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Healthcare Costs and Premiums: Michigan Compared With Selected Benchmark States

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1.0 Introduction and Executive Summary

1.1 Origins of the Study

In 2002, the Michigan Economic Development Corporation (MEDC) commissioned SRI International to perform a study on a number of high-level factors that could affect the business climate and competitiveness of Michigan. In the study, Michigan was compared with 17 similar ("benchmark") states.[1] The study identified Michigan's employer paid health insurance premiums for singles in 1999 as the highest of the benchmark states.[2]

MEDC commissioned Altarum, a non-profit research and innovation institute, to analyze the healthcare premium issue in greater depth. The primary objectives of the study were to:

- Determine the extent to which Michigan healthcare premiums are higher when compared with the benchmark states.
- Identify the factors that exert upward pressures on premiums in Michigan.
- Prepare recommendations on the actions Michigan can take to reduce healthcare premium inflation.

1.2 Overview of the Work Conducted for This Engagement

The steps below highlight the activities employed in this engagement.

1. Altarum performed an in-depth review of the most recently available six years of state level premiums data from the Medical Expenditure Panel Survey (MEPS) adding into the analysis the cost of family coverage, percentage of employees who take insurance and select family coverage, the employers' contribution to the cost of premiums, and other indicators. Michigan's data was compared with the weighted data of the benchmark states to determine the gap between employer paid premiums in Michigan and the benchmark states. A retrospective review was also employed to determine trends in the findings. At the beginning of this engagement, the MEPS data had only been collected and released for the years 1996 to 2000. Data for 2001, released at the end of August 2003, have been added to provide a broader perspective on healthcare premiums.
2. Based on prior policy and economic analyses performed in the healthcare industry, Altarum and the MEDC identified 16 factors that potentially have the greatest effect on employer premiums.

[1] The benchmark states are: Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Minnesota, North Carolina, Ohio, Pennsylvania, Texas, Virginia, Washington, and Wisconsin.
[2] This data comes from the Medical Expenditure Panel Survey (MEPS) and is collected by the Agency for Healthcare Research & Quality.

3. Comparable data for the 16 factors was researched for Michigan and each of the benchmark states. For most of the factors, multiple indicators were collected and in total over 200 descriptive data series at the state level were collected and analyzed for this study. The effect each factor had on healthcare premiums was evaluated. Factors where Michigan appeared to be outside of the norm were analyzed further to determine if the data suggested that the factor contributed to higher premiums.
4. Based on our analysis of the data, recommendations were developed.

This report assembles the key findings, supporting documentation, and strategies that Michigan should consider to improve the competitiveness of the state with respect to lowering the rate of growth of healthcare premiums.

1.3 Major Findings

Nationally, employer-based healthcare premiums have been increasing, leading to concern by policy makers across the country. Employer surveys indicate that premiums increased, on average, 10.9% in 2001, 12.9% in 2002, and 13.9% in 2003 – the highest rate of increase since 1990.[3] Healthcare costs have also been increasing but not at the same rate, though much faster than income. Per capita healthcare spending increased by 7.5% in 2001 and 8.3% in 2002.[4]

A number of observations arise from the analysis of the 16 factors**:**

- **Obesity, smoking, and related diseases are particularly prevalent in Michigan.** Michigan's high rate of obesity (2nd highest of the benchmark states), smoking (6th highest), coronary heart disease death (highest in the benchmark states), and diabetes (2nd highest) are most likely increasing healthcare costs and therefore healthcare premiums. Overweight and obese individuals incur up to $1,500 more in annual medical costs than healthy-weight individuals, according to a two-year study of nearly 200,000 employees of General Motors.[5] To complicate matters, obesity has been linked to coronary heart disease, diabetes, some types of cancer, and other medical problems.
- **Michigan's per capita use of prescription drugs is high.** Michigan's per capita drug expenditures and utilization are significantly higher than the benchmark and U.S. averages. Per capita expenditures on drugs and other medical non-durables is almost 14% higher in Michigan than the benchmark states and the number of retail prescriptions per capita in Michigan is 19% above the benchmark states.
- **Michigan employees are more likely to choose family coverage.** In 2001, 58% of Michigan's covered employees selected family coverage, compared with 53% for the benchmark states. Family premiums average 2½ times

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[3] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits – 2003 Annual Survey*, Washington, DC, September 2003.

[4] Levit et al, "Health Spending Rebound Continues in 2002" *Health Affairs*, 23(1):147-159, January/February 2004.

[5] Dee W. Edington, Ph.D., of the University of Michigan as reported in January/February issue of the *American Journal of Health Promotion.*

higher than the premiums for singles. This means that Michigan, with a higher proportion of family coverage, tends to have higher average premiums when both single and family coverages are included in the calculation. This raises Michigan's overall average premium relative to the benchmark states.

- **Michigan employers pay a greater share of the premiums/cost of health insurance.** This is particularly true for family coverage – In 2001 Michigan employers paid 84% of the premiums/cost of health services where employers in the benchmark states paid 77%.

The high rate of obesity, coronary heart disease, smoking, and diabetes and the higher prescription use has an effect on healthcare premiums in Michigan. Despite this, the state's per capita healthcare expenditures are about average,[6] based on 1998 data from Centers for Medicare and Medicaid Services, the most recent data available.

The higher percentage of Michigan employees taking family coverage and higher employer shares of premium payments also affects the average employer premium payment. Michigan's average employer paid premium per covered employee was 14% higher than the average for the benchmark states in 2001,[7] the most recently reported year for this data, up from an 11% gap in 1996, but not as high as the 22% gap in 2000.

Along with the factors that increased costs, there are factors that identify Michigan as either similar or put Michigan in an advantageous position relative to the benchmark states. The following factors affect premiums but do not cause Michigan to stand out significantly from the benchmark states.

- **Cost Shifting –** The percentage of Michigan citizens who are uninsured or have Medicare and Medicaid coverage is comparable to the percentage in the benchmark states.
- **Demographics –** The median age, household make-up, percentage of urban versus rural residents, and other demographic indicators for Michigan are similar to the benchmark states.
- **Quality of Care** – Michigan receives average ratings from independent third parties on the quality of care given by state providers.
- **State Mandates** – The number of state mandates for specific healthcare coverage in Michigan does not identify the state as being different from the norm.
- **Managed Care Penetration –** The percentage of the state's population with HMO coverage is slightly below average.
- **Economic Status –** Median household income, percentage of residents living in poverty, the unemployment rate and other indicators of economic status suggest that overall, Michigan is on a par with the benchmark states.
- **Physicians and Caregivers** – The number of physician, nursing, and hospital providers per capita in Michigan is about average.

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[6] 1998 State Estimates, All Payers, Per Capita Personal Health Care, Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

[7] This data comes from the Medical Expenditure Panel Survey (MEPS) and is collected for the Agency for Healthcare Research & Quality.

- **Hospital Utilization** – The admissions per million residents, hospital beds per thousand, and hospital occupancy for Michigan is average.
- **Malpractice Costs –** The cost of malpractice insurance that physician's purchase may be higher in Michigan, but the overall effect on employers' premiums should be small.[8] Michigan is not one of the states recently identified as having a problem with malpractice costs.

1.4 Recommendations

1. Redouble Efforts to Support Health Promotion and Disease Prevention

Current efforts by the state of Michigan to encourage healthy lifestyles, prevent disease, and otherwise promote health should be expanded. Specifically, the state should consider further steps to support health promotion efforts in the state, including workplace initiatives. Educational interventions on fitness and the effects of obesity should be especially prominent. Where possible, the state should enhance its programs to facilitate physical education.

