MDHHS has grown by 79% since FY2003-2004. Federal funding for Medicaid and the addition of the Healthy Michigan Plan (HMP) likely account for most of that increase. The state GF/GP portion of funding for MDHHS has stayed relatively steady during this period, remaining under $5 billion annually.[5] Health services (which are largely delivered through Medicaid) represent nearly 33% of the state's FY2017-2018 budget, the largest share of state spending. K-12 and higher education represent the next largest share of state spending, at 29% of the state budget.[6]

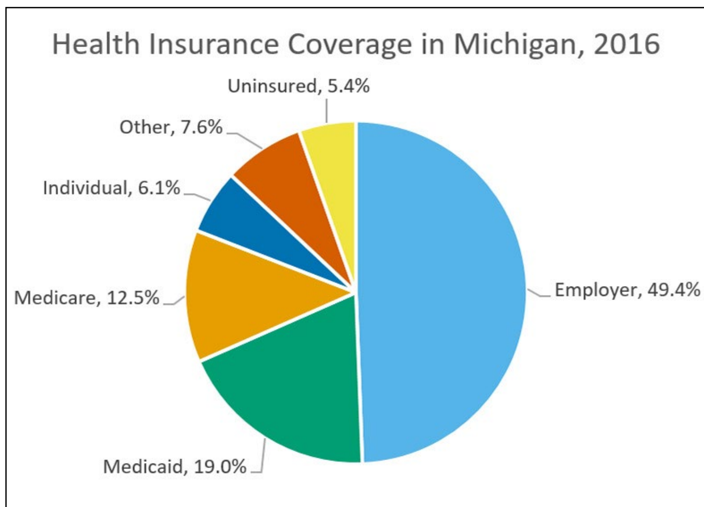
In FY2017-2018, Medicaid represented approximately 26% of the state budget ($10.84 billion for traditional Medicaid and $3.86 billion for HMP). The GF portion of Medicaid funding was $1.34 billion, including $1.17 billion for traditional Medicaid and $173 million for HMP. Medicaid spending in Michigan has risen steadily since FY2000-2001, but at a lower rate than that of general medical inflation. The average per-beneficiary annual cost has increased by 44%, from $4,900 in FY2000-2001 to $7,000 in FY2017-2018. For comparison, if the average per-beneficiary cost had increased by the rate of general medical inflation during this period, it would have risen by 82% to approximately $8,900 by FY2017-2018.[7]

Health Status

Michigan lags behind the national average in the overall health of our residents. According to America's Health Rankings, in 2017, Michigan was ranked the 35th healthiest state in the nation. While Michigan has a low uninsured rate and high numbers of primary care providers, we also have high rates of smoking, cardiovascular death, and obesity.[8] These findings illustrate an important point: health is often about much more than just health care. While it is important to have health insurance coverage and access to medical care, there are a multitude of other social, economic, and environmental factors that shape the health of Michiganders.

Health Insurance Coverage

Michigan residents obtain health insurance coverage from a variety of private and public sources. In 2016, nearly half of Michigan residents had employer health coverage. Nineteen percent of residents received Medicaid health coverage, 12.5% received Medicare, 6% purchased coverage directly from insurers, and 8% held another type of private or public coverage. 5.4% of Michigan residents went uninsured in 2016, the lowest rate in recent history.[9]

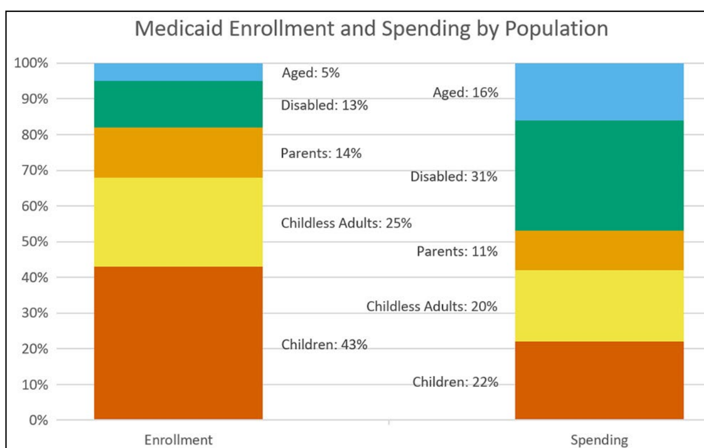


Source: 2016 American Community Survey 1-Year Estimates

Medicare, a federal program, and Medicaid, a federal-state program, are the two largest health insurance programs for Americans. Medicare primarily covers adults age 65 and older or individuals with serious disabilities under age 65; Medicaid covers low-income individuals. Medicare is funded federally through a combination of general revenues, payroll taxes and beneficiary premiums. Medicaid is jointly funded by the federal government and the states. Approximately 2 million Michigan residents are covered by Medicare and 2.5 million are covered by Medicaid.[10,11] Some low-income individuals qualify for both Medicaid and Medicare and are known as "dual-eligibles" or "duals." Duals receive assistance from Medicaid to help pay for Medicare cost-sharing, and can receive additional Medicaid benefits that are not covered under Medicare, such as long-term services and supports.

