Michigan State Planning Project for the Uninsured

Project Report

August 2006

Prepared by the Michigan Department of Community Health

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Acknowledgements

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STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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DIRECTOR

August 25, 2006

On behalf of the Michigan State Planning Project for the Uninsured, I am pleased to present the following Project Report. This report includes the Advisory Council's recommendations for expanding access to health insurance for all Michigan residents.

Council members reviewed a wealth of information about the uninsured and insurance expansion options, talked to national and state experts, and examined data gathered pursuant to the federal Health Resources and Services Administration (HRSA) grant, which funded this project. Thousands of Michigan residents and business owners were surveyed in the Household and Employer Surveys, and hundreds of Michiganians were heard from at focus groups and town hall meetings. Three workgroups, comprised of almost 200 individuals, contributed thousands of volunteer hours to research various health coverage expansion models and provide information to inform the Advisory Council's discussions. The results of the data gathering efforts, as well as the workgroup and Advisory Council documents are available at www.michigan.gov/spg.

The Michigan Department of Community Health appreciates the opportunity to provide this report and looks forward to achieving accessible, affordable, quality health insurance for all Michigan residents.

Sincerely,

Janet Olszewski.

Janet Olszewski
Director

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Michigan State Planning Project for the Uninsured Project Report

In light of pressing concerns surrounding the issue of the uninsured and the growing problem of access to affordable health insurance for Michigan's residents, the Michigan Department of Community Health (MDCH) launched the Michigan State Planning Project for the Uninsured. This initiative was funded by a federal Health Resources and Services Administration (HRSA) grant with the goal of developing realistic strategies to extend health insurance to all Michigan residents. MDCH coordinated this initiative from late 2004 through August 2006.

An integral component of the State Planning Project for the Uninsured was to expand the current knowledge base about uninsurance by collecting data about unmet needs, barriers to insurance coverage, and system changes needed to secure coverage for all Michigan residents. Data collection efforts included: the Michigan Household Health Insurance Survey of over 13,000 Michigan households; the Michigan Employer Health Insurance Survey of 1,200 Michigan employers; Focus Groups with employers, insurance brokers and the uninsured; and a Health Care Listening Tour consisting of eleven town hall meetings around the state.

Key to the project was a broad-based, responsive, and effective governance structure, including an Advisory Council to the Michigan Department of Community Health and three workgroups. The Advisory Council was appointed by the Director of MDCH, and included representatives of large and small businesses, unions, health care providers, local Chambers of Commerce, health plans, seniors, free clinics, consumers, local public health, and insurers. Three workgroups (Data Synthesis, Models Development, and Community Interface) assisted the Advisory Council by reviewing data gathering instruments and analyses; assessing models to expand insurance coverage; and developing strategies to engage stakeholders and build consensus.

The Advisory Council's recommendations can be found on page 12 of this report.

Problem Identification and Background Information

The health consequences of being uninsured are well documented, as are costs associated with caring for the uninsured. These, along with rising health care costs, are creating challenges throughout Michigan. According to the Current Population Survey (CPS) (2002-04 average), 11.4%, or approximately 1.1 million Michigan residents were uninsured. CPS estimates of the uninsured are higher than those based on the Michigan Household Health Insurance Survey, which found Michigan's uninsured population to be 800,000, or 7.8% of the population. (This difference between the survey findings may be explained by the number of people interviewed and by the questions, definitions, and methods used in the surveys. State surveys typically find lower rates of uninsurance than do CPS national surveys. While the Household Survey provided greater detail on the characteristics of the uninsured in Michigan, including regional data, CPS data is valuable as a source to compare Michigan's uninsured with those in other states and with the nation.)

Michigan has historically had a lower proportion of residents without health insurance than the national average, due primarily to the high-rate of employer-based coverage in Michigan. According to the CPS, in 2004, the percentage of non-elderly Michigan residents covered by employment-based health insurance was 68%, compared with 62% nationally; however, this was a reduction from previous years as the rate of employer-based coverage, both nationally and in Michigan, has dropped steadily over time.

The continued loss of manufacturing jobs, combined with a sluggish economy, has eroded employer-based coverage in Michigan. Michigan, like the nation, continues to struggle with increased demand for public insurance coverage; approximately 15% of Michigan's population is now covered by Medicaid.

Data Sources on the Uninsured
Prior to the State Planning Project for the Uninsured, Michigan relied on four sources to provide data on health insurance coverage in Michigan. These were: 1) U.S. Census Bureau Current Population Survey (CPS); 2) Urban Institute National Survey of American Families (NSAF); 3) Michigan Behavioral Risk Factor Surveillance System (BRFSS); and 4) Michigan State University's State of the State Survey (SOSS). These surveys provide data on Michigan's level of uninsurance by race/ethnicity, firm size, type of firm (public/private sector), and general information regarding the prevalence of uninsurance among children. However, gaps exist in this data.

The State of Michigan is large, both in terms of geography and population and the characteristics of uninsured individuals vary significantly across the state. In order to develop health care coverage strategies that address the diversity of persons who are uninsured, it is beneficial to consider data on the uninsured at the regional level. It is also important to examine data concerning business attitudes, practices and beliefs relative to employer-based insurance throughout the state. The data gathered as part of this project provided much of this necessary information.

Everyone Pays
Access to and cost of quality health care are important issues for Michigan's communities and for the state. In 2002, the Michigan Economic Development Corporation commissioned a study on factors that could affect the business climate and competitiveness of Michigan. This study identified Michigan's employer-based health insurance premiums for individual policies in 1999 as the highest of the benchmark states.[1] High premiums have contributed to the decline in recent years in employer-based coverage in Michigan and nationally.

Michiganians with insurance are paying more every year for health care benefits that are being reduced over time, and many are at risk of losing their coverage altogether. Employers face large, unpredictable increases in their health insurance premiums annually. The rise in health insurance premiums has generally outpaced inflation and increases in workers' earnings since the late 1980s. Since 2000, premiums for family coverage have increased by 73%, compared with a 13% growth in consumer prices and an earnings growth of 16%.[2]

Cost-shifting trends are also not sustainable. Hospitals and physicians shift the cost of services for the uninsured to other payers. In 2005, the direct impact of cost shifting on employers in Michigan was estimated to be 6.5% of premium costs.[3] Employers and individuals who purchase insurance pay a significant portion of the costs for health care for the uninsured or underinsured. Families USA estimates that in 2005 in Michigan, $730 a year was added to the cost of a family policy and $274 a year to an individual policy, to cover health care costs of the uninsured.

Rapidly rising health care costs have weighed down Michigan's large automotive industry and have become a major competitive burden, adding $1,500 to the cost of each vehicle, according to General Motors Corporation Chairman and Chief Executive Officer G. Richard Wagoner Jr.[4]

Health Status of Michigan Residents
A major contributor to the high cost of health insurance in Michigan is the poor health status and unhealthy lifestyles of Michigan residents. Michigan has an unacceptably high ranking nationally for deaths from heart disease; it ranks number two in diabetes mortality, and has the seventh highest percentage of smokers.[5] About 61% of Michigan residents are overweight or obese.[6] To address these concerns, the first state Surgeon General in the country was appointed in 2003 in Michigan, Dr. Kimberlydawn Wisdom. The Surgeon General released the Healthy Michigan 2010 Health Status Report and the Prescription for a Healthier Michigan, which identify leading health threats to Michigan

[1] Altarum. *Healthcare Costs and Premiums: Michigan Compared with Selected Benchmark States*. March 31, 2004.

[2] Claxton, Gary, et al. *Employer Health Benefits: 2005 Annual Survey*. (Kaiser Family Foundation/Health Research and Educational Trust, 2004).
[3] Families USA. *Paying a Premium: The Added Cost of Care for the Uninsured*. June 2005.
[4] Ceci Connolly. Washington Post. *U.S. Firms Losing Health Care Battle, GM Chairman Says.* February 11, 2005.
[5] National Center for Chronic Disease Prevention and Health Promotion, CDC. 2003. *Prevalence Data*.
[6] 2004 Behavioral Risk Factor Survey. *Health Risk Behaviors in the State of Michigan*.

residents and recommend a plan of action for improving health. Progress in improving Michigan's health continues to be impeded by the increasing number of uninsured, and the concomitant reduction in access to health care.

The Burden of Uncompensated Care
The burden of uncompensated care on local health care systems threatens the survival of individual providers and hospitals, reducing access to care and the viability of the economic base of these communities. Further, increased demand for services by the uninsured in already busy hospital emergency departments jeopardizes access and quality of care for both the insured and the uninsured. In 2005, there was $43 billion worth of uncompensated care provided to the 48 million uninsured in the United States. Michigan had $1.1 billion in uncompensated care.[7]

Amassing Medical Debt
Large health care costs for uninsured low-income families can be financially disastrous. Two out of five Americans aged 19-65, or 77 million Americans report they had problems paying medical bills in the last 12 months or were paying off medical debt they had accrued over the past three years.[8] Medical debt is now a factor in as many as 50% of personal bankruptcies.[9]

Real People with Real Health Risks
The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less care and have higher mortality rates than the insured.[10] Uninsured adults have a 25% greater mortality risk than do insured adults, accounting for an estimated 18,000 deaths annually. They have worse outcomes for chronic conditions such as diabetes, cardiovascular disease, end-stage renal disease, and HIV. Uninsured children are at greater risk of suffering delays in development that may affect their educational achievements, earning capacity and long-term health. The economic value of a healthier and longer life that an uninsured individual forgoes ranges between $1,645 and $3,280 for each year without coverage.[11]

Benefits to Covering the Uninsured
The uninsured receive many benefits when they become insured; however, the benefits to the insured are also significant. As noted by the Institute of Medicine, "It is both mistaken and dangerous to assume that the prevalence of uninsurance in the United States harms only those who are uninsured."[12]

Efforts to Reduce the Number of Uninsured
The Household Survey found that publicly-funded programs, such as Medicare and Medicaid, cover 16% of the state's insured adults under the age of 65 and 28% of insured children. The number of people covered by Medicaid, both in Michigan and throughout the United States, is growing. Medicaid now covers 1.5 million Michiganians, an increase of 35%, or nearly 400,000 over the past five years, many of whom are low-income children who have lost dependent coverage and adults who have lost their jobs and exhausted their unemployment benefits.

The state has been actively involved in expanding coverage since the enactment of the Public Health Code in 1978. These efforts have contributed to an uninsurance rate in Michigan that is lower than the average for the nation. Strategies to reduce the number of uninsured include: the enactment of Public Act 350, which established Blue Cross Blue Shield of Michigan as the insurer of last resort; the creation of MICH Care, later expanded and renamed Healthy Kids and the Maternity Outpatient Medical Services (MOMS) program; the Transitional Medical Assistance program; the Breast and Cervical Cancer Control Program; the MIChoice Waiver, expanding home and community-based health services for aged and disabled persons who are nursing home eligible; the State Children's Health Insurance Program; the Adult Benefit Waiver; and, most recently, the Family Planning Waiver.

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[7] Families USA. *Paying a Premium: The Added Cost of Care for the Uninsured*. June 2005.
[8] Commonwealth Fund.
[9] David U. Himmelstein et al. *Marketwatch: Illness and Injury as Contributors to Bankruptcy*. Health Affairs, Web Exclusive. February 2, 2005.
[10] Kaiser Commission on Medicaid and the Uninsured. *The Cost of Not Covering the Uninsured*. June 2003.
[11] Institute of Medicine of the National Academies. *Hidden Costs, Value Lost: Uninsurance in America*. June 2003.
[12] Institute of Medicine of the National Academies. *A Shared Destiny: Community Effects of Uninsurance*. February 2003.