2. Introduce Insurance Industry Structure Reforms

In the past, Michigan needed to "level the playing field" for all insurers and health plans selling coverage in Michigan's small-group health insurance market by requiring that they all abide by the similar rules regulating the extent to which they can vary premiums. Legislative actions in Michigan are the first step in reaching this goal. In Public Act 88, signed by Governor Granholm, the state has established "adjusted community rating" rules that are applicable to all small-group insurers and health plans and limit total allowable group-to-group variation in premiums. As the provisions of this act are implemented and health plans begin to community rate, the state should review the resulting effects on small employer premiums.

Additionally, given the strong likelihood that the market share of Blue Cross and Blue Shield (BCBSM) will remain high, both the state and the BCBSM Board of Directors should be rigorous in holding the organization accountable for efforts to operate efficiently and to use its market power in the interest of those who get health coverage through BCBSM.

3. Focus Efforts to Reduce Prescription Drug Expenditures

To reduce prescription drug expenditures Michigan should:

- Promote the use of generic medications and tiered pharmacy benefit programs that result in higher prices for brand name drugs (non-generic), and even higher prices for lifestyle drugs.

[8] A March 2002 government report by MedPAC, a congressional advisory commission, says doctors, on average, were expected to spend 3.2% of their revenue on malpractice insurance in 2001. That compares with 12.4% for staff salaries, 11.6% for office expenses, and 1.9% for medical equipment.

- Continue in its efforts to increase its purchasing power via multi-state coalitions and contracted prices for highly used prescription drugs.

4. Obtain Federal Funding Enhancements for Low-Income Populations

It is to the state's advantage to make every effort to increase its share of federal reimbursement for publicly insured residents along the following lines:

- The state should support a national solution to the problem of the uninsured that encompasses a substantially increased federal financial commitment including appropriate payment levels for the covered services. Additionally, a federally funded stimulus package that substantially, but temporarily, raises the Federal Medical Assistance program's match rate should be sought.
- At the local level the state should ensure that it is taking advantage of all available opportunities for federal funding of various health initiatives, especially establishing Federally Qualified Health Centers.

2.0 Analysis of Factors that Affect Healthcare Costs and Premiums

2.1 Factors Researched in the Analysis of Healthcare and Premium Costs

This section summarizes the analysis of 16 factors that could have an effect on healthcare costs and therefore premiums, and shows where Michigan stands compared with the benchmark states. The following section focuses on a comparison of the premiums employers pay. Data, where available, were collected and compared for the 16 factors listed in Exhibit 2-1.

Exhibit 2-1: Factors Researched in the Analysis of Healthcare Costs and Premiums

Factor	Factor Description
A.	Economic structure of the state
B.	Differences in coverage and benefits
C.	Healthcare insurance industry structure
D.	Cost shifting
E.	Demographics
F.	Health status
G.	Health behaviors
H.	Quality of care
I.	State Mandates
J.	Managed care penetration
K.	Economic status
L.	Physicians and caregivers
M.	Hospital utilization
N.	Malpractice costs
O.	Prescription drug costs
P.	Healthcare costs

Each factor was carefully researched. Where comparable aggregate state level data was found, an analysis was performed to determine if the data depicted a compelling story as to reasons Michigan's premiums/cost of health insurance were higher. Factor B the "Differences in coverage and benefits," was researched, but comprehensive state level data was not readily available.

The following discussion provides the top line analysis of how each of the factors affect premiums and the cost of health insurance, and whether Michigan is favorably or unfavorably affected by the factor.

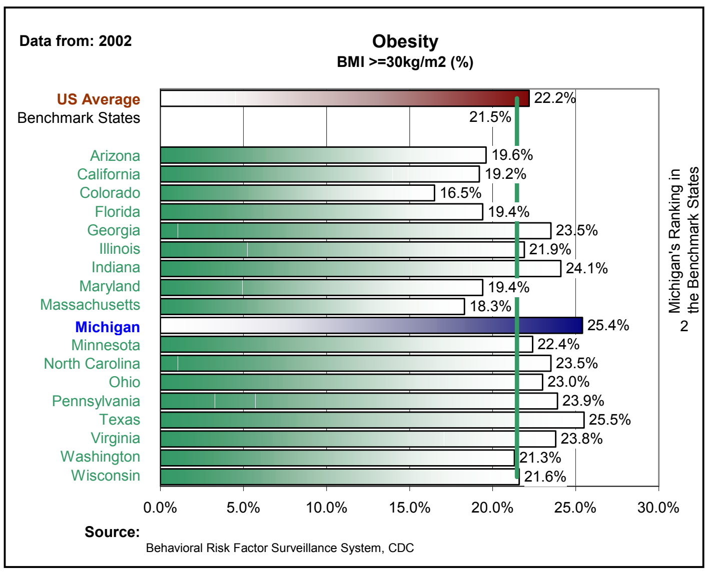
2.2 Factors that Contribute to Higher Healthcare Costs in Michigan

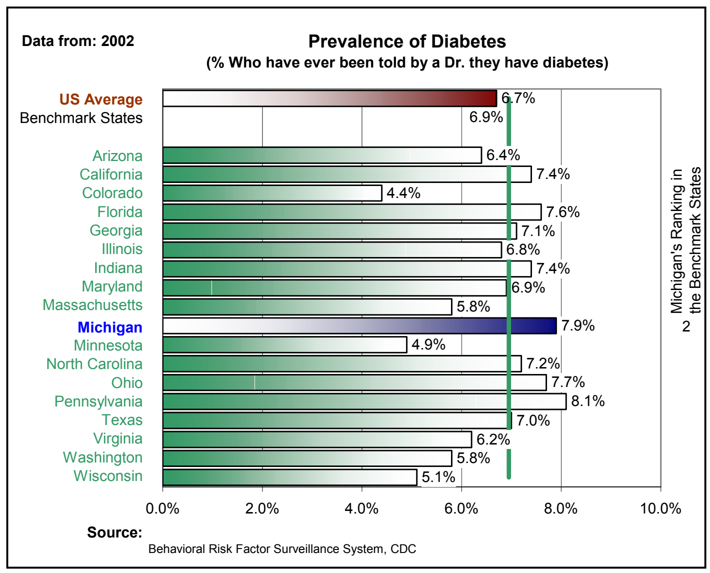
Strictly looking at the cost of healthcare, three factors that exert upward pressure on costs in Michigan are:

- Aspects of the health status of Michigan's residents (Factor F);
- Certain health behaviors of Michigan's residents (Factor G); and
- Prescription drug use (Factor O).

Michigan's high rates of obesity, diabetes, (Exhibit 2-2), coronary heart disease death and smoking, (Exhibit 2-3) are most likely increasing healthcare costs and therefore healthcare premiums. Overweight and obese individuals incur up to $1,500 more in annual medical costs than healthy-weight individuals, according to a two-year study of nearly 200,000 employees of General Motors.[9] To complicate matters, obesity has been linked to coronary heart disease, diabetes, cancer, and other medical problems.