Issue 1: Medicaid and the Healthy Michigan Plan

Low-income children and parents comprise the majority of individuals receiving coverage through Medicaid (57%), and Medicaid funds nearly half of all births in Michigan.[12,13] One in four Michigan residents– 2,499,464 individuals as of March 2018 – receive health coverage through Medicaid. Of these, 72% were enrolled in "traditional" Medicaid and 28% were enrolled in the Healthy Michigan Plan.[14]



Source: Michigan Department of Health and Human Services

While children and parents are the majority of those getting coverage through Medicaid, seniors and those who are disabled represent a significant percentage of the spending in Medicaid. Many of these individuals are duals who have health coverage through both Medicare and Medicaid. Although seniors and individuals with disabilities make up just 18% of Medicaid enrollment, they account for 49 percent of Medicaid spending.[15]

"Traditional" Medicaid

"Traditional" Medicaid generally refers to the program's structure prior to the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. Prior to the enactment of the ACA, many states, including Michigan, restricted the ability for adults without children or disabilities to enroll in Medicaid. The federal government sets overall standards to determine who is eligible for Medicaid coverage, but states have flexibility to establish income standards based on the federal poverty level (FPL).[1] In Michigan, the following groups with the noted maximum income limit qualify for traditional Medicaid:

Eligibility Category	Maximum income limit in Michigan
Families receiving cash assistance benefits	49% FPL
Aged, blind, or disabled individuals receiving Supplemental Security Income	75% FPL
Elderly and disabled	100% FPL
Children under 18	160% FPL
Pregnant women and newborns	195% FPL
MI Child (Children's Health Insurance Program)	212% FPL
Individuals who need long-term supports and services	222% FPL

[1] In 2018, the federal poverty level was $12,140 annually for an individual and $25,100 for a family of four.

All state Medicaid programs must cover certain services. Michigan Medicaid includes several additional services in its coverage:

Services Required by CMS	Additional Services covered by Michigan Medicaid
Inpatient and outpatient hospital, physician, nursing facility, laboratory and x-ray, emergency, and pregnancy-related services; all approved prescription drugs	Behavioral health, pharmacy, adult home help, dental, home and community-based services, hospice, and the Program of All-Inclusive Care for the Elderly (PACE)

For traditional Medicaid, the portion of cost paid by the federal government varies based on a formula that takes into account the average per capita income for each state. The maximum federal share is 73%. In Michigan, in 2018, the federal Medicaid share was 64.45%.

Healthy Michigan Plan

The ACA originally required states to expand Medicaid coverage to all adults with incomes below 138% of the federal poverty line (approximately $16,800/year for an individual and $34,600/year for a family of four in 2018). A 2012 Supreme Court decision, however, made Medicaid expansion optional for states. As of May 2018, 33 states and the District of Columbia have adopted a version of the Medicaid expansion. Michigan's expansion, the Healthy Michigan Plan (HMP), launched in April 2014. HMP is available to adults age 19-64 who earn less than 138% of the federal poverty line.

Public Act 107 of 2013, the Healthy Michigan Plan legislation, authorized the state to expand its Medicaid program, and passed with bipartisan support in both chambers of the Legislature using a series of federal "section 1115" waivers. These federal waivers allow Michigan to make changes to the structure of its Medicaid program beyond parameters set by the federal government. Along with several other features, Michigan's Healthy Michigan Plan is unique nationally in its focus on healthy behaviors. HMP enrollees are expected to complete a health risk assessment, engage in a healthy behavior (such as smoking cessation or weight loss), and contribute modest premiums and co-pays (depending on income) to health savings accounts.

HMP enrollment quickly outpaced initial expectations, with over 240,000 individuals enrolling in coverage in the first two months of the program alone. As of June 2018, approximately 690,000 Michiganders are enrolled in HMP.[16]

The Healthy Michigan Plan has also generated state budget savings and economic activity. Prior to the launch of the Healthy Michigan Plan, the state of Michigan funded certain health care programs with GF/GP funds. As individuals previously served by those programs transitioned to the Healthy Michigan Plan, the federal government funds covered those programs, creating $1.2 billion in cumulative GF/GP savings from FY2013-2014 through FY2016-2017. In addition to the budgetary savings, the economic impacts of the Healthy Michigan Plan have generated 30,000 new jobs annually, resulting in $2.3 billion in additional personal spending power and $150 million in state tax revenue each year.[17]

For the Healthy Michigan Plan, the federal government paid 100% of the cost of coverage from 2014-2016. From 2017 through 2020, the federal government decreases its match rate, covering 95% of the cost of coverage in 2017 but decreasing to 90% of the cost of coverage in 2020 and beyond. In FY2017-2018, the state 5% GF/GP match for Healthy Michigan was $172 million while the federal government provided $3.6 billion.[18]

PA 107 of 2013 included a clause requiring the state to end HMP if costs to the state exceed savings from the program. The House Fiscal Agency projects that the state will continue to reap savings from the Healthy Michigan Plan through at least FY2019-2020. In subsequent years, they expect the costs of the program to exceed savings, which could trigger the sunset provision. Discontinuing the Healthy Michigan Plan would require the state to restore some GF/GP funding for health care services it had funded prior to HMP, mainly community mental health services, or reduce the level of those services.[19]

Emerging Policy Actions: Work Requirements

In early 2018, the U.S. Centers for Medicare and Medicaid Services (CMS) announced a sweeping change in federal Medicaid policy that would allow states to request federal permission to establish work and community engagement requirements for certain adults receiving health insurance coverage through Medicaid. As of May 2018, work requirement proposals have been approved for four states: Arkansas, Indiana, Kentucky, and New Hampshire. Seven additional states have submitted applications to the federal government for these work requirements, and a number of other states are considering or preparing proposals.