What Does the Project Data Indicate About Michigan's Uninsured?

The Michigan Department of Community Health (MDCH) contracted with the Michigan Public Health Institute (MPHI) to collect information on Michigan's uninsured and on employers who have traditionally provided health insurance to workers. In addition, MDCH conducted Town Hall meetings across Michigan to learn about the magnitude, causes and effects of uninsurance in each community. A complete report for each data source is available at www.michigan.gov/spg

The Michigan Household Health Insurance Survey

MPHI conducted the Household Survey from December 2004 through August 2005. This telephone survey focused on the uninsured at the state and regional levels. During this effort, MPHI collected information from 34,113 individuals in 13,091 Michigan households.

Michigan Employer Health Insurance Survey

Because the current status and future of employer-sponsored health coverage impact policy decisions about extending coverage, MPHI developed the Employer Survey. This was conducted from August through November 2005. This survey was sent to 12,000 randomly selected businesses located throughout the state, 1,261 of which completed and returned their questionnaires.

Town Hall Meetings

Town hall meetings conducted by MDCH staff and local community partners from September through December 2005, provided information about the beliefs of more than 600 Michigan residents who participated in the project's Health Care Listening Tour. These meetings "put a face" to the uninsured and helped the Advisory Council better understand the impact of uninsurance on local communities.

Focus Groups

MPHI held focus groups with employers, insurance agents and uninsured individuals in eight cities throughout Michigan. In addition, MPHI conducted 90 telephone interviews to supplement information from the focus groups.

Types of Data Gathered

The data sources cited above contain quantitative data from the Household and Employer Surveys, and qualitative data from the Town Hall meetings and Focus Groups.

Qualitative data from the Health Care Listening Tour and Focus Groups are in shaded boxes, and are included to show themes.

Who Are Michigan's Uninsured?

Michigan's uninsured are friends, neighbors, and possibly, even family members. The uninsured are very much like people who have health insurance, but they have found themselves in situations where coverage is not available or affordable.

According to the Household Survey, 10.9% of Michigan residents between the ages of 18 to 64 are uninsured, representing almost 700,000 uninsured adults. The rate of uninsurance for those under the age of 18 is 3.7%, accounting for almost 100,000 uninsured children. Although Michigan residents of any age may be uninsured, a disproportionate number are young adults. Over 26%, or almost 210,000 of the uninsured, are between the ages of 18 and 29.

The uninsured rate varies considerably among different regions within the state. The City of Detroit has the highest adult uninsured rate at 17.5%, with the Northern Lower Peninsula following closely with 16.5% uninsured. Southeast Michigan, not including the City of Detroit, has the lowest rate at 8.6%. The uninsured rate for children is more evenly distributed across the state.

Reasons for Being Uninsured

According to the Household Survey, about two-thirds of uninsured adults report that the primary reason they are uninsured is because they can't afford insurance, or they've lost or left a job that provided coverage. For children, 37% are uninsured because they became ineligible for coverage and another 33% because health insurance is unaffordable.

Most of Michigan's Uninsured Are the Working Poor

The Household Survey found that 80% of Michigan households with an uninsured member have at least one adult who is either employed by others, or is self-employed. Of these households, 73% include a

member working 40 or more hours per week, possibly at two or more part-time jobs. Nearly 62% of these households have a member who works for an employer that offers health insurance to at least some of his or her employees; however, only 47% of workers are actually eligible for coverage. Reasons for ineligibility include being a part-time or temporary worker, or not having worked long enough.

There are an estimated 60,000 households in Michigan where there is a worker who is eligible for coverage, but does not take it. More than 65% of the time it is because they cannot afford their share of the cost.

About 120,000 Michigan households include insured workers, living with uninsured individuals who are not covered by the worker's employer-sponsored plan. Almost 40% are ineligible because they are not immediate family members of the worker and 27% are ineligible generally due to their age. Another 19% are uninsured because the household cannot afford the cost for dependent coverage.

According to the Household Survey, the income for about one-quarter of Michigan's uninsured falls below the 2005 Federal Poverty Level (FPL) Guidelines. This means that 26% of the state's uninsured live on annual incomes of less than $9,570 for an individual or $16,090 for a family of three. Almost two-thirds of Michigan's uninsured live below 200% FPL, which is $19,140 for an individual or $32,180 for a family of three.

*Working Poor**

Listening Tour Participants' Comments:

- Most of the uninsured are employed; however some who are offered employer-based insurance are unable to afford their share of the premium, while others are not offered insurance by their employer and are unable to afford an individual policy.

- Individuals who are unable to afford health insurance premiums are charged considerably more for medical services than the insured because they are charged the full rate for services, whereas insurance companies negotiate a discounted rate.

Uninsured Focus Group Participants' Comments:

- Most uninsured focus group participants were employed. Many had been insured in the past, but lost coverage when their company downsized and they lost their jobs. Other participants were not eligible for insurance because they were working part-time.

** The opinions of Health Care Listening Tour and Focus Group participants are qualitative data. The themes are presented for descriptive purposes.*

Employer-Based Coverage Remains the Primary Source of Health Insurance

Of the 1,261 businesses that participated in the Employer Survey, 60% reported that they offer health insurance coverage to at least some of their employees, and 40% reported that they do not offer insurance to any of their employees. Over 84% of employers that provide health insurance to workers also cover spouses and dependents of employees.

The Household Survey found that the majority of Michigan residents with health insurance obtain their coverage through employer-sponsored plans. For adults aged 18 to 64 with insurance, 81% receive coverage though their employer. For insured children, 71% receive coverage through employer-sponsored health plans.

Industry type, Employer Size, and Time in Business Impact Employer-Based Coverage
The Household Survey found that the industry in which people work makes a difference as to whether they have health insurance. The uninsured are found disproportionately working in service jobs.

Among respondents to the Employer Survey, 83% of government entities offer insurance to at least some of their employees, as do 75% of manufacturers, 64% of health care providers, 60% of general merchandise and clothing stores, and 51% of personal or business service employers. In contrast, 42% of employers involved in farming or ranching offer health insurance to at least some of their employees, followed by 40% of employers that run food stores and 37% of employers operating eating and drinking establishments.

In general, the more employees businesses have, the more likely they are to offer insurance. The percentage of employers offering health insurance ranges from 31% of employers with less than five employees, to 98% for those with more than 100 employees.

The percentage of employers offering health insurance generally increases with gross revenue, ranging from 11% for employers with gross revenues between $10,001 and $50,000, to 84% for those with gross income of more than $500,000. The percentage also increases with length of time in business. The percentage of employers offering health insurance ranges from 25% for employers that have been in business for less than two years, up to 74% for those in business more than 20 years.

Workforce Characteristics of Employers Who Offer and Do Not Offer Insurance
Employers with a larger percentage of full-time workers are more likely to offer health insurance. On average, employers offering health insurance have 74% full-time and 20% part-time workers, compared to 53% full-time and 37% part-time workers for employers who do not.

On average, employees offered health insurance earn more than those who are not offered coverage. More than two-thirds of employees working for employers who offer health insurance earn more than $20,000 per year, while only about one-third of employees who work for employers who don't offer coverage earn more than $20,000.

Employer-Sponsored Retiree Coverage
Almost one in five employers that offers insurance to at least some of their employees offers Medicare supplemental or health insurance coverage to retirees over the age of 65. Nearly 17% cover retired employees under the age of 65. More than three-quarters of employers who offer coverage also cover their retirees' dependents.

Eligibility for Employer-Sponsored Coverage
Nearly 87% of employers require workers to be employed three months or less before becoming eligible for health insurance coverage, with 17% allowing immediate eligibility upon hire.

Thirty percent of employees who are offered health insurance must work at least 40 hours each week to be eligible. Almost half are required to work from 30 to 39 hours per week, and 22% need to work less than 30 hours per week to be eligible for health coverage.

Some Employees Decline Coverage
On average, employers report that 75% of their workforce is eligible for the company health insurance plan, but only 61% are enrolled. The major reason that employees decline coverage is because they're covered through a spouse's health insurance plan. Some decline coverage because they can't afford the premiums.

About one-fifth of employers require their employees to show proof of health insurance coverage before allowing them to decline enrollment in their company's health insurance plan. Almost one-third offer other compensation to employees who decline coverage.

Amount Employers Pay Toward Premiums
Nearly 73% of employers offering health insurance pay between 76% and 100% of premium costs for full-time employees, and 53% pay the same percentage for dependents of full-time workers. Only three percent of employers offering health insurance pay nothing toward the premium cost for their full-time employees and 27% pay nothing for dependents of full-time employees.

Of the 721 responding employers who offer health insurance, 20% self-insure a portion of their insurance program. In general, the more employees in a company, the more likely the employer is to self-insure.

Why Employers Offer or Do Not Offer Health Insurance

Employers cite the following reasons for offering coverage:

- It is the right thing to do (90%)
- It increases loyalty and decreases turnover (85%)
- It helps with employee recruitment (84%)
- Employees demand or expect it (79%)
- Competitors offer it (70%)
- It increases productivity by keeping employees healthy (70%)
- Owner wants or needs coverage (56%).

Employers who do not offer insurance cite the following reasons why they don't offer insurance:

- Premiums are too high (92%)
- Financial status of the company (79%)
- Employees are unwilling to contribute to the cost of premiums (66%)
- Employees are covered under other plans (64%)
- Can't meet insurance participation requirements (52%)
- Most employees are part-time, temporary or contractual (52%)
- It is not needed to attract good employees (50%).

High Health Care Cost is Culprit

Seventy-four percent of employers who do not offer health insurance to their workers "strongly agree" that they would be more likely to offer coverage if costs weren't so high, and 15% "somewhat agree". More than 80% would be willing to offer coverage if changes in premiums were more predictable.

*Challenges to Employers and Workers Caused by Increasing Health Care Costs**

Listening Tour Participants' Comments:

- Costs for uncompensated care for the uninsured result in higher health care costs for those who pay for care. Increased costs cause insurance premiums to rise beyond what some employers can afford, so they drop coverage for their employees, thus adding to the number of uninsured. Other employers increase their employees' share of the cost, which causes some employees to decline coverage, so they too become uninsured. Others take the insurance but find they can't afford the higher deductibles and co-payments, so they become effectively uninsured. This increase in the number of uninsured results in additional uncompensated care, and the cycle repeats itself.
- Some employers control their health insurance costs by keeping workers on part-time status, so they aren't eligible for their group plans.
- Most individuals find COBRA payments are too expensive to allow them to continue their health insurance coverage when they lose their job.
- Rising health care costs harm Michigan's economy by stifling entrepreneurship and suppressing small business start-ups. It also causes the uninsured to close small businesses and take jobs that provide health insurance.
- Some Michigan workers have seen their jobs transferred to other states and overseas as companies search for lower labor and production costs.

** The opinions of Health Care Listening Tour participants are qualitative data. The themes and quotes are presented for descriptive purposes.*

The Future of Employer-Sponsored Plans
Among employers who offer health insurance to their workers, six percent report it is "somewhat likely" and three percent report it is "very likely" they will not offer coverage next year.