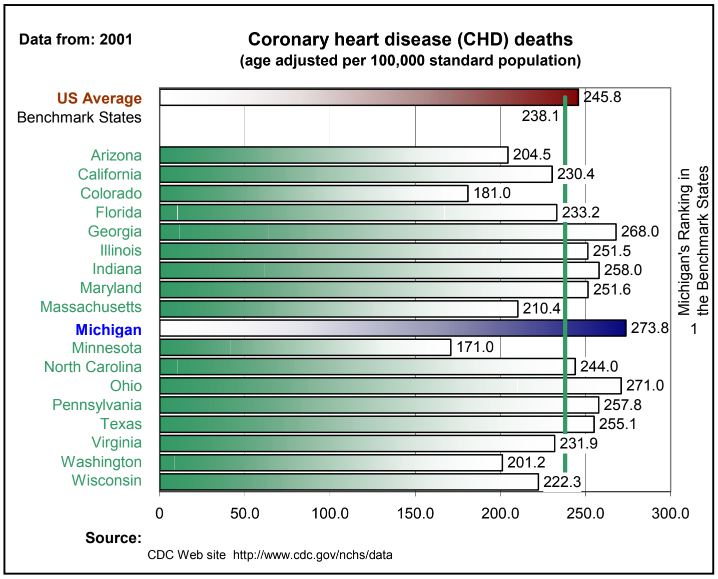
Exhibit 2-2: Obesity (BMI >= 30 kg/m2) and Prevalence of Diabetes

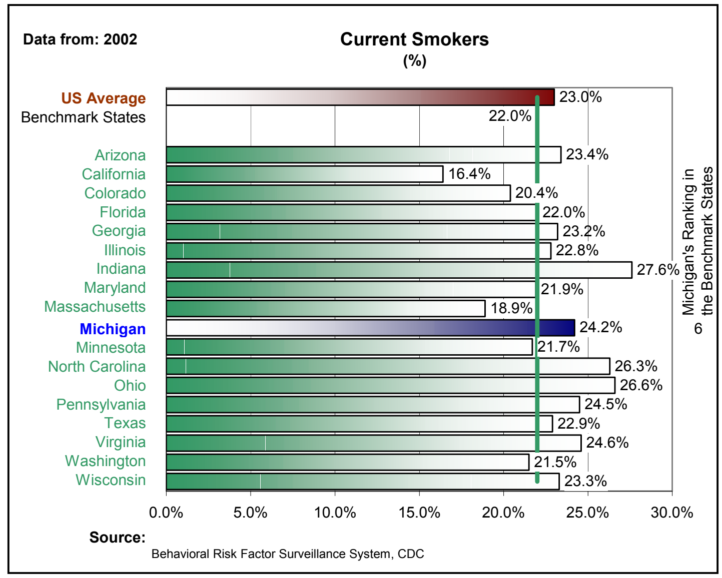




[9] Dee W. Edington, Ph.D., of the University of Michigan as reported in January/February 2003 issue of the *American Journal of Health Promotion*

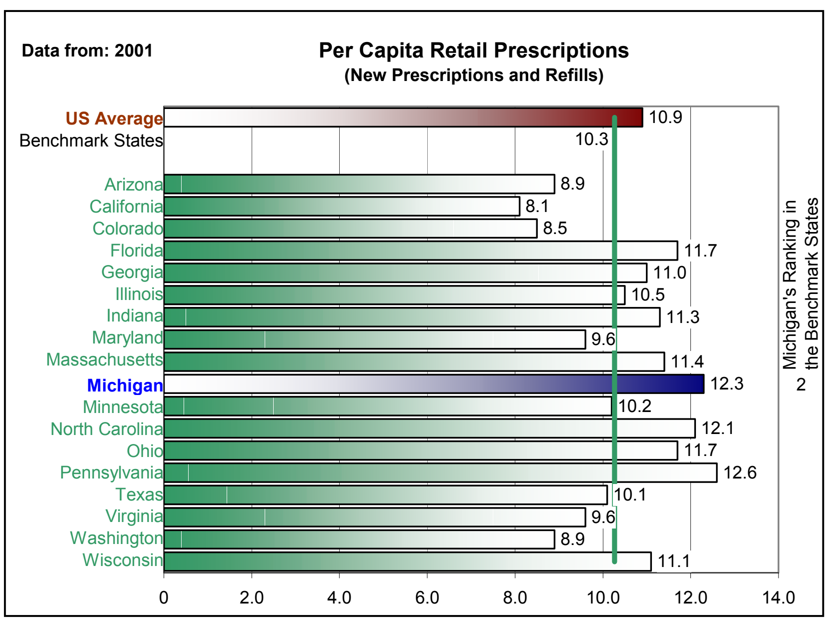
Exhibit 2-3: Michigan Risk Factors: Coronary Heart Disease Deaths and Smoking





Michigan's per capita drug expenditures and utilization are significantly higher than the benchmark and U.S. averages. Per capita expenditures on drugs and other medical non-durables is almost 14% higher in Michigan than the benchmark states and the number of retail prescriptions per capita in Michigan is 19% above the benchmark states (Exhibit 2-4). It is also possible that the health status and health behavior factors lead to higher utilization of prescription drugs.

Exhibit 2-4: Per Capita Prescription Utilization



Source: Verispan Scott Levin's Source™ Prescription Audit

Two other factors that may increase the cost of healthcare in Michigan relative to the benchmark states are:

- The structure of the healthcare insurance industry (Factor C); and
- The particulars of the healthcare benefit, i.e., the services covered, the deductible required before the health plan pays for care, the co-pays for prescriptions, office visits, procedures, and hospitalizations, any co-insurance amount required to receive care (Factor B).

Michigan's largest healthcare insurance plan, Blue Cross and Blue Shield of Michigan (BCBSM), covers about half of the state's residents who have commercial health insurance. Because of their market share, BCBSM would have the capacity to influence premiums in Michigan compared with states where there is not a dominant market leader yet no evidence was found to suggest this. On the other hand, the size of BCBSM and the number of providers that participate in the plan may have kept hospital expenses per patient day and payments to physicians below benchmark averages, thereby controlling costs.

We found no data to support that BCBSM's large market share has inflated premiums significantly and hypothesize that many of the campaigns that BCBSM has run have provided benefits to all insurers in the state (e.g., the media campaign for the use of generic drugs). BCBSM does monitor their administrative costs and the state's Insurance Commissioner monitors the company's premium rate increases.

While data are not available to compare the richness of the healthcare benefit in Michigan with other states (copays, deductibles, and services covered), it is generally accepted that, on average, Michigan employees enjoy a relatively rich health benefit package. This, in turn, is likely to put upward pressure on healthcare costs and premiums.

2.3 Factors Where No Significant Gap Exists Between Michigan and the Benchmark States

The following factors affect premiums but do not cause Michigan to stand out significantly from the benchmark states.

D – **Cost Shifting** – The combined effect of the uninsured, Medicare and Medicaid enrollment, and the care paid for these populations would not lead us to believe that providers are shifting the cost of care from any of these groups to commercial insurance groups at a level greater than the benchmark states. Compared to the benchmark states:

1. 2001 U.S. Census Bureau data shows Michigan's uninsured rate is lower than the benchmark states.

2. The percentage of the population covered under Medicare and Medicaid is similar to the benchmark states. Medicare expenditures per enrollee are lower than benchmark state average while Medicaid expenditures per enrollee are a little higher.

3. A recent study[10] concluded that Michigan has relatively low Medicaid health plan capitation rates. This could result in relatively more cost shifting in Michigan if these low rates translate into low payments to those providing care to Medicaid beneficiaries. Because this study only looked at a component of Medicaid and is somewhat contradicted by our finding on overall Medicaid per capita expenditures, we are hesitant to conclude that Medicaid cost shifting is a special problem for Michigan. More study would be useful on this topic.

E – **Demographics** – The percentage of Michigan employees selecting family coverage, while higher than any of the benchmark states, is not a demographically rooted phenomenon. The median age, household make-up, percentage of urban versus rural residents, and other demographic indicators show that Michigan mirrors the composite of the benchmark states.

H – **Quality of Care** – Published analyses of the quality of care in Michigan indicate that Michigan is neither a best in class state nor a state where quality of care is a significant problem. The state does have a number of well-regarded hospitals and HMO plans that rate well with the National Committee on Quality Assurance (NCQA). No quality of care data can be found to indicate that the quality of care in Michigan negatively or positively affects the cost of health services.