In June 2018, Governor Snyder signed PA 208 into law, the first step in preparing a work requirement proposal for Michigan. Beginning in 2020, the law would require non-elderly, non-disabled HMP enrollees aged 19-62 to document an average of 80 hours of work per month to maintain eligibility for Medicaid benefits. Activities that would meet the work requirement include employment, job training, community service (up to 3 months per year) education, unpaid workforce engagement (e.g., an internship), tribal

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employment program, or drug treatment. If enrollees fail to meet monthly requirements for any 3 months in a year, their coverage is suspended for at least one month until they come back into compliance. Exemptions would be available for individuals age 63 and older, individuals who are disabled and medically frail, full-time students, caregivers, pregnant women, those who were recently incarcerated, those with medical conditions resulting in work limitations, those receiving unemployment compensation, former foster care youth, and those who qualify for a good cause exemption. The House Fiscal Agency estimated that of the 690,000 individuals enrolled in HMP in June 2018, approximately 20% (138,000) would qualify for an exemption and 80% (552,000) would be required to report their work hours.[20]

In addition to these requirements, PA 208 added additional termination triggers for the Healthy Michigan Plan beyond the sunset provision included in PA 107. Under PA 208, the Healthy Michigan Plan will be terminated if:

1. CMS fails to approve Michigan's proposal within 12 months;
2. CMS denies Michigan's proposal and does not approve an amended proposal within 12 months of resubmission;
3. CMS cancels Michigan's proposal at a future date and does not approve an amended proposal within 12 months of resubmission; or
4. CMS approves Michigan's proposal, but the approved proposal does not comply with the Healthy Michigan Plan law.[21]

Many HMP enrollees are already working. A 2016 survey conducted by the Institute for Healthcare Policy and Innovation at the University of Michigan found that 49% of HMP enrollees were employed or self-employed full or part time, and those who reported being out of work or unable to work were more likely to have chronic physical and/or mental health conditions preventing them from working.[22] There is evidence that having health insurance makes individuals more likely to find or maintain work. A separate survey conducted by the Institute for Healthcare Policy and Innovation at the University of Michigan found that 55% of people enrolled in HMP said the coverage helped them with their job search, and 70% said it helped improve their work performance.[23]

Issue 2: Individual Market Coverage and the Health Insurance Marketplace

Michigan's Individual Market

Approximately 6% of Michigan residents purchase health insurance coverage through the individual market. Prior to the Affordable Care Act (ACA), Blue Cross and Blue Shield of Michigan (BCBSM) served as the insurer of last resort. BCBSM was required to cover all individuals regardless of health status (guaranteed issue). Since January 1, 2014, the ACA requires all health plans offering coverage in the individual market to cover all individuals regardless of health status and with certain limits on premium adjustments. Individuals can purchase ACA-compliant individual market coverage in two ways: either through the Health Insurance Marketplace created under the ACA ("on-Marketplace"), or by purchasing coverage directly from an insurer ("off-Marketplace"). Insurers offering plans both on and off the Marketplace must comply with several rules instituted by the ACA to ensure access to comprehensive health insurance coverage and establish common standards among private health insurance plans.

Insurance Market Reforms: Terms to Know

- Guaranteed Issue: Insurers are prohibited from denying coverage to an individual based on their health status or a pre-existing condition.
- Community Rating: Insurers are prohibited from varying premiums based on health status or gender. Insurers are, however, allowed to charge differing rates based on age, geographic location, and smoking status.
- Essential Health Benefits (EHBs): Health plans offered in the individual and small group markets must provide coverage for ten categories of services deemed essential health benefits. In addition, certain preventive care services are covered with no out-of-pocket cost sharing.
- Metal Levels: The ACA created Bronze, Silver, Gold, and Platinum plans that cover varying levels of costs. Silver plans, which are the most popular types, cover 70 percent of costs. Low-income individuals who enroll in silver plans are eligible for extra reductions in their out of pocket costs.

Financial Assistance for Marketplace Plans

The ACA also created several types of financial assistance for individuals purchasing coverage on the Health Insurance Marketplace. Individuals between 100 and 400 percent FPL receive **tax credits** to help pay the cost of their premiums. Premium tax credits are based on two factors: the premium for the local benchmark silver plan (defined as the second-lowest-cost silver plan in the enrollee's county), and an enrollee's household income. Individuals receiving these tax credits contribute a percentage of their household income to their premium (ranging from approximately 2.01 to 9.56 percent of income). The amount of the tax credit is determined by subtracting the enrollee's premium contribution from the premium for the local benchmark plan. In addition, individuals between 100 and 250 percent FPL receive **cost-sharing reductions** to help lower deductibles and other out-of-pocket costs. Finally, the ACA sets **limits on the amount of out-of-pocket** consumer cost-sharing ($7,350 for individuals and $14,700 for families in 2018).