In addition, 62% of employers think it is likely they will shift more of the cost of premiums to their employees in the next year; more than half stated they might switch to another insurance provider; 48% believe they might reduce benefits; and 44% believe they may offer a high deductible plan with a health savings account. More than 16% of employers say they are likely to eliminate or reduce dependent coverage. On the other hand, of responding employers who don't offer insurance, three percent report their companies are "likely" to offer health insurance, and 10% report their companies are "somewhat likely" to offer coverage within the next year.

Time without Insurance
According to the Household Survey, nearly 60% of uninsured adults and more than 40% of uninsured children have been without health insurance for more than two years, or have never been covered.

Length of Time Michigan's Residents Have Been Uninsured

	Less than 6 Months	6 Months to 2 Years	Longer than 2 Years	Never had Insurance
Uninsured Children	**31%**	**26.1%**	**31.9%**	**11%**
Uninsured Adults	**16.4%**	**24.6%**	**54.4%**	**4.6%**

Lack of Insurance and Cost of Services are Barriers to Accessing Health Care
The Household Survey found that over half of Michigan's uninsured adults have difficulty finding medical care since becoming uninsured. More than 40% pointed out that finding medical care for their children is also difficult. Over half (55%) of Michigan's uninsured adults feel they needed to see a doctor over the past year, but couldn't afford it and 27% indicated they could not afford to take their child to see a doctor. Nearly 40% of uninsured adults and 18% of children have no regular place to go for medical care.

Almost half of uninsured adults believe the most worrisome aspect of being uninsured is not being able to pay for their health care and 40% have a similar fear about their ability to pay for their children's care. The survey found that more than one-third of uninsured adults and 21% of families with uninsured children have accumulated large medical bills, which they have found difficult to pay.

*Challenges Facing the Uninsured**

Listening Tour Participants' Comments:

- Increasing numbers of uninsured individuals are seeking care at free and low-cost health care clinics. Many are people who were previously insured.
- The patchwork of insurance and coverage programs is expensive and doesn't meet the needs of many of Michigan's residents. As a result, those without insurance don't receive the care they need in a timely fashion, so they are sicker and their care is more costly when they finally receive it.
- Lack of dental care, and mental health and substance abuse treatment for the uninsured lead to greater health care expenses in the long run.
- Access to prescription drugs and specialty care are huge concerns for the uninsured.

Focus Group Participants' Comments

Uninsured Individuals:

- The uninsured feel that having health insurance is very important because it provides security, which they define as being able to see a doctor for preventive care to avoid future health problems, and not missing work due to illness. They also feel that insurance provides a way to avoid costly medical bills that may result in their financial ruin.
- Most focus group participants do not receive preventive care, laboratory tests, and maintenance prescriptions. Many also forego dental or vision check-ups. Participants with potentially serious medical conditions stated that they have been unable to see a specialist for tests or procedures because they use free clinics and low-cost health centers that do not provide specialty care.
- The uninsured try to avoid using emergency rooms, but say that there are times when they are unable to get an appointment elsewhere or find themselves needing care after business hours.
- Some focus group members with pre-existing conditions who had attempted to purchase health insurance discovered that their conditions made coverage unaffordable, if it was available at all.
- Specific age groups over-represented among the uninsured include: young adults; women 55 to 64, many of whom are caregivers; part-time workers; early retirees; health care workers; farmers; small business owners and their employees; divorced individuals; low-wage earners; substitute teachers, and paraprofessionals.
- The reasons group participants were without health insurance included: losing coverage when they were laid off from their jobs; not being able to afford their share of employer-based health insurance or COBRA; and not qualifying for government insurance programs, such as Medicaid.
- According to uninsured participants, paying for health insurance on their own is not feasible because it is unaffordable. Some participants had tried to afford insurance by cutting back on household expenses, but found the cost prohibitive. Many said that the cost of health insurance premiums is more than their monthly income.

* *The opinions of Health Care Listening Tour and Focus Group participants are qualitative data. The themes and quotes are presented for descriptive purposes.*

Paying for Health Care

According to the Household Survey, 93% of individuals living in a household with at least one uninsured member are willing to pay for health insurance that covers doctor visits, hospitalizations, and prescription drugs through an employer-based plan. Over 35% would be willing to pay up to $50 per month and another 30% would be willing to pay between $50 and $100 per month; 27% are willing to pay more than $100 per month.

Similarly, 90% of respondents in households with at least one uninsured individual would be willing to pay for a government-sponsored basic coverage plan, with 41% willing to pay up to $50 per month and another 30% willing to pay between $50 and $100 per month; 19% are willing to pay more than $100 per month. Over 92% of households with an uninsured child would enroll them in a government-sponsored health insurance program requiring no monthly premium, while 94% would enroll their children in such a program requiring a $5 monthly premium.

*Sharing the Responsibility of Paying for Health Care**

Listening Tour Participants' Comments:

- Everyone should contribute toward the cost of making affordable health insurance available to all residents. Employers, employees and individuals should all pay their fair share based on ability to pay.

Focus Group Participants' Comments

Uninsured Individuals:

- Uninsured individuals prefer that costs for health insurance be on a sliding scale, based on income.

Employers:

- Most employers believe health care to be a concern of business owners.

- Employers generally agreed that a fair system of financing health insurance would involve the employer and the employee sharing the costs of coverage. Others would like to see government contribute to the cost of health insurance and suggest the employer, employee and government each pay one-third of the cost. Others suggest that contributions from employers and employees should be a percentage of their income/revenues, with government subsidizing the remaining portion of premiums.

- Many employers, whether they offer or do not offer health insurance, say they feel that the government has to act to reduce the number of people without health insurance.

Insurance Agents:

- Agents believe that the current method of financing health insurance is fair because employers receive tax deductions and employees can finance their share with pre-tax dollars. Several agents suggested the government should provide a state plan with basic coverage for those who can't afford private plans.

- Most participants agreed that the government would be helpful in educating the public about the true cost of health care, and some support the government making quality and price information about physicians and hospitals available to the public. There was general support for state and federal governments creating more free and low-cost clinics.

** The opinions of Health Care Listening Tour and Focus Group participants are qualitative data. The themes and quotes are presented for descriptive purposes.*

*Health Care Access, Benefit Packages and Personal Responsibility**

Listening Tour Participants' Comments:

- Participants across Michigan believe that health care must be available to all, but should be linked to individuals making wiser lifestyle choices.

- All Michigan residents should have access to a basic array of preventive care, screenings, primary health care services, disease management and hospitalization.

- It is particularly critical that preventive care be provided to all Michigan residents, since prevention saves money, in addition to enhancing the quality of life. It would also make financial sense to better manage chronic disease in Michigan to prevent, or at least limit, episodes of critical illnesses.

Focus Group Participants' Comments

Uninsured Individuals:

- The majority of uninsured participants feel that it should be a priority to create more free and low-cost clinics. Others recommend: organizing free health screenings and health fairs; creating a universal health care plan; and changing the income guidelines for government-sponsored programs so more individuals qualify for assistance.

Insurance Agents:

- Agents believe that selling health insurance would be easier if agents were able to sell basic plans with optional add-on benefits.

- Agents indicated that if everyone had health insurance, risk pools would be larger, thus spreading health risks across the population. Some agents envision a government-subsidized high-risk pool, with high-risk insured individuals possibly paying higher premiums than lower-risk individuals.

** The opinions of Health Care Listening Tour and Focus Group participants are qualitative data. The themes and quotes are presented for descriptive purposes.*

Advisory Council Recommendations

Process
The Advisory Council met monthly between August 2005 and August 2006 to develop recommendations for expanding access to health insurance for all Michigan residents. During this project, over 40 options and mechanisms to extend health insurance to the uninsured were considered; these included health savings accounts, expansion of Medicaid, buy-in to the state employee plan, high deductible/catastrophic plans, high risk pools, and a multitude of other options.

The Advisory Council made its recommendations following thorough discussion and careful consideration of information from national organizations dedicated to studying health care issues, and documents specifically about Michigan's uninsured, as well as data gathered as part of the project, including the Household and Employer Surveys, and the focus group and town hall meetings. Consultants, who have worked extensively on health insurance expansion planning, were brought in to work with the Advisory Council, workgroup members and staff.

Using a consensus approach among key stakeholders and reflecting the quantitative and qualitative data collected, the Advisory Council developed the following recommendations to extend access to health insurance coverage to Michigan's uninsured.

Preamble
The Advisory Council for the Michigan State Planning Project for the Uninsured supports the goal of accessible, affordable, quality health insurance coverage for all Michigan residents. The Council reached agreement on numerous short-term recommendations to increase access to health insurance coverage. Implementation of these recommendations would secure access to health insurance coverage for the majority of those who are currently uninsured.

A key first step is a public education initiative to inform policy makers, the public, and businesses of the importance and value of health care coverage for all Michiganians, to improve not only the quality of life, but also the business and economic climate in this State.

The members of the Advisory Council pledge to work collaboratively to implement these recommendations. We encourage the Governor and the Legislature to take an active role and establish a high priority for implementing these recommendations. Reducing the number of uninsured in Michigan will greatly benefit all residents, as well as improve Michigan's business climate.

Achieving health insurance coverage for all Michiganians will require an extensive ongoing effort; thus, we propose the establishment of a successor council. The successor council will establish additional strategies to work toward the goal while responding to changes within the state, the country, the business community, and the insurance industry.

Short-term Recommendations

1. **Public Education Initiative:** To assure an informed public necessary for action towards the goal of accessible, affordable, quality health insurance coverage for all Michigan residents, we recommend that Michigan launch a public education initiative to inform residents and policy makers of the nature, severity and impact of Michigan having between 800,000 and 1.1 million of its residents without health insurance. This educational initiative should center on the ramifications of uninsurance and the importance of having health insurance coverage, such as:
   - More severe health problems for those without insurance when they do not receive timely and adequate health care services;
   - Cost shifting to purchasers of health insurance – employers, individuals and tax-funded public programs – which compounds the serious health cost problems facing Michigan employers and consumers;
   - Reduced competitiveness for all Michigan employers, but especially smaller businesses and those who compete in the international arena;

- Financial endangerment of Michigan hospitals and other providers.

2. **Business Climate:** Covering the uninsured should improve Michigan's business climate by reducing the cost burden of health insurance on Michigan employers. At the same time, expansion efforts, at least in the short term, should seek to maintain or expand upon the employer-based health insurance system. Efforts are needed to address the current erosion in private coverage, and to provide incentives for employers, especially small businesses, to maintain or provide health insurance for their workers.

3. **Michigan First Healthcare Plan:** The Advisory Council supports the direction of the "Michigan First Healthcare Plan" to extend coverage to all the low-income uninsured, which would mean coverage for about half of the total uninsured in Michigan. Council members look forward to working with the Michigan Department of Community Health in development of the program.

4. **Medicaid Payments:** Inadequate Medicaid payment rates for physicians, hospitals, and other health professionals are creating challenges today for the provision of health care services to the Medicaid population, which continues to experience sustained growth as it has over the past five years. Moreover, it is widely understood that inadequate Medicaid payment rates result in providers shifting costs to other payers, driving up expenses for Michigan employers and individuals. Ultimately, inadequate Medicaid payment rates and the shifting of costs to other payers are having an adverse impact on health care access for the people of Michigan. Therefore, it is necessary to address the adequacy of Medicaid payment rates for providers, hospitals, and managed care organizations.

5. **Health Safety Net Providers:** Across Michigan, there is a patchwork of private and public health centers, clinics, and providers that comprise the health care safety net[13]. In addition to serving a segment of the uninsured, safety net providers are also significant providers of care to low-income populations, including Medicaid beneficiaries and persons with limited private insurance coverage (the underinsured). The safety net plays a vital role for those who fall outside the medical and economic mainstream, providing access to primary and preventive care for many vulnerable populations. However, the demands placed on many safety net organizations continue to increase. The Advisory Council recommends that the health care safety net provider system be strengthened to better address the health care needs of our most vulnerable populations.