I – **State Mandates** – The number of mandates in Michigan is similar to other states.

J – **Managed Care Penetration** – Michigan's managed care penetration (about one in four) is slightly lower than the average of the benchmark states. Even

[10] *Health Affairs* – Volume 22, Number 1 January/February 2003

if the percentage of residents enrolled in HMOs was higher, it is unlikely that premiums would be significantly reduced. HMO insurance continues to be the least expensive type of coverage, but the difference is not great. PPO and indemnity plans have begun instituting utilization review programs, higher deductibles and co-pays, and more aggressive patient care plans.

K – **Economic Status –** Michigan has recently moved from enjoying a median household income that is slightly above average, low poverty, and a high percentage of residents covered by health insurance, to a state that is roughly on a par with the benchmark states on these measures. Accordingly, this factor should have little effect on employer premiums and the cost of health services.

L – **Physicians and Caregivers** – Compared to both the benchmark states and national averages, the number of physician, nursing, and hospital providers per capita in Michigan is in line with the benchmark states and national norms. The per capita expenditures for physician and other professional services is 14% below the benchmark state average.

M – **Hospital Utilization** – Hospital utilization does not appear to have a significant effect on healthcare premiums. The admissions per million residents, hospital beds per thousand, and hospital occupancy rates in Michigan are similar to the benchmark state averages.

N – **Malpractice Costs** – Available information suggests that while malpractice insurance rates are higher in Michigan, this should not significantly affect premiums. Nonetheless, malpractice costs should be monitored to determine if they become a burden to the provider community.

3.0 Analysis of Healthcare Premiums[11] in Michigan

SRI International's recent benchmarking study for MEDC reviewed the potential impact of a number of factors on the business climate and competitiveness in Michigan. The study identified that employer health insurance premiums are high in Michigan – among the highest in the nation (11th) and the highest of the benchmark states included in the study. This finding helped motivate the current study on why Michigan premiums are high and what can be done to lower them.

It is important to gain a clearer understanding of the scope of the issue. The data point used in the SRI comparison was taken from the 1999 MEPS survey[12] and represents the average employer premium payment for single coverage. In this analysis, the SRI results have been expanded to take into account both trends in the data and additional data points. In this expanded review, all of the private sector MEPS data from 1996 through 2001[13] were examined, resulting in a more comprehensive evaluation of the difference in employer healthcare premiums by state. These data included premiums for both single and family coverage, the proportion of employees adopting either coverage, and the share of premiums paid by the employer for both single and family coverage.

One final note on the analysis: The results of the MEPS survey come from a database large enough to allow statistically reliable state level analysis but not large enough to support analysis at subsequent cuts below this level. Therefore, premiums for Michigan's manufacturing sector could not be compared with similar data from other states. This level of data was nonetheless reviewed to understand how these factors might influence premiums and Michigan's competitive standing. There were hypotheses that the auto industries, unions, and the size of companies drove premiums higher in Michigan. Again, the state level MEPS data cannot support or refute any of these hypotheses. Additional analysis into premiums quoted in different parts of the state indicate that regional variations do exist, but the rationale for these variations can only be speculated. The scope of this project was to review data at the state level, and therefore a further analysis of variation in the premiums and economic factors within Michigan was not done.

[11] Please note, that the term "premiums" is used in this section, and in the MEPS survey, to represent the cost of standard health care services including hospitalization, testing, doctor's visits, and prescription coverage. This includes actual premiums paid by both employers and employees to a health insurance company, and the costs of health services paid for by self-funded groups who hire an administrator to process claims, contract with providers, and take care of other operational issues.

[12] MEPS is the Medical Expenditure Panel Survey Sponsored by the Agency for Healthcare Research & Quality.

[13] The 1996 through 2001 MEPS data are the most recent and complete data set of healthcare premiums for the private sector.

3.1 Updating the SRI Results With 2001 Data

Between 1999 and 2000, single coverage premium costs in Michigan have increased at a faster rate than those in the benchmark states. Michigan experienced a 19% increase in employer premiums for single coverage between 1999 and 2000.[14] This compares unfavorably with a 15% increase for the benchmark states and a 16% increase for the nation as a whole. The 2001 MEPS data for Michigan shows a different trend. While employer premiums for single coverage increased by 11% between 2000 and 2001 for the benchmark states, Michigan saw a 2% increase. Analyzing the entire six years of data, employer premiums for single coverage increased a total of 43% for the benchmark states and 45% for Michigan. In 1999, the employer premium for single coverage for Michigan was 8% higher than the benchmark states. In 2000 this figure grew to be 13% higher, but in 2001 it was only 4% higher.

The employer premium for single coverage presents only part of the story. To understand the total premium cost an employer will pay depends on the following factors:

- the percentage of employees who are eligible for health insurance,
- the percentage of employees who take the insurance when offered,
- the percentage of employees taking family coverage versus single coverage,
- the cost of family coverage compared with single coverage, and
- the contribution the employer makes toward the total healthcare premiums.

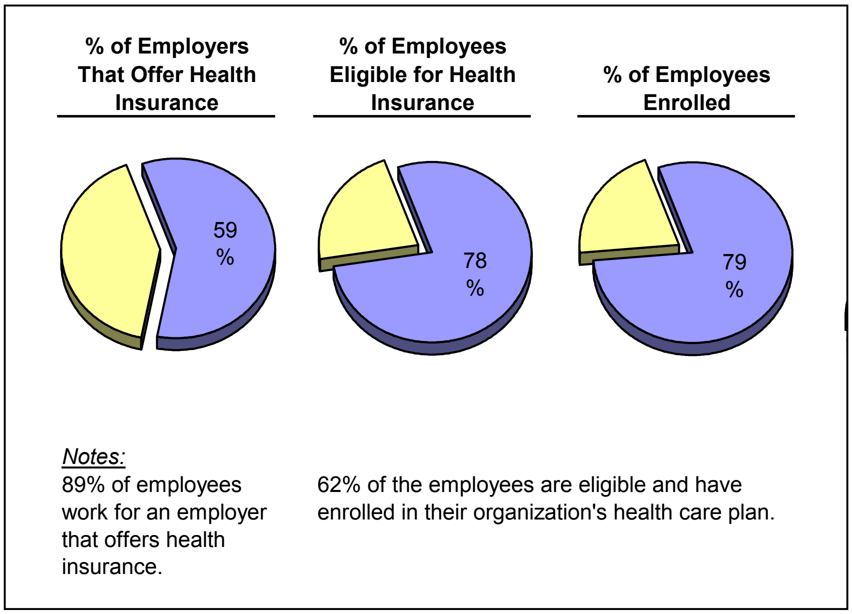
[14] Employer premiums for single coverage includes both the actual cost of the health insurance and the percentage of that amount that employers pay of the insurance. This is also called the employers' "contribution."