Trends in Plan Offerings, Pricing, and Enrollment

Michigan has a relatively stable and competitive individual health insurance market.[24] Since the launch of the Health Insurance Marketplace in 2014, the state has enjoyed high levels of insurer participation and plan options (see table below).

Michigan has not experienced the same degree of insurer exits as many other states, though several insurers did exit the Marketplace in 2016, 2017, and 2018. These insurers tended to be start-ups or had limited experience selling individual market products. In 2018, eight insurers sold coverage on the Marketplace, and each of Michigan's 83 counties had at least two insurers offering Marketplace coverage. Largely as a result of the decision by the federal government not to pay health plans for required cost sharing premium reductions and uncertainty about federal policy towards the ACA, premiums increased significantly in Michigan and many other states in 2018.[27] In addition, the federal government shortened the length of the 2018 open enrollment period by half – moving from a 12-week period for 2017 to a 6-week period for 2018. In part due to this volatility and policy uncertainty, Michigan and most other states experienced enrollment declines in 2017 and 2018. In Michigan, there were 293,940 individuals who enrolled in 2018 compared to 321,451 in 2017, a 9% decrease.

Michigan's Health Insurance Marketplace insurer participation and plan options

	2014	2015	2016	2017	2018
Number of carriers	13	16	14	10	8
Number of plans	73	193	165	167	90
Number of plan selections[25]	272,539	341,183	345,813	321,451	293,940
Average gross benchmark premium[26]	$254	$255	$260	$278	$381

Emerging Policy Actions: Federal Changes and Projected Impacts for 2019

Cost-sharing reduction payments and "silver loading"

Under the ACA, insurers offering Marketplace coverage must reduce cost-sharing expenses (e.g., deductibles and co-pays) for individuals earning less than 250% of the federal poverty line who enroll in silver plans. In 2017, 49% of Michigan residents who enrolled in Marketplace coverage received cost-sharing reductions.[28] The federal government reimbursed insurers to cover the cost of these payment reductions, but these federal payments were terminated in September 2017.

While the federal government will no longer make these payments to insurers, insurers are still required under the law to provide cost-sharing reductions to eligible individuals. In order to compensate for the lost CSR payment revenue, insurers in Michigan and many other states increased premiums on silver Marketplace plans, a practice referred to as "silver loading." As a result, in Michigan the average premium

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for a benchmark silver plan was on average 34% higher than the premium for those plans in 2017.[29] Because premium tax credits for individuals are based on the price of the second-lowest cost silver plan offered in an area, an increase in silver plan prices translates to an increase in the amount of tax credits eligible individuals receive. In 2018, 82% of Michigan's Marketplace enrollees received premium tax credits.[30] Silver loading insulates these individuals from the impacts of premium rate increases. It also allows consumers who would pay the full price of the Marketplace plan to enroll in a lower-priced but otherwise identical off-Marketplace silver plan. In 2018, silver plans accounted for 54% of plan selections in Michigan.

Individual mandate penalty repeal

The individual mandate of the ACA requires individuals to enroll in minimum essential coverage for a full year or face a financial penalty when filing that year's taxes. The intent of the individual mandate is to bring healthy individuals into insurance risk pools to ensure market stability. By requiring these individuals to purchase insurance, risk is spread across a broad population and premiums are kept lower than if only individuals with significant health needs were in the risk pool. In 2018, the individual mandate penalty is $695/adult or 2.5% of household income above $10,500, whichever is higher. According to the Internal Revenue Service (IRS), approximately 189,160 Michigan residents paid the individual mandate penalty in tax year 2015.[31]

In December 2017, President Trump signed into law the Tax Cuts and Jobs Act of 2017 (H.R.1). This legislation repeals the individual mandate penalty effective in 2019. It is expected that the lack of a financial penalty will cause some individuals to forego insurance coverage or switch to less generous, non-ACA compliant coverage. Because those who would shift coverage are likely to be young or healthy, premiums will increase for individuals who remain in the ACA-compliant market. However, in Michigan, fears of substantial premium increases in 2019 have not materialized: carriers are proposing a modest 1.7% average statewide rate increase for individual market plans in 2019.

Short-term coverage and Association Health Plans

In October 2017, President Trump issued an executive order directing the Departments of Health and Human Services, Labor, and the Treasury to issue regulations expanding access to Association Health Plans (AHPs) and Short Term Limited Duration Insurance (STLDI). These regulations are intended to provide greater access to alternative insurance options in the small group and individual markets.

In an Association Health Plan (AHP), multiple small employers with a common business interest may form an association to obtain health insurance for their employees. In June 2018, the U.S. Department of Labor finalized a rule to expand the types of employers that are allowed to form an AHP, and to regulate AHPs as large group health plans. By acting as a large group, AHPs may have greater negotiating power when purchasing insurance than if one small employer acted alone. AHPs are exempt from many of the ACA's requirements that apply to the individual and small group markets, though states have substantial authority to regulate this type of coverage. While AHPs cannot discriminate based on health status, these plans could still offer more limited benefit packages that would primarily appeal to those who are younger, healthier, or have lower health care costs. If healthy individuals shift from the small group market to AHPs, those that remained in the small group market would likely face higher premiums. According to the Congressional Budget Office (CBO), starting in 2023 approximately 4 million additional people will enroll in an AHP, 90 percent of whom will switch to an AHP from some other form of coverage.[32]