6. **Group Health Plans:** The Advisory Council supports efforts to maximize enrollment of eligible individuals and dependents into group-sponsored health insurance. Every Michigan resident who has access to affordable and adequate group health insurance coverage – through employers, collective bargaining agreements, or public programs – should elect to enroll. Employers, unions, and government should develop incentives to ensure full enrollment. Educational efforts are also needed to inform Michigan residents of the importance of enrolling in available group health plans.

7. **Dependent Coverage:** Employers that offer health insurance to employees should be encouraged and offered incentives to offer dependent coverage (with or without employer contributions). Offering participation in the health insurance pool provides the benefits of group purchase for dependents, as well as potential tax advantages for employers and employees. In addition, health insurance carriers should be encouraged to inform policyholders of available options to continue coverage for dependents that may be losing eligibility as a result of age or change in student status. Educational efforts are also needed to inform Michigan residents of the importance of enrolling dependents in health insurance plans.

8. **Child-Only and Young Adult Policies:** The Advisory Council encourages public and private efforts to raise awareness among families with uninsured children and young adults, of the availability of child-only and young adult health

[13] According to the Institute of Medicine, core safety net providers have two distinguishing characteristics: either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients. In addition, there are other safety net providers that may not meet the definition of a "core" safety net provider but nonetheless provide significant care to the uninsured.

insurance policies, including low-cost options. In addition, health insurance carriers should be encouraged to identify this emerging individual retail market and to develop and promote relevant insurance products for this market. Michigan colleges and universities should encourage students to have health insurance coverage, as well as offer and promote access to low-cost health insurance policies to students who do not have other options.

9. **Child Coverage:** The relatively high levels of coverage for children in Michigan should be maintained and, if possible, increased as efforts to move toward coverage for 100% of Michigan residents are pursued.

Successor Council: Ongoing Effort to Achieve Health Care Coverage for All Michiganians

10. **Successor Council:** The Advisory Council supports creation of a successor council – a partnership that will focus on securing health insurance coverage for all Michigan residents and address the inextricably intertwined issues of cost containment, access, and quality of health care. A priority for the successor council will be to implement the recommendations of the State Planning Project Advisory Council.

The successor council should be non-partisan, independent of state government, and non-profit. It should include representation from all Michigan stakeholders, and be staffed sufficiently to assure its operational effectiveness. Given these characteristics, the successor council would be able to provide broad policy input to key State officials from the political parties and in both the Executive and Legislative branches on elements associated with assuring access to health insurance coverage for all Michiganians. Those implementing the successor council should seek funding from foundation and other private sources, preferably blended funding from a consortium of foundations.

11. **Successor Council Business Plan:** A phased-in project/business plan shall be developed by the successor council for covering the remaining uninsured.

- Each phase shall include: number of uninsured to be covered, timeline, sources of revenue (state and federal), expected costs or outlays, and remaining number of uninsured yet to be covered.
- The successor council shall arrange for a healthcare financing study to determine how health care dollars are spent in Michigan, and provide recommendations for change as appropriate.
- The business/project plan shall incorporate the recommendations of the Advisory Council.
- The business/project plan should be linked with other efforts to secure dramatic, consistent, and measurable improvement in cost, quality, and access.

Concluding Comments about the Advisory Council's Process

The Advisory Council agreed to support the goal of health coverage for all Michiganians following a thorough discussion of the current health insurance environment in our state. The Council was able to reach consensus on the above recommendations because of the willingness of Council members to participate in extended discussion to overcome prior differences. That process enabled the members to better understand the philosophical and economic differences among the members, including all the major perspectives – consumers, employers, government, health care providers, health insurance carriers, organized labor, and voluntary advocacy organizations – and reach consensus that a continued dialogue would be required to meet the ultimate goal of coverage for all Michigan residents.

Implementation of the short-term recommendations would secure health coverage for those up to 200% of the poverty level, as well as for young adults and children, and thus the majority of those currently uninsured. The Successor Council would continue to pursue consensus on the key issue of the roles to be played by the affected parties – consumers, employers, government, health care providers, health insurance carriers, organized labor, voluntary advocacy associations and others – to achieve meaningful health insurance coverage for all Michigan residents.

APPENDIX I

Advisory Council

Roster of Members

Member	Organization
Chris Allen	Detroit Wayne County Health Authority
Vernice Davis Anthony	Greater Detroit Area Health Council
Elaine Beane (ex-officio)	Michigan Public Health Institute
William Black	Michigan Teamsters Joint Council #43
Debra Brinson	School-Community Health Alliance of Michigan
Jan Christensen (co-chair)	Michigan Department of Community Health
Patience Drake-Rosenbaum	Michigan Consumer Health Care Coalition
Paul Duguay	Michigan Association of Health Plans
Marge Faville, RN	SEIU Local 79
Rob Fowler	Small Business Association of Michigan
Steve Gools	AARP/Michigan
Denise Holmes	Michigan State University, College of Human Medicine
Larry Horwitz	Economic Alliance for Michigan
Sister Mary Ellen Howard, RSM	Free Clinics of Michigan
Jan Hudson	Michigan League for Human Services
Spencer Johnson	Michigan Health & Hospital Association
Kevin A. Kelly	Michigan State Medical Society
Tim McGuire	Michigan Association of Counties
Marjorie Mitchell	MI Universal Health Care Action Network
Joan Moiles	Department of Labor & Economic Growth
Colette Scrimger	Access to Care Community Coalition
Kevin Seitz (co-chair)	Blue Cross Blue Shield of Michigan
Susan Sevensma, DO	Michigan Osteopathic Association
Amy Shaw	Michigan Manufacturers Association
Kim Sibilsky	Michigan Primary Care Association
Kimberly Singh	Michigan Association for Local Public Health
Stephen Skorcz	Greater Flint Health Coalition
Hollis Turnham (ex-officio)	Paraprofessional Healthcare Institute
Sebastian Wade/Ed Wolking, Jr.	Detroit Regional Chamber
Vondie Woodbury (ex-officio)	Muskegon Community Health Project
Lody Zwarensteyn	Alliance for Health

Meetings

The Advisory Council meetings were held on:

August 22, 2005
October 19, 2005
December 5, 2005
January 18, 2006
February 8, 2006
February 22, 2006
March 15, 2006
April 19, 2006
May 24, 2006
June 19, 2006
August 16, 2006

Goals

As outlined in the Department's grant application to HRSA, the goals of the Advisory Council for the State Planning Project for the Uninsured were to develop strategies to ensure that all Michigan residents have access to health insurance coverage, and to promote an understanding of uninsurance issues among key stakeholders, policymakers and the public.

Activities

The Advisory Council, appointed by Janet Olszewski, Director of the Michigan Department of Community Health, included large and small businesses, unions, health care providers, health plans, seniors, free clinics, consumers, local public health, consumer coalitions, and insurers.

Early on, the Advisory Council adopted ground rules for effective communication and decision-making, as well as agreement regarding process and roles.

The Advisory Council received information from several sources, including the "Getting from Here to There" document from the Models Development Workgroup; household and employer survey reports; a town hall meeting report; a report of focus groups with employers, insurance agents and the uninsured; and several relevant documents from the Data Synthesis Workgroup. Using this information, the Advisory Council developed recommendations to extend health insurance to additional Michiganians. A successor organization will now focus on health care coverage for all Michigan residents and address the intertwined issues of cost containment, access, and quality of health care.

APPENDIX II

Community Interface Workgroup

Roster of Members

Member	Organization
Diana Algra	Volunteer Center of Michigan
John Barnas	Center for Rural Health
Tameshia Bridges	Paraprofessional Health Institute
Pat Clemens	Ogemaw-Roscommon Counties Human Services
Sharon Collins	Community Action Agency-Head Start/Jackson
Michelle Debbink	American Medical Student Association
Christi Downing	Michigan Department of Community Health
Laura Ferrara	Bringing the Eden Alternative to Michigan
John Freeman	Service Employees International Union
Juanita Gittings	St. Clair County Community Services Coordinating Body
Doug Halladay	Detroit Wayne County Health Authority
Kim Hodge	Paraprofessional Health Institute
Sandy Hudson	Detroit Wayne County Health Authority
Jacqueline Jones	United Way of Southeast Michigan
Donna Littlejohn	Mercy Primary Care
Tom Leyden	Michigan Peer Review Organization
Susan Martin	Representative Shaffer's Office
Laurie Meoak	Community Health Action Coalition
Jennifer Mora	Michigan Primary Care Association
Shoma Pal	Blue Cross Blue Shield of Michigan
Lisa Rajt	Blue Cross Blue Shield of Michigan
Connie Rieger	Northwest Michigan Human Services Agency
Mary Smith	Community Action Agency of South Central Michigan - Education and Children's Services.
Victor Sztengel	Wexford Mercy Physician Hospital Organization
Vondie Woodbury (facilitator)	Muskegon Community Health Project
Jeanne Wright	Eaton County Commissioner

Consultants:

Ed Banks	Michigan Public Health Institute
Marti Kay Sherry	Michigan Public Health Institute

Michigan Department of Community Health Staff:

Lonnie Barnett
Scott Blakeney
T.J. Bucholz
Bill Hart
Geralyn Lasher
Ken Miller
Ellen Speckman-Randall

Meetings

Community Interface Workgroup meetings were held on the following dates:

July 19, 2005	September 8, 2005	November 10, 2005
August 11, 2005	October 13, 2005	

Goals

The Community Interface Workgroup goals were to: oversee town hall meetings and public website content, promote opportunities for the public to have input into the State Planning Project for the Uninsured, and develop strategies to engage community stakeholders and leaders to build consensus.

Activities

Relative to the website, the Community Interface Workgroup:

- Provided guidance as MDCH developed a website for dissemination of documents connected with the State Planning Project for the Uninsured.
- Provided input to MDCH as web pages were established for workgroup and Advisory Council members. These web pages provided access to relevant documents, meeting minutes, agendas, meeting schedules, and timely updates.
- Promoted public access to the website so citizens could follow the progress of the uninsured project, review findings, pose questions and provide feedback.

Relative to the Focus Groups with Employers, the Community Interface Workgroup:

- Assisted with developing focus group questions to learn about:
    - Barriers employers face in offering health insurance.
    - Motivating factors for offering health insurance to employees.
    - Essential and important elements of programs aimed at providing coverage to all Michigan citizens.
    - Systemic changes that are needed.
    - Participants' interest in offering insurance through the small group market.
- Promoted attendance of employers at focus group meetings.

Relative to Focus Groups with Brokers and Insurance Agents, the Community Interface Workgroup:

- Assisted with developing focus group questions to learn about:
    - Common myths held by small and mid-sized business owners about providing health insurance to employees.
    - Successful strategies brokers and agents have developed to encourage small businesses to provide health insurance to their employees.
    - Participants' perceptions of awareness and interest in small group market reforms.
- Participated in recruitment activities.

Relative to Focus Groups with the Uninsured, the Community Interface Workgroup:

- Developed questions to be posed at focus groups to solicit information about the impact of uninsurance on the uninsured.