3.2 Enrollment in Employer Sponsored Healthcare Plans

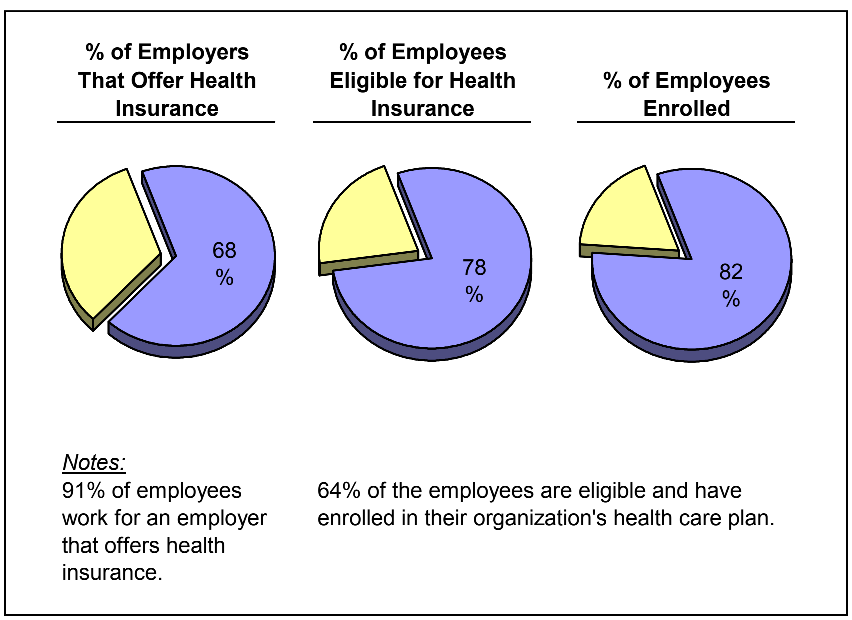
The percentage of employees working for an employer that offers coverage along with the percentage of employees who are eligible and enroll in coverage is not substantially different as shown in Exhibit 3-1. While a larger percentage of Michigan employers offer health insurance (68% compared with 59%) the percentage of employees who are eligible and have enrolled is about the same.

Exhibit 3-1: Employee Enrollment in Employer Sponsored Healthcare Plans - 2001

Benchmark States



Michigan

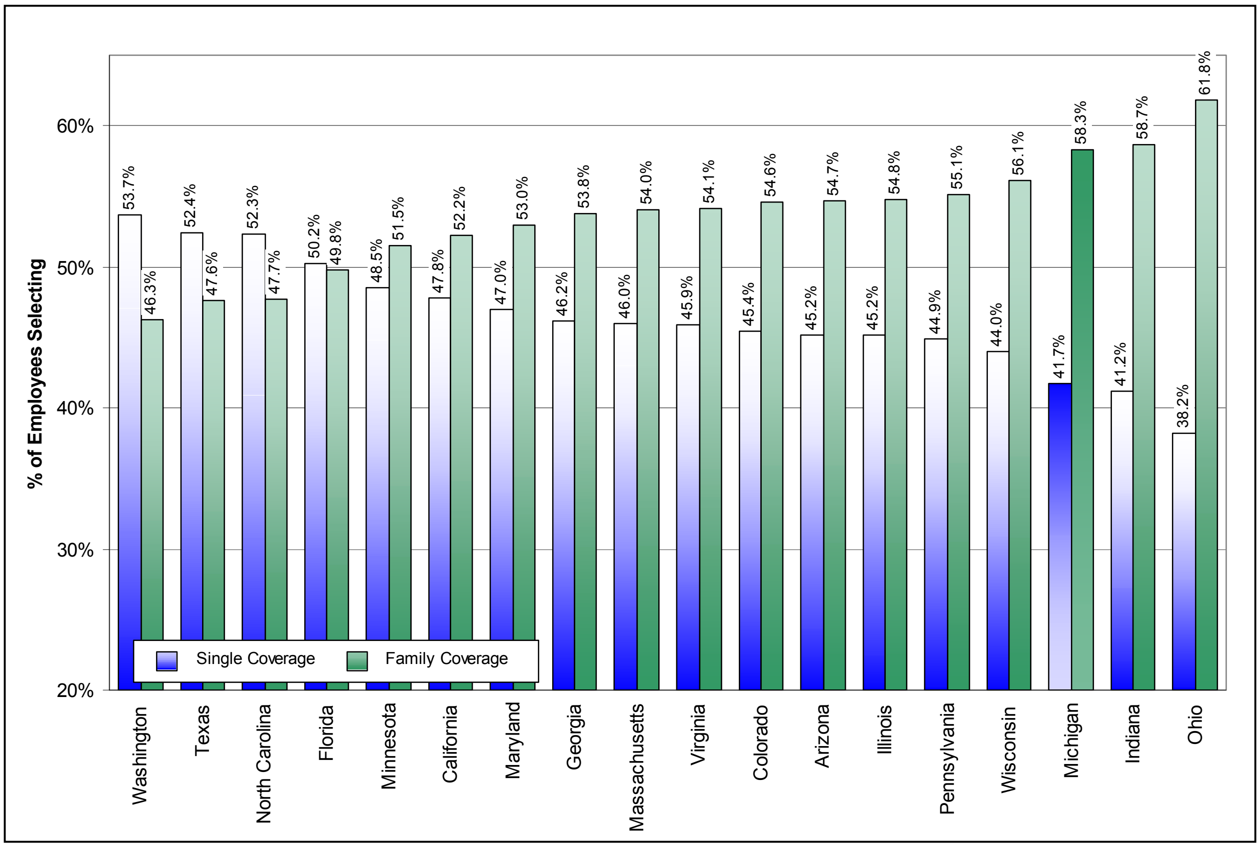


Source: 2001 MEPS data

3.3 The Type of Coverage Employees Select

Nationally, about half (53%) of all employees opt for family coverage, according to the 2001 MEPS report. Slightly more (58%), choose family coverage in Michigan. Since family coverage is about 2½ times more expensive than single coverage, the percentage of employees who take family coverage can affect total healthcare expenditures for an employer. As shown in Exhibit 3-2, Michigan has a higher percentage of employees who opt for family coverage compared with most of the benchmark states.

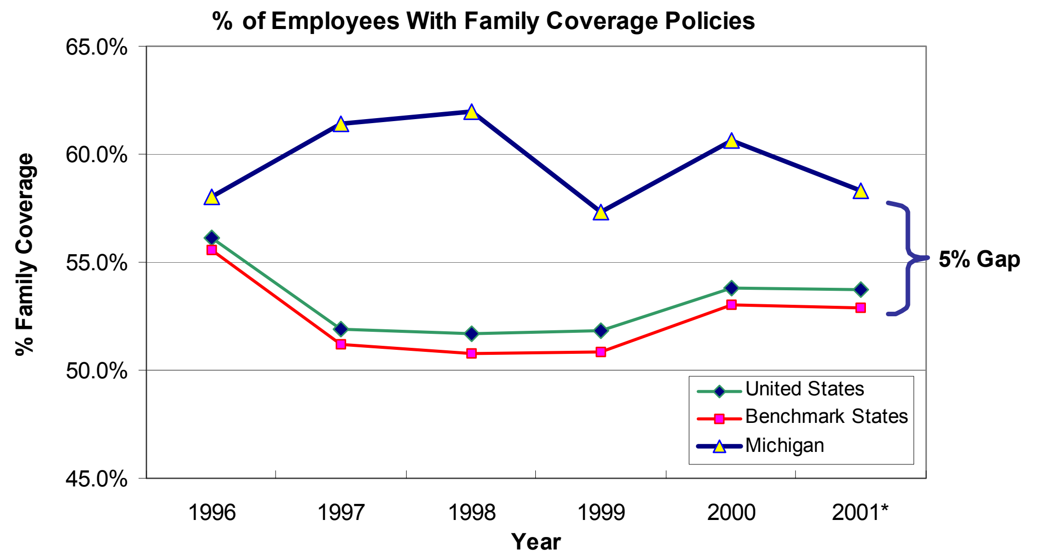
Exhibit 3-2: Type of Coverage Employees Selected by State — 2001



Source: 2001 MEPS data

Exhibit 3-3 shows the historical trend of selection of family coverage. Michigan employees have selected family coverage at a higher rate than those in the benchmark states for every year between 1996 and 2001. Between 2000 and 2001, this gap between Michigan and the benchmark states has narrowed. One important note — even though Michigan employees are more likely to select family coverage, according to the U.S. Census, the percentage of Michigan residents who are married and live with their family is not significantly different from that of the benchmark states.