Short-term insurance plans are intended to provide temporary coverage to individuals and are generally not renewable, unlike most other insurance products. These plans have been available for purchase on the individual market since before the ACA. In 2016, the Obama Administration issued guidance restricting the duration of short-term plans to three months. In August 2018, the Departments of Health and Human Services, Labor, and Treasury issued a final rule that would expand the maximum duration of short-term coverage from 3 months to 364 days, with the ability to renew short-term plans for up to 36 months. While the rule allows states to continue to regulate short-term plans, many stakeholders, including state regulators, have raised concerns that short term coverage as defined by the new rules could further

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destabilize the individual market. State regulators do, however, have considerable authority to regulate these products.[33]

Short-term plans are exempt from most ACA requirements. They are not required to cover essential health benefits, are not subject to limits on cost-sharing, can impose annual and lifetime limits on coverage, and are allowed to exclude or charge higher premiums to individuals with pre-existing conditions. Because the scope of coverage is limited, short-term plans are often substantially cheaper than ACA-compliant plans. A Kaiser Family Foundation analysis estimated that the cheapest short-term plan available charged 20% of the premium for the cheapest ACA-compliant Bronze plan in an area.[34] However, this analysis also found that only 38% of available short-term plans covered substance use treatment services, 29% offered prescription drug coverage, and none offered maternity coverage.[35]

Short-term plans do not qualify as minimum essential coverage under the ACA, so individuals selecting these plans currently are subject to the individual mandate penalty. With repeal of the individual mandate penalty scheduled to take effect in 2019 and new federal rules extending the maximum length of these plans, it is expected that more individuals will shift from ACA-compliant coverage to short-term coverage. The CBO estimates that an additional 2 million individuals will enroll in short-term plans beginning in 2023, 65 percent of whom will have switched from another type of coverage.[36] Because these individuals are likely to be younger and healthier than the overall individual market, those who remain in ACA-compliant coverage will likely face a 2 to 3% increase in premiums, according to the CBO.[37]

The final rule upholds states' ability to regulate short-term plans, and states will have considerable latitude to restrict the sale of short-term plans and institute protections for those who purchase short-term coverage. Some states, including Michigan, currently regulate the sale of short-term plans beyond federal guidance. New Jersey, for example, bans the sale of short-term plans. Other states limit the duration of these plans, limit their renewal, or require coverage of certain benefits (though no state requires STLDI to cover essential health benefits). Currently, Michigan restricts the length of short-term coverage (including any renewals of that coverage) to a maximum of 185 days per year.[38] In addition, premiums from short-term plans cannot exceed 10% of an insurer's total individual market premiums.[39]

Issue 3: Opioids

Opioid Use in Michigan

The legal and illegal use of opioids – including prescription painkillers and illegal opioids such as heroin – has risen dramatically in both the United States and Michigan since the 1990s. Today, Michigan has the tenth worst opioid death rate in the nation. In 2016, there were 1,762 opioid overdose deaths in Michigan, accounting for 75% of all drug overdose deaths in the state.[40] In addition, Michigan has higher rates of opioid overdose deaths, opioid prescriptions, and neonatal abstinence syndrome (NAS) than the national average (see table on this page).

Rates of opioid overdose deaths, opioid prescriptions, and neonatal abstinence syndrome (NAS)

	Michigan	United States
Opioid overdose death rate (deaths per 100,000 persons) [41]	18.5	13.3
Opioid prescribing rate (opioid prescriptions per 100 persons) [42]	96.1	70
Neonatal abstinence syndrome rate (NAS cases per 1,000 births) [43]	6.7	6

Today's opioid epidemic began in the 1990s, when providers began prescribing increasing rates of opioid painkillers, such as oxycodone and hydrocodone, to their patients. Overdose deaths from prescription opioids began rising as early as 1999, and has steadily risen since then. More recently, illicit forms of opioids have contributed to the continued rise in overdose deaths. In 2010, overdose deaths from heroin began to rise, and more recently, overdose deaths involving synthetic opioids such as fentanyl have sharply risen as well.[44] Increases in illicit opioid use are a symptom of broader opioid use. As prescription opioids became more expensive and were reformulated to deter abuse, many prescription opioid users transitioned to heroin use because it was easier to obtain, cheaper, and more potent than prescription opioids.[45]

In Michigan, prescription painkillers account for most opioid-related overdose deaths. According to MDHHS, in 2015 there were 884 overdose deaths involving prescription opioids, compared to 391 overdose deaths involving heroin.[46] From 2009 to 2015, Michigan experienced a 41% increase in the number of opioid prescriptions written in the state. By 2016, there were 11 million prescriptions written for opioids in Michigan – meaning there were more opioid prescriptions written that year than there were residents of the state. Opioid prescribing rates are highest in mid-Michigan, the northern Lower Peninsula, and the Upper Peninsula.[47] However, deaths from prescription opioids and heroin are more dispersed across the state, and many of the counties with the highest death rates are located in the southeastern part of the state.

There are several types of strategies to address the opioid epidemic, including: access to treatment for opioid use (including both medication-assisted treatment and long-term recovery programs), harm reduction (e.g., using naloxone to reverse opioid overdoses), prescribing practices, and safe disposal.