Relative to Town Hall Meetings, the Community Interface Workgroup:

- Assisted in selecting locations for town hall meetings.
- In conjunction with DCH staff, developed questions to increase the Workgroups' and Advisory Council's understanding of community perspectives.
- Individually sponsored or helped recruit local sponsors to assist with logistics of town hall meetings.
- Promoted town hall meetings throughout the state.
- Promoted plans for the town hall meetings to solicit input on the following:
    - The impact that the lack of insurance has on communities.
    - Specify what should be included in basic insurance coverage and access in Michigan.
    - Set priorities and put forth ideas for expansion.

APPENDIX III

Data Synthesis Workgroup

Roster of Members

Members	Organization
Beth Ainsworth	Michigan Works
Anne Barna	Barry-Eaton District Health Department
Elaine Beane (facilitator)	Michigan Public Health Institute
Nick Benjamin	MichUHCAN
Katherine Boynton	Michigan Department of Community Health
Tameshia Bridges	Paraprofessional Healthcare Institute
Gary Burmeister	Consultants for Quality Healthcare
Dale Carlson	Ingham Regional Medical Center
Gerald Chase	Northwest Michigan Community Health Agency
Marcus Cheatham	Ingham County Health Department
Rebecca Cienki	Michigan Primary Care Association
Colleen Cieszkowski	Michigan Peer Review Organization
Greg Cline	Trinity Health
Janette Davis	Detroit Wayne County Health Authority
Marega DeLizio	Association for Children's Mental Health & MCET
Diane Dykstra	United Way of Wexford County
Eileen Ellis	Health Management Associates
Monty Fakhouri	Michigan Public Health Association
Rosalind Garcia-Tosi	Mott Children's Health Center
Melany Gavulic	Hurley Medical Center
William Gifford	Michigan Academy of Family Physicians
Raymond Higbea	Doctoral Student, Western Michigan University
Kim Hodge	Paraprofessional Healthcare Institute
Sheryl Lowe	Blue Cross Blue Shield of Michigan
Kate Martin	Community Action Agency
Cathy Maxwell	Healthkey of Alpena and Tawas
Denise Morrow	Michigan Department of Community Health
Robert Mosher	MB Research Associates
Michelle Munson-McCorry	Complete Compassionate Care
Lynn Nee	Michigan Network for Youth and Families
Ken Oishi	Michigan Peer Review Organization
Mary Palazzolo	Detroit Medical Center
Ann Rafferty	Michigan Department of Community Health
Carolynn Rowland	Healthy Mothers Healthy Babies
Robert Stampfly	Michigan State University
Randy Stuck	The Virtual Health Plan
Beverly Takahashi	Wayne State University
Geoffrey Vasquez	MichUHCAN
Fran Wallace	Michigan Department of Labor and Economic Growth
DeAnna Warren	Michigan Primary Care Association
Adreanne Waller	Washtenaw County Public Health Department
Elizabeth Wasilevich	Michigan Department of Community Health
Carolyn Wiener	Blue Cross Blue Shield of Michigan

Shannon Zackery	Michigan Department of Community Health
Michael Zaroukian	Michigan State University, School of Human Medicine
Laurence Ziomkowski	Marquette Medical Access Coalition

Michigan Department of Community Health Staff
Umbrin Ateequi
Lonnie Barnett
Bill Hart
Ken Miller
Ellen Speckman-Randall
Traci Wightman

Meetings

Data Synthesis Workgroup meetings were held on the following dates:

July 20, 2005
August 16, 2005
September 13, 2005
October 14, 2005
November 19, 2005
December 13, 2005
January 10, 2006
February 14, 2006
March 14, 2006
May 9, 2006

Goals

The goals of the Data Synthesis Workgroup were: to work with contractors on data issues, and modify survey instruments and synthesize data findings into useable documents; collect and analyze detailed data on the insurance status of Michigan's population and on the uninsured; assess the current market, insurance initiatives, and safety net capacity; and catalog existing health care coverage in Michigan, including the sponsors of each coverage and a matrix of the individuals who qualify for that coverage. These tasks were especially important given the existence of many community-based programs that provide ambulatory health care and Third-Share Programs that provide subsidized health coverage or health insurance for employees of low-wage businesses.

Activities

The Data Synthesis Workgroup engaged in the following activities to achieve their goals:

- Worked with Michigan Public Health Institute–Center for Research in Health Outcomes and Policy (MPHI-CRHOP) to review and structure the findings of the Michigan Household Health Insurance Survey and the Michigan Employer Health Insurance Survey.
- Worked with MDCH and the Michigan Primary Care Association (MPCA) to develop a health care safety net review that examined the roles of the many providers of care to the uninsured.
- Worked with MPHI-CRHOP, MDCH, and the Access to Care Community Coalition to promote completion of the Michigan Employer Health Insurance Survey.
- Worked with MPHI-CRHOP, MDCH, and the Access to Care Community Coalition to recruit employers to participate in focus groups.
- Helped fulfill data requests from the Advisory Council and from other workgroups.
- Provided input on data in the Household Survey and Employer Survey reports, particularly with respect to: comparisons among the Michigan Household Health Insurance Survey findings and those of the Current Population Survey (CPS), Medical Expenditure Panel Survey (MEPS), and other national sources.
- Developed a list of indicators to be used to evaluate health status under health insurance expansion plans. These indicators will be tied to the impact of preventive services and chronic disease management.

- Developed a list of indicators to be used in characterizing the status of the Michigan health care safety net, including health care providers of preventive, primary, specialty, and tertiary care, Hospital Service Areas and Medical Service Areas, and data provided by the Free Clinics of Michigan on the health care seeking behaviors of the uninsured.
- Evaluated approaching shortages in the health care workforce, especially physicians and nurses, relative to their impact on the future of the safety net, the effect of Medicaid reimbursement rates on the retention of health care professionals, and how proposed health insurance expansions may be affected by the shortage of health care providers.

APPENDIX IV

Models Development Workgroup

Roster of Members

Members	Organization
Beth Ainsworth	Michigan Works
Suzy Alberts	Comerica Insurance Services/Michigan Association of Health Underwriters
Anne Barna	Barry Eaton District Health Department
Elaine Beane	Michigan Public Health Institute
Angie Beattie	Michigan Peer Review Organization
Gary Benjamin	MI Legal Services; MichUHCAN
Arlene Brennan	Grand Traverse Regional Health Care Coalition
Tameshia Bridges	Paraprofessional Healthcare Institute
Ben Bryner	University of Michigan Medical School Legislative Affairs
Marcy Buren	Health Access
Gary Burmeister	Consultants for Quality Healthcare
Gerald Chase	Michigan Association for Local Public Health, Michigan Primary Care Association
Nick Ciaramitaro	Michigan AFSCME Council 25
Colleen Cieszkowski	Michigan Peer Review Organization
Greg Cline	Trinity Health
Kathleen Conway	Henry Ford Health System
Norman DeLisle Jr.	Michigan Disability Rights Coalition
Marega DeLizio	Association for Children's Mental Health
Jackie Doig	Center for Civil Justice
Frances Pouch Downes	Michigan Department of Community Health
Paulette Duggins	Parents of Children with Down Syndrome
Eileen Ellis	Health Management Associates
Christine Farrell	Michigan Department of Community Health
Burt Fenby	Lenawee County Community Action Agency
Catherine Ficara	Austin Financial Group
Sarah Fink	Michigan Health and Hospital Association
Jeff Fortenbacher	Access Health
Jaeson Fournier	Ingham County Health Department
John Freeman	Service Employees International Union
Edward Gamache	Deckerville Community Hospital
Barbara Gonzales	St. John Health
Princella Graham	St. John Health
Kim Hodge	Paraprofessional Healthcare Institute
Deborah Hollis	Michigan Department of Community Health
Denise Holmes	Michigan State University
Sandy Hudson	Detroit Wayne County Health Authority
Jacqueline Jones	United Way for Southeastern Michigan
Molly Kaser	Center for Family Health
John Kerr	Greater Detroit Area Health Council
Jennifer Kibicho	Office of the Governor, Public Policy Division
Cheryl Korpela	Advomas
Andy Kruse	Genesys Health System
Paul Lazar	Michigan Academy of Family Physicians

Peter Levine	Genesee County Medical Society
Nancy Lindman	Michigan 2-1-1, Michigan United Way
Sheryl Lowe	Blue Cross Blue Shield of Michigan
Scott Lyon	Small Business Association of Michigan
Del Malloch	Jackson Health Plan Corp-3-share
Noble Maseru	City of Detroit
Cathy Maxwell	Healthkey
Lisa McCafferty	Ionia County Health Department
William McGregor	Hurley Medical Center
Don McMahon	Michigan Department of Community Health
Robert Meeker	Spectrum Health
Margaret Meyers	Mercy Primary Care Center
Bruce Miller	Northern Health Plan
Joan Moiles	Michigan Department of Labor and Economic Growth, Office of Financial and Insurance Services
Cherie Mollison	Michigan Office of Services to the Aging
Denise Morrow	Michigan Department of Community Health
Michelle Munson-McCorry	Complete Compassionate Care
Richard Nowakowski	Wayne County Four Star
Mary Palazzolo	Detroit Medical Center
Chris Palombo	Medical Care Access Coalition
Robert Pestronk	Genesee County Health Department
Gary Petroni	Southeast Michigan Health Association/Center for Population Health
James Phillips, M.D.	Private practice
Janis Pinter	Bay Arenac Behavioral Health
George J. Pramstaller	Michigan Department of Corrections
Valerie Przywara	Henry Ford Health System
Ellen Rabinowitz	Washtenaw Health Plans
Lisa Rajt	Blue Cross Blue Shield of Michigan
John Saalwaechter	Michigan Academy of Family Physicians
Kristie Schmiege	Genesee County Health Department
Collette Scrimger	Barry-Eaton District Health Department
Tyffany Shadd-Coleman	Blue Cross Blue Shield of Michigan
Charissa Shawcross	Joy-Southfield Community Health Center
Chris Shea	Cherry Street Health Services
Joanne Sheldon	Life Ways Community Mental Health Authority
Marti Kay Sherry	Michigan Public Health Institute
Kim Sibilsky	Michigan Primary Care Association
Lucille Smith	Voices of Detroit Initiative
Patricia Somsel	Michigan Department of Community Health
Colleen Sproul	HealthPlus of Michigan
Robert Stampfly	Michigan State University, Institute for Health Care Studies
Susan Steinke	Michigan Quality Community Care Council
Randy Stuck	The Virtual Health Plan
Lauren Swanson	Michigan Office of Services to the Aging
Victor Sztengel	Wexford Mercy Physician Hospital Organization
Cheryl Tannaf	University of Michigan Medical Education
Cynthia Taueg	St. John Health
Hollis Turnham (facilitator)	Paraprofessional Healthcare Institute
Don VeCasey	Michigan Consumer Health Care Coalition
Evert Vermeer	Healthy Kent 2010
Sebastian Wade	Detroit Regional Chamber

Gordon Weatherhead	Downriver Community Services
Teresa Wehrwein	Michigan State University College of Nursing
Lary Wells	Michigan League for Human Services
Elliott Wicks	Health Management Associates
Carolyn Wiener	Blue Cross Blue Shield of Michigan
Mark Witte	Treatment and Prevention of Substance Use Disorders
Edward Wolking, Jr.	Detroit Regional Chamber
Scott Woods	Priority Health
Linda Yaroch	Northwest Michigan Community Health Agency
Susan Yontz	Michigan Department of Community Health
Rachel Yoskowitz	Jewish Family Service
Lynda Zeller	Kent Health Plan
Lody Zwarensteyn	Alliance for Health
Jane Zwiers	First Presbyterian Church Health Clinics & Free Clinics of Michigan

Michigan Department of Community Health Staff
Umbrin Ateequi
Angela Awrey
Lonnie Barnett
Ken Miller
Ellen Speckman-Randall

Meetings

Over the course of nine months, the Models Development Workgroup met on the following dates:

July 22, 2005	October 12 and 26, 2005	January 4 and 11, 2006
August 3 and 7, 2005	November 9 and 22, 2005	February 1, 2006
September 14 and 29, 2005	December 7 and 21, 2005	March 1, 2006

Goals

The Models Development Workgroup's broad goals were to review the current insurance environment, assess safety net capacity, develop guiding principles for evaluating models in terms of feasibility, cost, and acceptability; and formulate issue papers on coverage options.