Exhibit 3-3: Percent of Employees Selecting Family Coverage



* **NOTE:** In 2001 MEPS created a "Single + One" category for those who receive health insurance for themselves and a child. The 2001 data reflects those in the Family and Single + One categories.

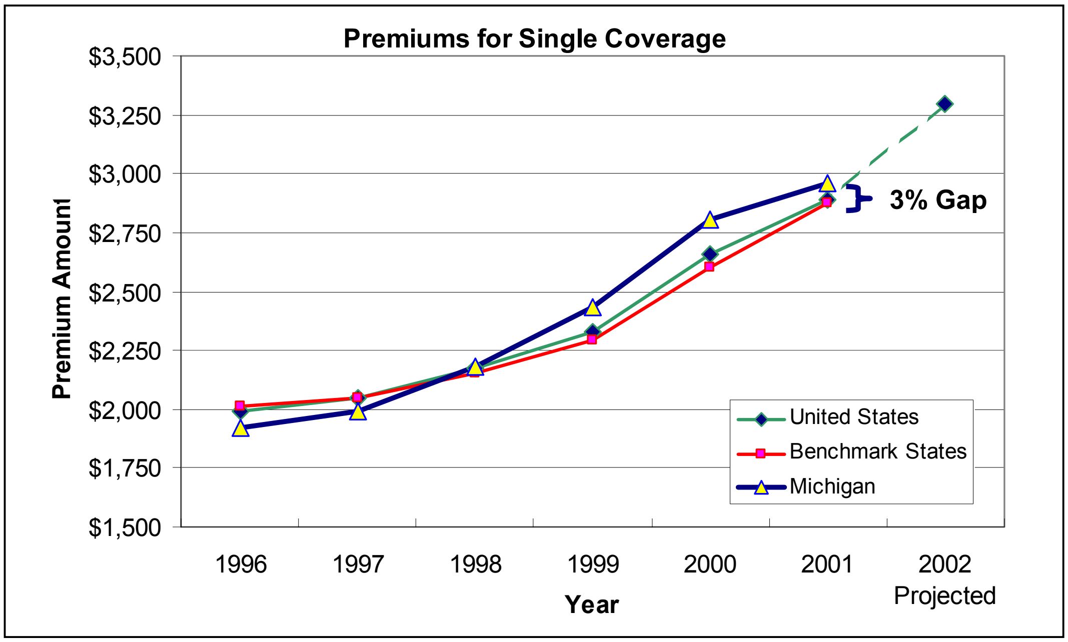
Source: 2001 MEPS data

In 2001, reporting of family coverage was segmented by the Agency for Healthcare Quality and Research (the providers of the MEPS data) into two categories, "Family" coverage and "Single plus One" coverage. In prior year reports, these two categories were reported as "Family" coverage. Wherever family coverage is compared with prior years data, the weighted average of family and single plus one coverage has been calculated and displayed.

3.4 Premium Cost Comparisons for Single and Family Coverage

Not only have healthcare insurance premiums for single coverage been rising, premiums for family coverage have been rising as well. The six-year trend in the total (employer + employee) premium cost for single coverage (Exhibit 3-4), Michigan has gone from a competitive advantage in 1996 to a disadvantage in 1999. By 2000, the difference between Michigan and the benchmark states for single coverage was 7.9%, but in 2001 that gap declined to just 3%.

Exhibit 3-4: Total (Employer + Employee) Premium Costs for Single Coverage — Trend

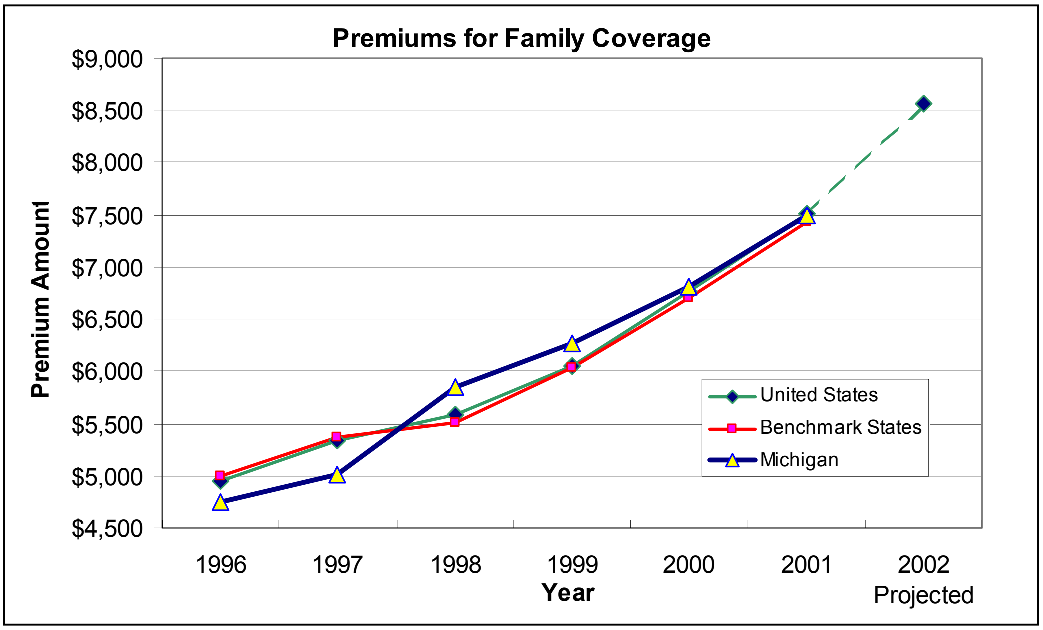


Source: 2001 MEPS data; Kaiser Family Foundation

At the beginning of this engagement, the MEPS data had only been collected and released for the years 1996 to 2000. Data for 2001 have been added to provide a broader perspective on health care premiums. Updates of this data set typically have a two-year lag. To obtain a forecast on what premiums would be today using the MEPS data as a base, the 2002 Kaiser Family Foundation/Health Research and Educational Trust Survey was used. The projected 2002 premiums shown in Exhibits 3-4 and 3-5 are based on percentage increases of premiums from a national survey as reported by the Foundation.

Since 2000, health care premiums for family coverage in Michigan have been comparable to those in the benchmark states. While Michigan's average premium for family coverage was slightly above the benchmark states in 1998, the gap between Michigan and the benchmark states has closed (See Exhibit 3-5) and in 2001 was only 2% above.

Exhibit 3-5: Total (Employer + Employee) Premium Costs for Family Coverage — Trend



