Children's Special Health Care Services and Michigan's High Risk Pool
Issue Brief
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Executive Findings

The Michigan Department of Community Health, Children's Special Health Care Services Division conducted an analysis to determine whether it would be financially advantageous for the state to require CSHCS adult enrollees with cystic fibrosis and hemophilia to enroll in the Health Insurance Plan of Michigan (HIP) – Michigan's federally funded high risk pool, and the potential cost savings to the state. Enrollment is currently voluntary for any individual eligible for HIP. Based on the results of this analysis, it is recommended that:

- Enrollment in HIP be mandatory for adult CSHCS clients with cystic fibrosis
- Enrollment in HIP be mandatory for adult CSHCS clients with hemophilia with diagnosis codes 2860, 2861, 2862, and 2863.
- Enrollment in HIP be encouraged but remain voluntary for adult CSHCS clients with hemophilia with diagnosis code 2864 (Von Willebrands Disease).
- Enrollment in HIP be encouraged but remain voluntary for other adult CSHCS clients as well as eligible children until further analysis can be conducted.

Background

A central goal of health care reform has been to ensure that everyone, regardless of health status, has access to adequate, affordable insurance coverage and medical care. The Affordable Care Act (ACA) was signed into law in March of 2010. Many of the major protections afforded to consumers in the ACA will not be implemented until January 1, 2014, including the prohibition of denying coverage to adults based on pre-existing conditions. Effective September 23, 2010, the ACA prohibits the denial of coverage to anyone under age 19 regardless of pre-existing condition. To provide some current relief for consumers with pre-existing conditions prior to 2014, the ACA established temporary high risk pools to bridge this time gap in coverage. Section 1101 of the ACA established a "temporary high risk health insurance pool program". The pools provide health coverage for uninsured individuals with pre−existing conditions until insurance exchanges are available in 2014. These temporary high risks pools, called the Pre-existing Condition Insurance Plans (PCIPs), are federally supported programs run within each state.

In Michigan the PCIP is the Health Insurance Plan of Michigan (HIP), and it is run through Physicians Health Plan, an affiliate of Sparrow Hospital. HIP Michigan has three eligibility requirements:

- U.S. citizen/legal resident in Michigan.
- Uninsured by creditable coverage for at least six months.
- Have an eligible pre−existing health condition.

Before any consideration of dually enrolling the Children's Special Health Care Services (CSHCS) population with HIP, the definition of creditable insurance coverage and how that definition applies to CSHCS needed to be formally determined. The federal Centers for Medicare and Medicaid Services (CMS) determined that CSHCS is not 'creditable coverage' since CSHCS only covers the specialty care for the CSHCS qualifying condition. Because of this determination, CSHCS clients with no other insurance meet this particular HIP Michigan eligibility requirement and therefore CSHCS was able to continue with an analysis of the cost effectiveness of enrolling certain enrollees in HIP of Michigan in addition to maintaining their CSHCS as payer of last resort.

A further potential benefit of enrollment in HIP is access to comprehensive care because CSHCS only covers the CSHCS qualifying condition. HIP enrollment would provide a more comprehensive coverage for this population not available through CSHCS alone. Access to comprehensive care which includes primary and other care has been shown to improve health outcomes which could result in reduced costs for the CSHCS qualifying diagnosis as well.

CSHCS and HIP Michigan

CSHCS currently has an insurance premium payment benefit for enrollees who cannot afford their private insurance premiums and this benefit is only applicable when it is found to be cost effective to the state. The benefit pays the private health insurance premium for the CSHCS client. This benefit enables the state to maintain a status of payer of last resort and prevents a shift in the full cost of medical services from private health insurance to CSHCS state dollars.

CSHCS began investigating whether the use of the HIP Michigan program could reduce the expenditure of state dollars. The analysis focused on the adult CSHCS population (ages 18 and up) since the prohibition of pre-existing condition exclusions does not take effect for adults until 2014.

Any individual with CSHCS may apply for HIP enrollment voluntarily at any time and, if determined eligible, may request premium payment assistance from CSHCS. The premium payment requests for voluntary enrollment into HIP must undergo the cost effectiveness analysis per person per the current CSHCS procedure.

However, due to the potential cost benefits to the state in addition to the health benefits for enrollees, the state needs to consider requiring enrollment for adult CSHCS clients in high cost diagnostic categories. Cystic fibrosis and hemophilia are the only diagnoses that are eligible for CSHCS beyond the age of 21, and the cystic fibrosis and hemophilia groups tend to have high medical costs. Therefore, the initial cost analysis for enrollment of CSHCS adult enrollees into HIP focused on these two diagnoses.