Structure of the Substance Use Treatment System

As in many other states, Michigan residents wishing to receive services for substance use often face significant barriers to accessing treatment. Nationally, the Kaiser Family Foundation estimates that only 29% of individuals with opioid addiction received treatment for their addiction in 2016.[48] Medicaid is a primary source of treatment services for individuals with substance use disorder (SUD). Nationally, nearly 40% of adults under age 65 with an opioid addiction are covered by Medicaid, and adults covered by Medicaid are more likely to receive substance use treatment than those with private coverage.[49] Medicaid covers inpatient and outpatient substance use treatment services, as well as medication-assisted treatment (such as buprenorphine or methadone). Unlike many private insurers, Medicaid also provides case management, counseling, peer supports, supported employment, and other services for individuals with substance use disorders.

Within the Michigan Department of Health and Human Services (MDHHS), behavioral health and SUD treatment services fall under the authority of the Behavioral Health and Developmental Disabilities Administration (BHDDA) and Medical Services Administration (MSA), the state Medicaid agency. MSA manages outpatient mental health services for Medicaid-covered individuals with mild to moderate mental health needs. BHDDA administers state-funded substance use disorder programs, the federal Substance Abuse Prevention and Treatment Block Grant and Mental Health block grant, and other specialty services and supports.

There are three types of organizations that manage and administer publicly-funded behavioral health benefits: Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHs), and Substance Abuse Coordinating Agencies (CAs). PIHPs receive fixed monthly (“capitated”) payments from MDHHS to manage behavioral health services for Medicaid enrollees. MDHHS allocates funds to PIHPs based on the number of Medicaid enrollees in their service area. PIHPs use their capitated payments to pay providers directly for their services. County-based CMH agencies provide comprehensive mental health services to children and adults with serious mental illness and/or intellectual/developmental disabilities. CAs provide comprehensive planning for substance use treatment, recovery, and prevention services. Following the merger of CAs with PIHPs in 2014, PIHPs are now responsible for the coordination of substance use disorder services. Ten PIHPs and 46 CMHs serve all 83 of Michigan’s counties.

Prior to the passage of the ACA, SUD services were primarily funded through the state general fund, local community funds, and federal block grant funds. Medicaid expansion shifted nearly the full cost of these services to the federal government as many individuals receiving SUD services enrolled in the Healthy Michigan Plan and therefore received enhanced federal funding for services. Of the $235 million in annual state budget savings resulting from Medicaid expansion, $168 million came from Medicaid-funded mental health services that were previously funded through the state general fund.[50] At the same time, the federal government continued to provide stable funding for the Substance Abuse Prevention and Treatment Block Grant, meaning more resources became available for SUD with the shift in Medicaid costs to the federal government. In Michigan, this resulted in increased access to coverage for peer services and medication-assisted treatment that PIHPs had previously been unable to provide. In FY2016, 14% more people in Michigan received SUD services than in FY2012, prior to Medicaid expansion. Residential admissions for SUD treatment increased by nearly 40% during this period.[51]

Emerging Policy Actions: Prevention and Treatment

The Michigan Legislature and the Snyder Administration have taken several actions to attempt to address the opioid epidemic in Michigan, including the introduction of a bipartisan legislative strategy in early 2017. These actions attempt to address opioid prescribing practices, expand access to treatment, and increase the availability of naloxone to reverse opioid overdoses.

In 2017, Michigan launched a new prescription drug monitoring system, known as the Michigan Automated Prescription System (MAPS). MAPS tracks prescriptions of controlled substances and scheduled drugs, which can help health care providers identify individuals at risk of prescription drug abuse. On December 27, 2017, Lt. Gov. Brian Calley signed into law legislation requiring health care providers to check the Michigan Automated Prescription System (MAPS) before prescribing opioids to a patient. The state is providing funding for health systems, physician groups, and pharmacies to integrate MAPS into their clinical workflows, allowing health care providers to have immediate access to prescription drug information in a patient's electronic medical record. These changes aim to increase the number of prescribers using MAPS.

Health systems in Michigan are also pursuing initiatives to change opioid prescribing practices among physicians. The Michigan Opioid Prescribing Engagement Network (Michigan OPEN), housed at the University of Michigan, received a $7 million five-year grant from MDHHS to curb opioid prescribing in acute care settings, particularly after surgery. Michigan OPEN also works with health systems to reduce the illegal diversion of prescription opioids and provides information to the public on safe opioid disposal.