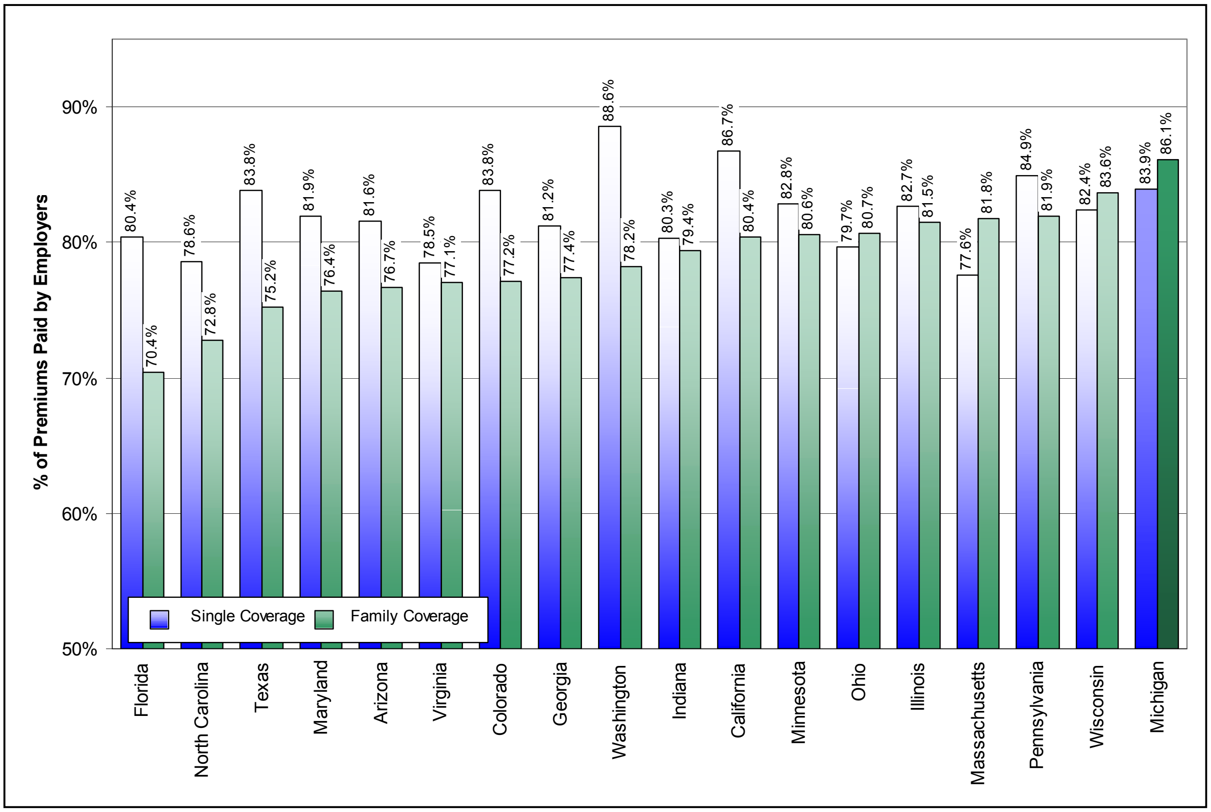
Source: 2001 MEPS data; Kaiser Family Foundation

In summary, Michigan's total premiums in 2001 are very similar to premiums paid in the benchmark states for both single and family coverage.

3.5 The Employer's Share of Healthcare Premiums

To calculate the total amount the average employer pays for employee healthcare, the share of the premiums paid by the employer for both single and family coverage needs to be considered. As shown in Exhibit 3-6, Michigan employers pay a greater percentage of the family premiums than any of the other benchmark states and more of the single premiums than almost all of the benchmark states.

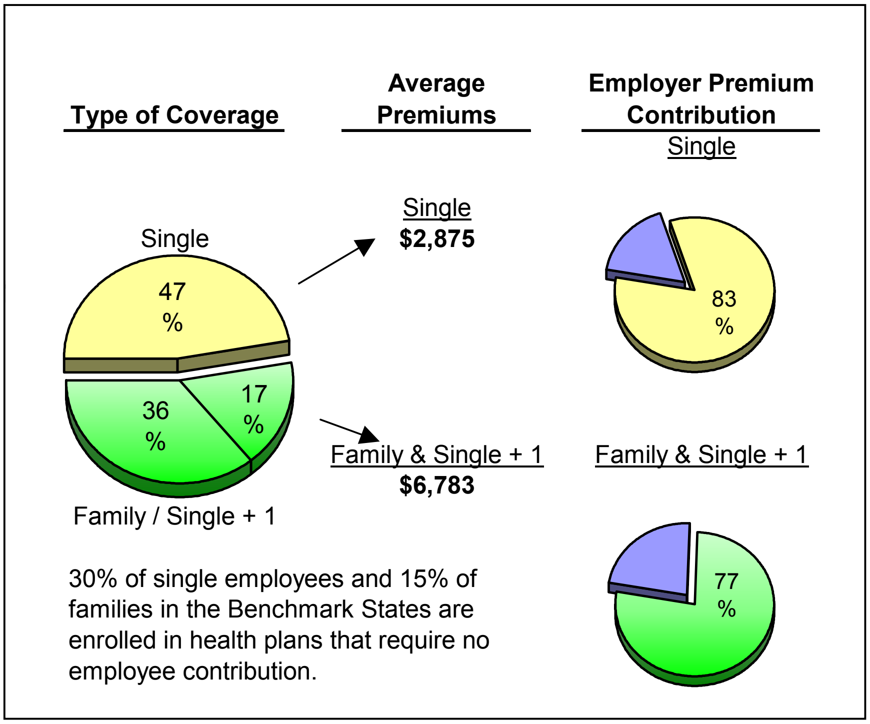
Exhibit 3-6: Percent of Premiums Paid by Employers — 2001



Source: 2001 MEPS data

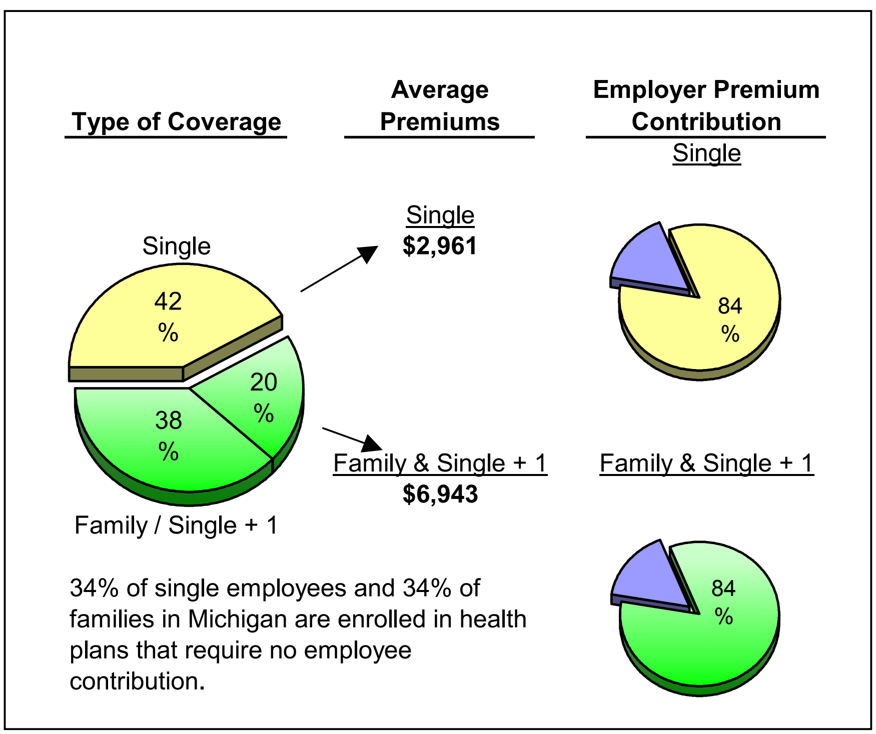
Considering single and family premiums, and the percentage of the premium paid by the employer, the total employer contribution for healthcare can be determined. The following graphs demonstrate how the combination of the share the employer pays for healthcare coverage and the type of coverage employees elect affects the total employer's cost for employee healthcare coverage both for the benchmark states and in Michigan. (Exhibits 3-7 and 3-8, respectively.)

Exhibit 3-7: Employer Paid Premium Calculations for 2001 — Benchmark States



Source: 2001 MEPS data

Exhibit 3-8: Employer Paid Premium Calculations for 2001 — Michigan



Source: 2001 MEPS data

In summary, there are three primary observations arising from the analysis of the 2001 data**:**

- Michigan has a larger proportion of covered employees who have family coverage.
- Health insurance premiums in Michigan are just slightly higher than premiums in the benchmark states. As of 2001, the premium for singles in Michigan was 3% above the benchmark states and the weighted average premium for family and single- plus one coverage was just 2% above.
- On average, Michigan employers pay a greater share of the premium costs, compared with the employers in the benchmark states.