Analysis

Initial Population

An analysis was conducted to determine whether it would be financially advantageous for the state to require CSHCS adult enrollees with cystic fibrosis and hemophilia to enroll in HIP, and

the potential cost savings. Mandatory enrollment for a group of individuals would also bypass the need for the labor-intensive case by case determination of cost effectiveness. The enrollees identified for analysis were age 18 and above with a diagnosis that is covered over the age of 21 (cystic fibrosis and hemophilia), and who do not have commercial health insurance, Medicaid, Medicare or MIChild. With these parameters in place, CSHCS identified 226 enrollees who fit the criteria. These include 90 cystic fibrosis cases and 136 cases with blood clotting disorders. The blood clotting cases were broken down by five diagnosis codes:

- 69 with diagnosis 2860, CONG FACTOR VIII DIORD
- 23 with diagnosis 2861, CONG FACTOR IX DISORDER
- 1 with diagnosis 2862, CONG FACTOR XI DISORDER
- 2 with diagnosis 2863, CONG DEF CLOT FACTOR NEC
- 41 with diagnosis 2864, VON WILLEBRAND'S DISEASE

Assumptions

In order to conduct the cost analysis some assumptions were made. HIP offers plans with three varying premium and deductible levels. The higher premium plans include a lower deductible, whereas the higher deductible plans include a lower premium. For this analysis, we estimated the cost savings for both the highest premium plan and the highest deductible plan. It was assumed that the actual deductible amount paid by the state would be about half of the total deductible, since the reimbursement from the state for services provided would be below commercial reimbursement rates. Providers who participate with CSHCS are obligated to accept the lower payment from CSHCS as payment in full, and therefore the enrollees' full deductible will be reached even though the state will pay a lesser amount.

The HIP program has an annual $100,000 limit on pharmacy benefits. For clients with an average yearly cost to the state of over $100,000, it was assumed that the cost savings to the state for these clients would be $100,000. Expenditures over $100,000 would continue to be covered by CSHCS. The annual cost for many enrollees with hemophilia exceeds $100,000 due to the high pharmaceutical costs.

Revenue to the state from CSHCS enrollee payment agreements represents just a small fraction of the medical costs paid for by the state for these enrollees. Since the payment agreement amount varies for each enrollee and can vary each year, this revenue was not included in the cost analysis.

Cost Analysis

An analysis with a sample of 37 (16%) cases was conducted to compare the cost of enrolling in HIP – premiums and non-covered medical expenses -- to the cost (based on experience) for medical care and treatment. The analysis consisted of 10 clients with cystic fibrosis and 27 with a blood clotting disorder. A sample of CSHCS beneficiaries from each identified diagnosis code group was identified. Data for the sample population was gathered from the CSHCS database expenditure report. The results of the analysis were based on the average yearly cost to the state of Michigan. The average yearly cost was determined by looking at the total medical costs per client over a 20 month period from January 2010 through August 2011, and then calculating an

average annual amount based on this experience. This average yearly cost to CSHCS for paying for all medical and treatment for the qualifying diagnosis was compared to the annual HIP premium and related deductible costs the state of Michigan would still expend after enrolling the sample population in the HIP program for comprehensive coverage. A potential cost savings for the sample population was calculated based on these figures. The total cost savings for each sample population were used to extrapolate the potential cost savings for the entire population.

The table below represents the results of the cost analysis for adults with cystic fibrosis and blood clotting disorders (BCD), for the highest annual premium, lowest deductible plan. The potential savings in this plan exceeded the savings for the lowest annual premium, highest deductible plan. The sample size is included in the table next to potential cost savings along with the actual population in the extrapolated cost savings column.

Diagnosis Code	**Potential Cost Savings from Sample**	**Extrapolated Cost Savings for Population**
Cystic Fibrosis	$226,576 (n=10)	$2,039,185 (n=90)
BCD 2860	$679,079 (n=9)	$5,161,006 (n=69)
BCD 2861	$195,814 (n=5)	$900,746 (n=23)
BCD 2862	$12,915 (n=1)	$12,915 (n=1)
BCD 2863	$19,453 (n=2)	$19,453 (n=2)
BCD 2864	$15,080 (n=10)	$60,322 (n=41)
Total	**$1,148,917 (n=37)**	**$8,193,627 (n=226)**

*CSHCS Database Expenditure Report October 2011

Findings

Based on the analysis, a cost savings for the state would be achieved by enrolling the 18 and over population with cystic fibrosis and hemophilia into HIP. For all six diagnosis categories examined, an overall cost savings would be achieved. However, seventy percent of the cases in the 2864 code diagnosis group showed an increased cost to the state by enrolling in HIP. For the other five diagnosis codes, an overwhelming majority of the cases showed a decreased cost to the state if enrolled in HIP. Therefore, it is recommended that enrollment for the 2864 code group remain voluntary and that individuals in this group would need to have a cost effectiveness analysis performed individually. It is recommended that enrollment for the other five diagnosis groups become mandatory, with an estimated savings to the state of approximately $8,000,000 per year.

CSHCS has been working closely with HIP Michigan on the dual enrollment of this population into HIP. Discussions continue on how to approach the enrollment process most efficiently for CSHCS, enrollees, and HIP. The expectation at this time is for CSHCS to send a package to the mandatory HIP enrollment group that contains the HIP application, and a letter that explains the requirement to enroll with HIP along with instructions. The premium amount will already be identified by CSHCS. Mandatory enrollees will be instructed to return the application to CSHCS. Once received, CSHCS will then attach a document that has been signed by a CSHCS medical consultant and submit the documentation to a specified person at HIP. CSHCS and HIP will

agree on the most efficient manner with which to handle the premium payments as enrollment occurs.

In addition, other CSHCS enrollees (adults and children) will be contacted and informed that they might be eligible for HIP, and to contact CSHCS for a cost effectiveness determination regarding the payment of the HIP premium. At this time mandatory enrollment is not recommended for other diagnostic groups, but additional analyses for other groups will be conducted. Further analyses will be required once decisions have been made in Michigan regarding the design and implementation of the MIHealth Marketplace – Michigan's health insurance exchange. A state-run health insurance exchange or participation in a federally run exchange is expected in 2014.