In May 2017, MDHHS Chief Medical Executive Dr. Eden Wells authorized a standing order for naloxone, which allows Michigan pharmacies to dispense naloxone over-the-counter to individuals at risk of an overdose and their family members and friends, without a doctor's prescription. The intent of the standing order is to increase access to naloxone, which reverses the effects of an opioid overdose and can prevent overdose deaths. As of May 2018, Michigan pharmacies have dispensed 7,154 orders of naloxone, 2,306 of which were authorized through the standing order and 4,848 of which were prescribed by other physicians.[52]

Some states have enacted opioid prescribing limits for physicians; these generally include limits on the quantity of opioids prescribed, the number of days supplied, or dosage limits. Some states have also instituted "first fill" restrictions – limits on the amount of opioids prescribed to first-time users – in an attempt to prevent new opioid users from progressing down a continuum of opioid use. Michigan has not adopted these approaches, but several commercial payers in the state have. For example, Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan instituted 30-day limits on opioid prescriptions for their members beginning in February 2018. Priority Health and Health Alliance Plan have implemented similar prescribing limits.[53]

States are also working to address barriers to accessing substance use treatment. Many opioid users recover from addiction using medication-assisted treatment (MAT) to mitigate symptoms of opioid withdrawal. Methadone has historically been the primary MAT method, but newer medications such as buprenorphine have less potential for abuse and are somewhat easier to administer. However, physicians who are authorized to prescribe buprenorphine can do so for no more than 100 patients. Recent changes in federal law have attempted to increase the number of certified buprenorphine providers, but Michigan has a shortage of certified providers, meaning many individuals are unable to access buprenorphine. According to a recent analysis conducted by Avalere, in 2016 there were only 670 certified buprenorphine providers in Michigan – meaning there were over 2.5 opioid overdose deaths for every buprenorphine prescriber in the state that year, compared to a national average of 1.6 opioid overdose deaths for every buprenorphine prescriber.[54] Increasing the number of providers who can prescribe buprenorphine could allow more individuals to access MAT.

Issue 4: Integration of Services

Integrating Health and Human Services to Address Social Determinants of Health

Social and environmental conditions, such as housing, education, employment, and socioeconomic status, have an important influence on health outcomes. These factors account for 50 to 60 percent of health outcomes, while clinical care accounts for just 10 to 20 percent.[55] Commonly referred to as "social determinants of health," the environments in which people live are the primary drivers of their health. Social determinants of health can include income, education, employment, food security, access to transportation, air and water quality, and racial and ethnic discrimination. Inequities in social and economic conditions often lead to health disparities, defined as differences in health outcomes between populations. Policymakers seeking to reduce health disparities in our state should understand the outsized impacts of social determinants of health in order to target policy solutions accordingly.

Clear health disparities can be found in Michigan across both geography and race/ethnicity. An example of a geographic disparity would be the difference in health outcomes between residents of neighboring Oakland and Wayne counties. Though these counties share a border, their residents experience a vastly different quality of life. Oakland County ranks ninth in the state and Wayne County ranks last among Michigan's 83 counties for general health outcomes (length and quality of life).[56] As an example of a racial disparity, the overall infant mortality rate in Michigan has declined significantly over the past 40 years, but declines in infant mortality were greater for White residents than for Black residents.[57] Infant mortality rates have not declined at the same rate across different racial and ethnic groups, and the infant mortality rate has actually worsened for infants born to Arab women.[58]

Infant mortality rate (per 1,000 births)	2005-2007	2011-2013	Change, 2005-2007 to 2011-2013
Black	17.3	13.8	-20.2%
American Indian/ Alaska Native	9.7	7.5	-22.7%
Arab	6.8	7.2	+5.9%
Asian	7.6	4.6	-39.5%
Hispanic	7.5	6.5	-13.3%
White	6.0	5.2	-13.3%

Given the large impact that social and economic factors have on health outcomes, the health care sector has begun to pay more attention to interventions that can address these factors. Historically, efforts to improve health outcomes have focused primarily on improvements within the traditional health care system. However, with a growing recognition that social and economic factors significantly impact health, recent initiatives at the local, state, and federal levels as well as within the private sector have attempted to address social determinants of health, reduce health disparities, and link health care and human services systems. In Michigan, there are numerous efforts at the state and local levels to address social determinants of health. Two main areas in which communities are working are: strengthening connections between the worlds of health care and human services, and integrating behavioral and physical health care.

Historically, the delivery of services related to social determinants of health have been a primary focus of two public systems: local public health and community mental health. 30 county-level health departments, 14 multi-county health departments and one city health department serve all 83 of Michigan's counties. In addition to clinical services, disease surveillance, food safety, and other public health responsibilities, local health departments promote healthy behaviors and chronic disease prevention, work to improve nutrition and physical activity, address tobacco and substance use, and engage in policies related to access to health insurance, affordable and safe housing, and education.[59] Of the 46 community mental health service programs in Michigan, 32 are single-county and 14 serve multiple counties. In addition to mental health services, CMHs provide a variety of other supportive services to address social determinants. To carry out these responsibilities, local health departments and CMHs receive funding from a variety of sources, including state and federal grants, Medicaid funding, state general funds, and county funds.

The Affordable Care Act encouraged health systems to place a greater emphasis on addressing the health of the populations and communities they serve. Under the ACA, tax-exempt nonprofit health systems are now required to conduct Community Health Needs Assessments (CHNAs) every three years. Often conducted in partnership with community organizations and local government entities, CHNAs help hospitals identify health needs in a community, prioritize strategies to respond to the needs, and communicate progress on addressing the needs. Over time, health insurers have also become increasingly aware of the connection between medical care and social determinants of health, and many health plans in Michigan have launched efforts to address social determinants of health among their members.