Specifically, the Models Development Workgroup goals were to:

- Formulate issue papers on coverage options after assessing models in terms of feasibility, cost and acceptability, which included:
    - A study of options utilized by other states.
    - Development of a framework analyzing information received and organizing information to be presented (e.g., a matrix showing each option and its features and impacts).
- Review information from the household survey, employer survey, and focus groups, as follows:
    - Number of people who are insured and uninsured.
    - Relevant characteristics of both groups.
    - Reasons why the uninsured do not have health insurance.
- Review information from the town hall meetings including:
    - Citizen perceptions and expectations about health insurance.
    - Standards of acceptability for guiding the model development process.

    - The nature and extent of the problems faced by Michigan's uninsured.
- Evaluate the advantages and disadvantages of each expansion option.
- Estimate costs of selected options and explore financing mechanisms.
- Evaluate the experiences of other states having implemented various options.
- Assess each option's features in the context of Michigan's:
    - Current needs (e.g. the characteristics of Michigan's uninsured).
    - Health insurance market.
    - Health care delivery system.
    - Safety net providers (e.g., third-share providers).
- Assess employers' attitudes toward public subsidies.
- Investigate the extent of "crowd-out" for various expansion options.
- Develop and recommend a prioritized list of health insurance expansion options to the Advisory Council.

The MDWG also developed goals to evaluate potential models and a short- and long-term plan for ensuring that all of Michigan's residents have health care coverage.

Activities

With a broad-based membership and a desire to insure broad participation through frank dialogue, the MDWG agreed to a specifically-defined consensus process for its deliberations and recommendations. Each member was asked to support, stand aside, or block specific recommendations and the overall report.

The Models Development Workgroup divided themselves into four groups to look at expansion options. Initially, the four groups were, Basic Benefit/Specific Subpopulations of Uninsured, Universal Coverage, Medicaid/SCHIP Expansion, and Pooling/Insurance Reforms. They used the document "What Does a Win Look Like?" as initial guidance from the Advisory Council, and the Expansion Model Evaluation Template documents to structure and guide their deliberations.

During the course of their meetings, the MDWG provided input into the Health Insurance Landscape Analysis, which is a "living document" developed by Eileen Ellis from Health Management Associates.

The workgroup then developed the consensus document entitled "Getting from Here to There" (Appendix V) to expand coverage to 100% of Michigan's residents within five years. These recommendations outline some specific recommended activities and in other cases, describe alternatives for consideration or further study. This recommended proposal was developed to aid the Advisory Council in their deliberations.

APPENDIX V

Models Development Workgroup Recommendations to the Advisory Council

February 8, 2006

"Getting from Here to There"

The Michigan Department of Community Health is in the midst of an initiative to ensure that all Michigan residents have access to health insurance. The federally funded Michigan State Planning Project for the Uninsured is developing a plan with realistic strategies and viable options to provide access to comprehensive, affordable health insurance coverage for all Michigan residents.

The consequences of being uninsured are well documented, and the costs associated with caring for the uninsured, along with rising health care costs, are creating challenges throughout Michigan. One of the project's goals includes expanding the current knowledge base regarding uninsurance issues by collecting data about unmet need, barriers to insurance coverage, and system changes needed to secure coverage for all Michigan citizens.

Data collection efforts by the Michigan State Planning Project included: a randomized Michigan Household Health Survey (Household Survey) of over 13,000 households, with focused questions for residents without health insurance; a randomized mail survey of over 1,200 Michigan employers; focus groups with small and mid-sized employers, insurance brokers and the uninsured; town hall meetings; and key informant interviews with policymakers.

The structure for the Michigan State Planning Project for the Uninsured included an Advisory Council to the Michigan Department of Community Health (MDCH) and three workgroups. The Advisory Council, which includes representatives from business, health care, insurers, regulators, and consumers, was appointed by the Director of MDCH.

The three workgroups (Data Synthesis, Models Development, and Community Interface) assisted project staff with: designing data collection approaches and reviewing data; reviewing and assessing models; reviewing and assessing plan components; and developing strategies to engage community stakeholders and build consensus.

The Models Development Workgroup (MDWG) met two afternoons a month from August 2005 through February 2006 and developed the following proposal for extending health insurance to all Michigan residents. Workgroup members had a very wide breadth of knowledge and commitment. Numerous hours went into development of this proposal.

This document outlines the recommendations of the Models Development Workgroup. It does not capture all the details explored by the entire Workgroup or its subcommittees. In brief, members of four subcommittees developed options for extending health care coverage to additional uninsured individuals. These options were then developed into a continuum that provides health insurance to all Michiganians when fully implemented.

The MDWG used a consensus process to develop this report and its recommendations. For each section of this report, members could agree, stand aside or block inclusion of the section's content. Members could stand aside if they did not actively support an item, but were content with including it in the report. When a member blocked an item, the MDGW discussed it until everyone either supported it or was willing to stand aside. This proposal as currently drafted was approved using this consensus process.

While each workgroup member did not actively support every option, suggestion, or activity in every phase, all are willing to let the document go forward in support of health coverage for 100% of Michigan's residents.

Introduction:

This report from the Models Development Work Group (MDWG) to the Advisory Council outlines options to secure health insurance for all Michigan residents. The proposal outlines options that build upon each other, with the initial phase providing health insurance for individuals and families with income up to 100% of poverty, the second phase adds those up to 200% of poverty and the later phases provide coverage for all remaining uninsured Michigan residents. Securing health coverage of all people living at or below 200% of poverty ($33,200/year for a family of three) will cover 63% of the state's uninsured, according to the Household Survey.

A key component is to reduce the cost of health care so that Michigan employers can better afford to provide health insurance to their employees. Spiraling health care costs have created a major burden for Michigan businesses in the global marketplace. However, we must insure that access and quality of care do not suffer as costs are reduced.

There are no magic bullet solutions to extending health insurance to those without coverage. It is a very complicated task. As a result, each option discussed will have risks and benefits, advantages and disadvantages. While some of the risks and disadvantages can be minimized by careful design and implementation, the ultimate objective is to extend health care coverage to all Michigan residents.

Background:

Michigan's employer-based health insurance system provides coverage to 81% of the state's insured adults aged 19 to 64, and 71% of insured children. Publicly-funded programs, such as Medicare and Medicaid, cover 16% of the state's insured adults under the age of 65, and 28% of insured children.[1] Since almost all elderly individuals have access to the Medicare program, this proposal focuses on securing health coverage for people under the age of 65.

Estimates of the number of non-elderly uninsured individuals in Michigan vary. Reasons for that are discussed in greater detail in the Household Survey Report that was conducted in conjunction with the State Planning Project for the Uninsured. This proposal uses Household Survey data whenever possible. However, when such data is not available, we use data from the Current Population Survey (CPS).

The number of people in Michigan without insurance coverage on any given day, according to the project-conducted Household Survey, is about 800,000 or 7.8% of the state's population. While this is lower than the national uninsured average, the continued loss of manufacturing jobs, combined with a sluggish economy, is eroding employer-based coverage in Michigan, especially for workers' dependents. This means the number of people covered by Medicaid is growing. Medicaid now covers 1.5 million Michiganians or 15% of the population. The Michigan Medicaid program covers 35% more individuals today than it did five years ago. Much of this increase represents low-income children who have lost dependent coverage and adults who have lost their jobs and exhausted their unemployment benefits.

The demographics of the uninsured must be considered when developing a strategy to expand health care coverage. More than half (63%) of Michigan's uninsured individuals live in families with incomes below 200% of the federal poverty level ($33,200/year for a family of three). Over half of Michigan's uninsured individuals are non-disabled adults below the age of 65, who are not parents of minor children.[2] This group will be labeled "childless adults" in this document in keeping with federal language. More than half of uninsured childless adults have incomes below 200% of poverty ($19,600 for a single person) and they represent more than 25% of all uninsured people in Michigan.

Employers and individuals who purchase insurance pay a significant portion of the cost for health care

[1] State Planning Project for the Uninsured, Michigan Household Health Insurance Survey Report, August 2006.

[2] For this discussion, "non-disabled" means an individual who do not meet the Social Security Administration's standard, which requires total disability for at least 12 months. Thus, the "non-disabled" includes many individuals with serious health problems and shorter-term disabilities.

for the uninsured or underinsured. Families USA estimates that in Michigan, $730 a year is added to the cost of a family policy and $274 a year to an individual policy, to cover health care costs of the uninsured. [3] Therefore, any program that increases the number of insured individuals benefits employers and individuals who purchase insurance by eliminating this excess cost. Additionally, cost saving options which would streamline and consolidate authorization and billing systems, and lower administrative costs, would be advantageous to health insurance purchasers.

Our challenge is to develop a plan that provides smooth transitions into a system in which all residents will have health insurance.

Strategic Concerns:

Before developing its models, the MDWG carefully considered the following concerns expressed by Advisory Council members in various meetings:

- Expansion options should be designed to improve business competitiveness by making health care more affordable in Michigan.

- Expansion options should maximize the use of federal dollars; this is clearly accomplished by using Medicaid matching funds.

- Options should pursue coverage for all children in Michigan.

- Any expansion program cannot use current Medicaid provider reimbursement rates since continued use of these rates could further reduce provider participation in the Medicaid program. More Medicaid recipients seeking health services at current Medicaid rates threaten the financial viability of providers whose patient base is disproportionately on Medicaid. Any reduction in the numbers of Medicaid providers will exacerbate current access problems both for Medicaid recipients and others in communities served by providers who give care to large numbers of Medicaid patients. Continued use of current Medicaid rates also could result in further erosion of employer-based coverage, when unreimbursed costs of caring for Medicaid patients are shifted to those with private insurance.

- Expansion options must minimize further erosion of employer-based coverage and must support its growth. Any expansion of public coverage must be designed to minimize incentives for reductions in private coverage, known as "crowd-out". It is important that low-income individuals and families who currently have employer-based insurance retain that coverage so we can concentrate on insuring the uninsured rather than simply shifting the currently insured from employer-based coverage to public coverage. This growth in public coverage and loss of employer-based coverage has occurred in other states that have attempted to reduce the number of uninsured.

- Finally, expansion options should create a new role for state government to partner with employers to reduce health care costs, improve the quality of health care, and expand access to care.

Problem Identification—Who are Michigan's Uninsured?

Large numbers of Michigan's uninsured individuals have low or modest incomes and thus have limited ability to purchase health insurance. According to the Household Survey, more than 25% of the uninsured in Michigan live below 100% of the federal poverty level ($16,600/year for a family of three), 63% live below 200 percent of poverty ($33,200/year for a family of three), and 85% of the uninsured population live below 300% of the federal poverty level ($49,800/year for a family of three). (See glossary for a chart detailing federal poverty levels for various family sizes.)