4.0 Healthcare Cost Containment Strategies

From the analysis of the factors and input from healthcare experts, five cost containment strategies were developed and are presented in this section. The following pages describe the issue, recommendations and potential benefits for each of the cost containment strategies. One final note — none of the cost containment strategies recommended here would reduce healthcare premiums overnight. Many of the recommendations will require time before measurable reductions in employer health insurance premiums are observed.

4.1 Intensify Efforts to Support Health Promotion and Disease Prevention

Issue: Michigan leads the benchmark states in coronary heart disease deaths, has the second highest prevalence of obesity and diabetes, and the sixth highest prevalence of smoking. Evidence is mounting that obesity creates health problems that are more devastating and more costly than the health problems associated with smoking or drinking.[15]

Recommendations: Expand current efforts by the state to encourage healthy lifestyles, prevent disease, and otherwise promote health. Specifically:

- The state should consider further steps to support health promotion efforts in Michigan. Educational interventions on fitness and the effects of obesity should be especially prominent.
- The state should explore ways to enhance physical education in elementary and secondary schools.[16]

Benefits: Recent studies have shown that obese individuals require an additional $1,500 per year in healthcare expenses. With approximately 2.2 million citizens considered to be obese, Michigan pays over $3.3 billion dollars per year in obesity related healthcare expenses. Additional disease prevention and health promotion programs would also lead to decreased healthcare expenses.

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[15] Roland Sturm, "The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs," *Health Affairs*, 21(2), March/April 2002: 245-254. One researcher has estimated that overweight and obese people have medical bills that are up to $1,500 greater per year than those at a healthy weight level. See Ira Dreyfuss, "Companies Fight Employee Fat, Hoping to Trim the Bottom Line," Ann Arbor News (AP), February 4, 2003. Also, new research links obesity to cancer: "Study Hailed as Convincing in Tying Fat to Cancers," Associated Press, April 24, 2003. Finally, a new study shows that rising obesity could wipe out recent improvements in disability among older Americans: R Sturm et al, "Increasing Obesity Rates and Disability Trends," *Health Affairs*, 23(2):199-205, March/April 2004.

[16] "Physical Inactivity Costing Michigan $8.9 Billion," released May 23, 2003 at www.Michigan.gov. Study conducted by Dr. David Chenoweth of Health Management Associates. The Governor's Council on Physical Fitness, Health and Sports estimates that physical inactivity in Michigan is costing $8.9 billion dollars a year including direct and indirect cost of medical care (including Medicaid), workers' compensation and lost productivity.

4.2 Work With Legislature, Business, Community, and Providers to Implement Insurance Industry Reforms

Issues: Small businesses are finding affordable healthcare insurance coverage difficult to find. Organizations with healthy employees often can get reasonably priced health insurance, but small businesses with older employees or employees with a history of higher medical expenses often are quoted high rates that effectively discourage them from providing health insurance. In Public Act 88, signed by Governor Granholm, the state has established "adjusted community rating" rules that are applicable to all small-group insurers and health plans and limit total allowable group-to-group variation in premiums.

A second issue that has the capacity to increase premiums for Michigan's employers is the large percentage of the consumer market that has coverage through Blue Cross and Blue Shield of Michigan (BCBSM). We found no data to support that BCBSM's large market share has inflated premiums significantly and hypothesize that many of the campaigns that BCBSM has run have provided benefits to all insurers in the state (e.g., the media campaign for the use of generic drugs). BCBSM does monitor their administrative costs and the state's Insurance Commissioner monitors the company's premium rate increases.

Recommendations:

- Support insurance industry reforms such as Public Act 88 that "levels the playing field" for all insurers and health plans selling coverage in Michigan's small-group health insurance market. The Act regulates the extent to which health plans can vary premium rates based on the characteristics of the individuals in each small group seeking coverage. As the provisions of this Act are implemented and health plans begin to community rate, the state should review the resulting effects on small employer premiums
- Establish "adjusted community rating" rules, uniformly applicable to all small-group insurers and health plans that limit total allowable group-to-group variation in premiums to some reasonable amount.
- Given the strong likelihood that the market share of Blue Cross and Blue Shield will remain high, both the state and the BCBSM Board of Directors should be rigorous in holding the organization accountable for efforts to operate efficiently and to use its market power in the interest of those who get health coverage through BCBSM.

Benefits: Effectively implemented, small group insurance reform would reduce the variation in health insurance premiums that small employers often observe. Implementing adjusted community rating rules – often referred to as "rate bands" – would reduce the range of variation small employers experience in healthcare premiums.

Another benefit of small group insurance reform is that it may bring more health plans into the state. Large national health insurers like Aetna, CIGNA, Humana, and United HealthCare have a small or non-existent membership in Michigan. Small group insurance reform may make these companies more viable competitors.

4.3 Focus Efforts to Reduce Prescription Drug Expenditures

Issue: Michigan's high utilization of prescription drugs represents a major opportunity for improvement but should be put in perspective. Michigan's obesity, diabetes, and heart disease could have lead to increased drug utilization. Prescription drugs account for slightly less than 10% of health expenditures and can reduce cost through fewer hospitalizations, shortened lengths of stay, and reduced need for high tech procedures. Still, the per capita expenditures on prescription drugs and other medical non-durables in Michigan is 14% ($60 per resident) above the benchmark states and the number of new prescriptions and refills is 19% above the benchmark states.

Recommendations: Michigan should:

- Promote the use of generic medications and tiered pharmacy benefit programs that result in higher prices for brand name drugs (non-generic), and even higher prices for lifestyle drugs.
- As recommended in section 4.1, programs that educate and encourage healthy lifestyles will reduce healthcare costs and drug utilization.
- Continue in its efforts to increase its purchasing power via multi-state coalitions similar to current initiatives enacted by the Granholm administration and contracted prices for highly used prescription drugs.

Benefits: If the per capita expenditures on drugs and other medical non-durables were reduced by $60 per Michigan resident, matching expenditures in the benchmark states, Michigan's employers and residents would save over $500 million dollars per year.

4.4 Aggressively Seek Federal Funding Enhancements for Low-Income Populations

Issue: Although the state has a relatively low number of uninsured residents, Detroit has not received Federal Funding for Federally Qualified Health Centers (FQHC) at a rate comparable to other major cities in the benchmark states. Detroit receives $4.20 per resident for FQHC's compared with $9.27 per resident in Chicago. Currently there is a ceiling on the number of dollars that are appropriated each year for this program.

Recommendations: It is to the state's advantage to make every effort to increase its share of federal reimbursement for publicly insured residents along the following lines:

- The state should support a national solution to the problem of the uninsured that encompasses a substantially increased federal financial commitment including appropriate payment levels for the covered services. Additionally, a federally funded stimulus package that substantially, but temporarily, raises the Federal Medical Assistance program's match rate should be sought. The recent federal stimulus package that temporarily raised the Federal Medical Assistance program's match rate establishes a significant precedent.

- At the local level the state should ensure that it is taking advantage of all available opportunities for federal funding of various health initiatives, especially establishing Federally Qualified Health Centers (FQHCs). A recent analysis shows that Detroit is last among seven cities in our region regarding the number and Federal Funding for FQHCs.

Benefits: Any money the state can obtain from the Federal Government for the provision of healthcare for uninsured residents not only reduces the state's expenditures but also reduces the likelihood of cost shifting from uninsured and under insured to commercial insurance plans.