Emerging Policy Actions: State Innovation Model

The State Innovation Model (SIM), a federal grant program administered by the Center for Medicare and Medicaid Innovation (CMMI), encourages states to pursue innovative approaches to connect health care and human services systems. Michigan's 3-year SIM grant aims to meet the goals of the Institute for Healthcare Improvement's Triple Aim: improving population health, improving quality and patient satisfaction, and reducing per capita health care costs. Michigan's SIM has two major initiatives: Patient-Centered Medical Homes, and Community Health Innovation Regions.

Over 300 primary care practices statewide are designated as SIM Patient-Centered Medical Homes (PCMHs). These practices receive payments to transform their health care delivery, as well as dedicated funding for care teams to manage population health. SIM PCMH practices are also required to screen patients on an annual basis for socio-economic needs and connect patients to local resources to address those needs. Practices screen for a variety of social determinants of health, including food insecurity, housing, transportation, and unemployment.

Five regions of the state are designated as Community Health Innovation Regions (CHIRs): Genesee County, Jackson County, Muskegon County, Washtenaw/Livingston Counties, and ten counties in the Northwest Lower Peninsula. CHIRs are tasked with testing innovative ways to align health care and human services systems in their community and establish interventions to address the needs of individuals who frequently use the emergency department. These interventions are developed through a community process to connect residents with high emergency department (ED) usage to needed social services. In addition, some CHIRs are aggregating data from local SIM PCMH social needs screenings to identify gaps in services and prioritize funding for resources in their communities.

Integrating Mental Health and Primary Care Services

Michigan residents have higher rates of depression and anxiety than the national average. According to the Centers for Disease Control and Prevention (CDC), 22% of Michiganders reported being diagnosed with depression at one point in their life, compared to 17% nationwide.[60] However, Michigan's mental health care system is fragmented and does not have sufficient capacity to meet demand for mental health services.

In Michigan, as in most other states, behavioral and mental health care is delivered separately from physical health care. Individuals most commonly seek treatment for mental health issues in emergency rooms and primary care settings, but ER and primary care providers often are not able to treat mental health needs. Physical health providers will sometimes refer these patients to behavioral health providers, but face barriers due to mental health provider capacity issues or insurance coverage. Many behavioral health referrals end up being unfulfilled, either due to lack of provider capacity or because the patient did not follow through on the referral. As a result, between 60 and 70 percent of those who seek behavioral health treatment in ERs and primary care settings in the United States end up leaving those settings without receiving treatment for their behavioral health condition.[61]

To address unmet mental health treatment needs, states and the federal government are increasingly investing in new primary care models that provide comprehensive and coordinated physical and behavioral health services, with the goal of improving health outcomes and lowering health care costs. One area of focus is the integration of behavioral health services in primary care sites. Some mental health conditions, such as depression and anxiety, can be managed within a primary care setting.[62] In a fully integrated model, primary care providers screen all patients for behavioral health issues, including SUD, depression, and other conditions; provide self-management support and some behavioral interventions; direct a care team (which can include a care manager and/or behavioral health specialist) to treat behavioral health conditions; and refer patients to psychologists or psychiatrists, as needed.[63]

Emerging Policy Actions: Section 298 Initiative

In Michigan, the effort to integrate physical health and behavioral health benefits within Medicaid is commonly referred to as the "Section 298 Initiative." This term refers to section 298 of Governor Snyder's FY2016-2017 executive budget, which called for the transition of Medicaid behavioral health benefits from the existing PIHP system to Medicaid Health Plans. Partially in response to backlash from stakeholders who wanted more input in the planning process, the final FY2016-2017 budget instead directed MDHHS to form a working group to develop recommendations for the integration of physical and behavioral health services within Medicaid. Throughout 2016, the Section 298 work group met regularly to develop over 70 policy recommendations delivered to the Legislature in March 2017.[64]

The FY17-18 budget directed MDHHS to develop a pilot program where Medicaid Health Plans would contract with the state to manage both physical and behavioral health services in the pilot's geographic region. Medicaid Health Plans will, in turn, contract with local CMHSPs to deliver specialty behavioral health services in pilot regions. The pilots will test whether or not financial integration of Medicaid physical and behavioral health benefits will result in greater coordination of these services for consumers – defined in terms of better health outcomes, increased efficiencies in service delivery, and increased reinvestment in behavioral health services.[65] In March 2018, MDHHS announced the selection of three pilot sites: Muskegon County CMH and West Michigan Community Mental Health; Genesee Health System; and Saginaw County Community Mental Health Authority. MDHHS originally targeted a pilot launch date of October 1, 2018, but has since delayed implementation until October 1, 2019.[66] Pilots will operate for at least two years.

Conclusion

With the expansion of Medicaid and the launch of the Affordable Care Act's individual Health Insurance Marketplace, the numbers of uninsured Michiganders have been considerably reduced since 2013. Yet Michigan policy makers will still face numerous policy issues and decisions related to health care coverage, health disparities, and access to care in the years to come. Our state will continue to struggle with complex health issues such as substance use and access to mental health services. Michigan policy leaders, local public health agencies, and the private sector are engaged in many innovative initiatives to address these issues and improve the health of communities. In particular, the state has committed to programs that are intended to improve health equity and focus on the social determinants of health. All of this work is being conducted at a time of great political change and considerable turmoil at the federal level. The new governor and the 100th Legislature will be faced with both tremendous responsibility and opportunity to shape the health policy landscape for years to come.

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