The prevalence of employer-based coverage is decreasing everywhere. In 2004, 77% of insured Michiganians had employer-based insurance, while nationally only 70% had such coverage. However, according to the Kaiser Family Foundation, in 2000, 83% of insured Michiganians had employer-based coverage while the national rate was 75%.[4] The six percent reduction in employer-based coverage in Michigan between 2000 and 2004 represents almost 350,000 uninsured individuals.

[3] Paying a Premium: The Added Cost of Care for the Uninsured, a Report by Families USA, June 2005.

[4] Henry J. Kaiser Family Foundation, Statehealthfacts.org

While millions of Michigan citizens have access to health insurance coverage through their employers, many working individuals are not offered health insurance, cannot afford their share of the costs, or are not eligible for coverage their employers offer. Over 60,000 households that are eligible do not take employer coverage, primarily because they cannot afford their share of the cost. In addition, almost 84,000 Michigan households have an adult who works for an employer that offers insurance, but the employee is not eligible because he or she is part-time, has not worked long enough, or is a temporary worker. According to the Household Survey, 80% of uninsured households in Michigan include an adult who is employed and almost 75% of these individuals are employed full-time. More than 400,000 households with at least one uninsured member, out of a total of almost 500,000 uninsured households, have an adult who is employed or self-employed.

Principle Sources of Federal Funding for Coverage of Low-Income Michiganians

The federal government pays for more than half the costs of health care for low-income individuals and families through Medicaid and the State Children's Health Insurance Program (SCHIP). Federal funds cover 56% of the state's Medicaid costs and 70% of programs under SCHIP, which includes MIChild and a significant portion of the Adult Benefits Waiver (ABW) program. Federal Medicaid Disproportionate Share Hospital (DSH) funds pay for a portion of the ABW program, as well as some of the County Health Plans around the state. While the federal government caps the amounts of SCHIP and DSH funds that the state can claim, additional federal Medicaid funds may be captured if the state puts up the required state match, which is 44% of Medicaid costs.

Current Public Coverage

Michigan currently provides Medicaid health benefits to:

- Pregnant women and infants under age one from households with incomes up to 185% of poverty ($30,710/year for a family of three)
- Children age one through 18 from households with incomes up to 150% of poverty ($24,900/year for a family of three)
- Parents from households with incomes below 50% of poverty ($8,300/year for a family of three)
- Unemployed individuals with disabilities with incomes up to 100% of poverty ($9,800/year for a single adult) who also meet an asset test
- Working adults with disabilities with earned income up to 250% of poverty ($24,500/year for a single person), and up to $75,000/year (with a premium) under the Freedom to Work initiative
- Higher income parents or persons with disabilities if they have unusual health care costs, under Medicaid with a deductible (formerly known as spend-down Medicaid)
- SCHIP-funded MIChild coverage (which requires a $5/month premium) for children in families with income up to 200% of poverty ($33,200/year for a family of three)
- The Adult Medical Program, better known as Adult Benefit Waiver (ABW), for childless adults up to 35% of FPL ($3,430/year for a single adult), but enrollment is capped at 55,000 persons

Many individuals with incomes below 100% of poverty who do not qualify for Medicaid or the Adult Medical Program have access to limited ambulatory health care through County Health Plans available in 64 of Michigan's 83 counties.[5] Most of these programs provide very limited health benefits to individuals with incomes below 150% of poverty, while some programs offer coverage up to 250% of poverty.

[5] The Wayne County program can only accommodate 5,000 individuals and several other county health plans have closed enrollment. Four county health plans that cover six additional counties are now funded and are developing coverage programs which should become operational in the next few months.

MDWG PROPOSAL FOR SECURING HEALTH INSURANCE FOR ALL MICHIGAN RESIDENTS

Phase I:

- **Maximize Participation in Existing Plans**
- **Educate Employers and Employees**
- **Develop a Public Education Campaign**
- **Create a Health Care Commission**

Enroll All Eligible Individuals in Public Programs

In fiscal year 2006, no new sources of state general funds were identified to extend health care coverage to low-income uninsured individuals whose income exceeds current Medicaid levels.[6] However, coverage is available for all individuals who are currently eligible but not enrolled in public programs. Survey data indicates that there are thousands of individuals who are eligible for coverage under existing publicly-funded insurance programs, but who are not enrolled.[7] It is critical that all Medicaid eligible individuals be enrolled.

According to the Household Survey, there are approximately 58,000 uninsured children in Michigan in families with incomes below 200% of poverty. These children likely qualify for Healthy Kids or MIChild. According to Current Population Survey (CPS) data, about 35,000 uninsured parents in Michigan have incomes below 50% of the federal poverty level ($690/month). These adults should also be eligible for Medicaid unless they do not meet the asset test, and should therefore be enrolled.

While Michigan has simplified the application and enrollment process for children more than most states, Michigan's Medicaid application process for parents remains cumbersome and should be further streamlined. Simplifying the adult Medicaid application process may require minimal funding; however it is possible that savings from simplification would cover most of these costs.

Through outreach and educational activities, Michigan should strive to enroll all individuals who are eligible for Medicaid or MIChild.

Educate Employees and Employers to Maintain and Increase Participation in Employer-Based Insurance

In collaboration with employers, employer associations and organized labor, we should educate employers and employees on the need for insurance and the value of health insurance to them personally and collectively. This education initiative should focus on how to increase the number of employees who take employer-offered coverage.

Develop a General Educational Campaign Regarding the Economic Impact of Uninsurance

A statewide public education campaign would inform insured residents about the many ways in which uninsurance impacts their lives. Public messages should include information about who is uninsured in Michigan, the causes of being uninsured, how the number of uninsured is growing, how current cost shifting of uncompensated care throughout the health care system affects each insured Michigan resident, and the ways in which uninsurance affects us.

Establish a Health Care Commission (FY 2006)

A health care commission would develop implementation strategies to ensure that all Michigan residents are covered. The commission would also develop ongoing strategies for continuous improvement in the areas of cost containment, quality, and access. Some of the Commission's initiatives should include the following.

- A system of chronic care management (disease management, care management, and case management) and disease and health maintenance protocols aligned with evidence-based medicine.
- A pay-for-performance system based on the above protocols.
- Incentives for Michigan residents to increase healthy behaviors (a public/private partnership).

[6] There are additional local matching funds available in FY 2006 that could be used to expand County Health Plans if there were any unused Medicaid Disproportionate Share Hospital (DSH) capacity or if another mechanism were identified to match those local funds.

[7] For the HRSA State Planning Grant, programs such as Medicaid and MIChild that provide comprehensive health care benefits are included in the definition of health insurance. While publicly-funded, these programs insure individuals for comprehensive health care services.

- A single unified billing and service authorization system for providers, including medical claims such as Workers' Compensation, auto insurance reimbursement, health insurance claims, etc.

- A strategy to maximize the efficiency and cost savings from full implementation of an electronic system for submitting provider claims, service authorization, and accessing medical records.

- A mechanism to capture savings that may result from simplification of administrative processes, as well as other savings that may be realized as health care becomes universally available.

- A long-term detailed implementation strategy, including financing, to extend health insurance to all Michiganians.

Phase II: Coverage for Adults Living Below 100% of Poverty

- **Parents and Young Adults: Two options offered**
- **Childless adults: Two options offered**

The majority of Michigan's uninsured individuals are low-income, non-disabled adults, most of whom are childless. Since the Household Survey data does not differentiate between childless adults and parents, we turned to CPS data and its estimate that there are 165,000 childless uninsured adults with incomes below the federal poverty level, and about 80,000 uninsured parents living in poverty. Medicaid can be expanded to cover the 45,000 parents between 50% and 100% of poverty, but different approaches must be used to cover childless adults under federal law.

Alternatives for Covering Low-Income Parents and Young Adults:

Option 1: Medicaid Expansion for Low-Income Parents and Young Adults
Expanding Medicaid would be the simplest way to extend coverage to additional low-income parents and young adults. Under this approach federal funds would pay 56% of the additional cost for covering all 45,000 adults. By increasing the amount of income that is disregarded in computing Medicaid eligibility and by removing or increasing the asset limit, Michigan could offer Medicaid coverage to more low-income parents.[8] To expand coverage to young adults, the State could change the definition of "child" to include individuals age 19 and 20.

Increasing the number of Medicaid recipients would require an increase in Medicaid provider rates, since failure to do so could result in further erosion of the Medicaid provider network, which creates additional barriers to accessing care.

Parents eligible under the expansion plan would receive the same comprehensive benefit package as current recipients--physician, hospital, pharmacy, mental health, vision, hearing, dental, physical therapy, lab and diagnostic testing, and other services. Utilization controls and co-payments would be the same as for current Medicaid recipients.[9]

According to the Department of Community Health, the average monthly cost of Medicaid coverage for a non-pregnant adult is about a $213/month. Assuming that 66% of the eligible adults would apply for Medicaid (which according to CPS data would include 30,000 parents), the cost would total about $76.7 million ($33.7 million state, $43 million federal) to pay for expansion of Medicaid to parents with incomes below 100% of the federal poverty level, at current Medicaid payment rates. Increasing provider rates as recommended would increase this amount.

Option 2: Create a New Medicaid-Like Program for Low-Income Parents
Another strategy to cover parents would be to create a new Medicaid-like program, perhaps under a waiver from the federal government if one is necessary at the time this phase is implemented. The waiver could allow coverage that would be more like commercial coverage in its benefit structure, have a new brand name, and pay providers more than the current Medicaid provider payments.

[8] The name of the program could be something other than Medicaid and enrollment could occur through sites and processes other than through the Department of Human Services offices.
[9] The Budget Reduction Act of 2005 may allow different coverage and cost-sharing options for certain groups of parents on Medicaid.

The coverage could be through a pool managed by the state, the current Medicaid managed care network, or some other combination of providers.[10]

Even for the population under 100% of poverty, some "crowd-out" is possible. According to Kaiser State Health Facts, in 2002-03 Michigan had nearly 240,000 individuals in families with incomes below 100% of poverty who were insured through their employer. Data from the Household Survey are similar. It is imperative that, at least in the short-run, the employer-provided insurance to this population not be eliminated or the overall number of people uninsured will increase rather than decrease.

Alternatives for Covering Childless Adults

Option 1: Redirect County Health Plan Resources to Childless Adults
More childless adults could be covered in County Health Plans (CHP) if Medicaid coverage for parents were expanded to cover those with incomes up to 100% of poverty, as suggested above. About 30 to 40 percent of the current enrollees in what are known as "Plan B" County Health Plans around the state are parents of minor children. If some of these parents who live at 100% of poverty became eligible and enrolled in an expanded Medicaid program, CHP resources could then be redirected to serve a greater number of childless adults.

CHPs generally offer only physician services and limited laboratory and radiology services; they very rarely cover inpatient or outpatient hospital care. Additionally, CHPs use reimbursement rates equal to, or similar to Medicaid rates, which limit recipients' access to providers. New state funding or a significant expansion of Disproportionate Share Hospital (DSH) funds allocated to CHPs would be required to expand the benefit package for CHP enrollees to include inpatient and outpatient hospital care, or increase payment rates for providers.

[10] One issue with the current network is the absence of Medicaid HMOs in several counties in northern Lower Michigan and the presence of only a single Medicaid HMO in other northern Michigan counties.

Option 2: Cover Childless Adults Under a Medicaid Waiver
Another option for extending Medicaid coverage to childless adults would be through a Medicaid waiver from the federal government. While childless adults do not fit any of the federally defined categories for Medicaid eligibility (children, parents, pregnant women, aged, blind, or disabled), states have been allowed to cover these low-income individuals using Medicaid waivers.

Phase III: Expansion of Coverage to Young Adults, Parents, Childless Adults and the Disabled to 200% of Poverty and Children above 200% of Poverty

Background: Crowd-Out and Cost-Sharing Issues
For families in this income stratum, there is a greater likelihood that employer-based coverage is available, but workers may not be able to afford their share of the costs, or the employer may provide coverage that is not sufficient to meet the employees' health care needs. The Kaiser State Health Facts indicate that in 2002-2003, there were 700,000 Michiganians with incomes between 100% and 200% of poverty with employer-based health insurance. This represents only 12% of Michiganians with employer-based insurance, but accounts for more than 50% of the individuals with this income. This is why great care must be taken to not create a program that crowds-out cost-effective employer-based coverage. Maintenance of employer contributions to the health care system is a key to successful implementation of Phase III and increasing the number of uninsured Michiganians.

Cost-sharing that addresses crowd-out issues may pose a barrier to care for low-income families. Even modest cost-sharing represents a large proportion of a low-income family's wages. A $50/month premium or deductible represents almost two percent of the income of a family of three with an income at 185% of federal poverty level ($30,710/year). According to the Household Survey, most of the uninsured are willing to pay only a modest amount for their health care. Seven percent of the uninsured indicated that they are unwilling to pay any amount for employer-based insurance, and eight percent indicated an

unwillingness to pay anything for publicly-funded coverage. Thirty-five percent would be willing to pay less than $50/month for either private or public coverage, while 31% indicated they would be willing to pay $51 to $100/month for private coverage, and 25% indicated they were willing to pay that amount for public coverage.

In order to provide equitable coverage for all Medicaid-eligible adults, this phase would provide publicly-funded coverage for all adults up to 200% of poverty, including persons with disabilities (who currently are Medicaid-eligible if their income is below 100% of the federal poverty level) as well as parents, and young adults ages 19-20 (if they were not covered in a previous phase). By increasing income eligibility to 200% of poverty, according to CPS, roughly 120,000 additional individuals could be covered under Medicaid.[11]

Alternatives for Covering the Disabled, Young Adults and Parents (These options are not mutually exclusive)

Option 1: Extend Medicaid Eligibility for Young Adults, Parents and the Disabled Up to 200% of Poverty

One approach would be to expand eligibility for Medicaid to individuals up to 200% of the federal poverty level, since 56% of the cost would be financed with federal Medicaid dollars. This expansion could be done with or without a waiver, depending on what is most advantageous at the time of implementation. Because crowd-out may be a concern for individuals in this income range since they typically share the cost of employer-based coverage, an option that may better fit the goals of the State Planning Project would be an expansion that includes some level of cost-sharing, such as premiums or co-payments in an amount that is less than five percent of a recipient's income. However, some level of crowd-out can still be expected even with such cost-sharing strategies.

Shifting costs to Medicaid recipients through co-payments would reduce the federal contribution toward the cost of providing care to Michigan Medicaid recipients. When the state pays $1 for a Medicaid covered service, it receives $1.30 in federal matching funds to pay for other Medicaid services. If, however, a recipient pays $1 for a Medicaid-covered service, the federal government does not match that payment. Thus, the state can purchase $2.30 worth of health care for a dollar of state funds, but the recipient's dollar only purchases a dollar's worth of care.

Option 2: Premium Assistance for Young Adults, Parents, and the Disabled with Access to Employer-Based Coverage

Another strategy for insuring parents between 100% and 200% of poverty builds upon employer-based coverage by allowing individuals to apply for premium assistance so they can afford their share of the cost for employer-sponsored insurance.[12] For families without access to employer-based coverage, a commercial insurance benefit package would be offered. Families at this income level would be expected to contribute less than five percent of their annual income to the cost of health care. Under this option, employers that do not offer health insurance benefits help their workers by withholding health insurance premiums from pre-tax dollars.

Purchasing employer-provided insurance could leave workers underinsured, depending on the policy's benefits, as well as the extent of cost-sharing provisions such as deductibles and co-payments that are included in the plan. This problem could be addressed by providing Medicaid-funded wrap-around coverage to secure adequate coverage through combining public and private funds and benefit packages.

[11] This number includes about 100,000 parents and an estimated combined 20,000 young adults and adults with disabilities. The estimate assumes that approximately 11% of the uninsured are disabled (the percentage of the general population that is disabled according to census data), but this number may be high because of the stringent disability standard used for Medicaid eligibility.

[12] There are several options for the mechanics of premium assistance. The experience of other states, such as Maine and Rhode Island, should be considered in developing the specifics of a premium assistance model.

Alternatives for Covering Childless Adults

Option 1: Childless Adult Medicaid Waiver and Redirected County Health Plan Resources
One option for childless adults up to 100% of poverty is to cover them through a Medicaid program, which may require a waiver. Any savings to Medicaid under other waivers, combined with funds currently spent on the Adult Benefits Waiver might be enough to provide a comprehensive benefit package to these childless adults. This would allow County Health Plans to concentrate on childless adults between 100% and 200% of poverty and provide at least a limited ambulatory benefit to most of these individuals under the current funding structure. County Health Plans could also use a significant portion of their funds to subsidize employer-based coverage through Third Share plans or similar models.

Option 2: State-Sponsored Program for Childless Adults
If additional state funds or redirected funds are available, a state-funded program could provide a comprehensive benefit package for childless adults or could be used to supplement employer-based coverage.

Health Care Coverage for Children Above 200% of Poverty
Medicaid and SCHIP funds may be used to cover children above 200% of poverty, which would occur primarily through subsidization of dependent coverage under employer-based insurance. For children without access to employer-based coverage, a commercial insurance benefit package could be offered. Parents at this income level would be expected to contribute up to five percent of their annual income to the cost of health care.

Phase IV: Capitalize/Fund the Health Care System

The phases described earlier rely on expansion of publicly-funded health insurance programs or public subsidy of employer-sponsored health care to reduce the number of uninsured who live at or below 200% of the poverty level.

The goal of this phase is to reduce the burden on employers by controlling costs, spreading the financing more broadly and equitably, and removing hidden costs like uncompensated care.

Equalizing the contributions between employers that offer health insurance and those that do not is one option for moving beyond Phase III to full coverage. One alternative will require employers that do not provide a certain level of health care coverage to their employees to contribute to a pool to cover the uninsured. The pool would have been developed by the Health Care Commission mentioned earlier in Phase I and would already be partially capitalized/funded by savings realized from the cost reduction measures introduced in earlier phases. The Commission could also add other medical programs into the pool by Phase IV – such as workers' disability, auto medical coverage and others – to increase the size of the fund. The State has other taxation tools at its disposal that could increase the amount in the fund prior to Phase IV. Options might include:

- Taxes on luxury goods, such as tobacco, alcohol, and other items.
- Eliminating auto medical coverage and collecting the premium savings for the fund.
- Eliminating workers' disability medical coverage and diverting some of the premiums currently paid by employers into the fund
- If there are measurable savings to providers, creating a tax on providers and add this to the fund
- Sales tax on services
- Income tax dedicated to the health care system
- A scaled business or employer fee/tax
- Means-tested premiums for insurance
- Capture additional savings from the system

The Commission will study the various income streams and the size of the pool needed to cover everyone in the state. The MDWG recommends no particular form of financing but emphasizes that the overall funding of this system should place a lesser

burden on employers than at present in order to reverse the competitive disadvantage caused by the present health care financing system.

For discussion purposes, we will call this state pool the Michigan Health Fund. The Fund would be used to purchase insurance from private sector health plans approved by the Commission for individuals who do not have employer-based insurance.

Phase V: A Multiple Payer System

General Description:
This phase of the proposal ensures health care coverage is automatic. In Phase V, the Fund would continue to contract with multiple health plans for coverage. The plan would be financed primarily by income-related premiums or taxes, and from the options described in Phase IV, but coverage would not be linked to employment. People would be able to choose any plan under contract to the state.

Eligibility:
Everyone, except Medicare recipients, would enroll in any plan under contract to the state (i.e., a plan participating in the state pool), but if they failed to do so by a given date (or the first time they sought health care services), they would automatically be assigned to the least expensive plan(s). The people auto-enrolled this way would be billed for premiums, based on income.

Source of Coverage:
The Fund, governed by the Commission, would contract with health plans to provide a standard package of benefits offered on a community-rated, guaranteed-issue basis. Health plans could offer more generous coverage, but this supplemental coverage would have a separate premium.

People could choose any plan under contract to the state. If they choose other than the least expensive plan(s), they will pay any additional premium.

Standard Benefit Package:
A standard benefit package would be available to everyone. Each year the Commission would review premiums and the benefit package.

Supplemental Coverage:
Anyone (individuals or employers) could buy supplemental coverage from insurers to expand their benefits beyond those available in the standard plan. Supplemental benefit policies would be subject to current insurance regulations. Employers could choose to pay for supplemental coverage, as well as any portion of the premium for standard benefit coverage.

Financing:
The system would be financed by any number of the financing devices from the list in Phase IV. At this stage the Commission will have determined appropriate funding streams and implemented full-financing strategies to insure health care coverage to all Michigan residents through the Fund.

Insurance Market Rules:
Premiums for current residents of the state would be community-rated. That is, the basic premiums (before the subsidies for those below the median income) would not be risk-rated. A risk-adjustment mechanism would be established by the Commission to compensate insurers enrolling a disproportionate number of higher-risk enrollees.

New Residents:
The Commission would develop policies to provide coverage for people who relocate to Michigan. The policies should not encourage individuals to move to Michigan just to receive health care coverage, but should not create an impediment for businesses that wish to relocate to Michigan or Michigan businesses that wish to hire from outside the state.[13]

Administration:
The Commission's administrative staff would administer the pool; the plans would each have their own administration.

[13] One option would be that new residents with incomes in excess of 150% of the federal poverty level would be risk-rated, that is, medically underwritten based on age and prior medical conditions, for a period of two or three years after they establish residency, after which they would be covered as other residents. The maximum premium would be no higher than 200% of the statewide community rate. The minimum premium would be the state average rate. No subsidies would be available until the person had been a resident for two or three years, except for those with incomes below 150% of the poverty level.

Cost Containment:
The Commission would negotiate contracts with health plans and ensure that the total cost for all enrollees is no more than the revenue collected through taxes and fees. Health plans would be expected to compete vigorously for enrollees and demonstrate cost containment.

Choice:
Michiganians would be free to choose from and enroll in any of the approved health plans, whether HMO, PPO or Fee for Service. Failure to enroll would result in being assigned to the lowest cost plan in the appropriate geographic area.

Funding Issues

This document does not address all the funding strategies needed to cover all residents. Once the model has been refined, developing funding alternatives will be a key step. Further study will be needed to determine the expected savings from administrative simplification and cost-containment measures.

Several significant points will affect the funding strategy. First is the consideration of what can be done under Medicaid options:

- Several states, such as New York, have received additional federal Medicaid funds beyond those ordinarily available by arguing that the federal government should share some of the savings it has achieved because of how a state has managed its Medicaid program. Michigan's expansive managed care program for Medicaid recipients has resulted in significant savings to the federal government, so Michigan could argue that the federal government should share some of the savings they have realized with Michigan.

- There may be options for leveraging existing state health care expenditures under a Medicaid waiver.

- Some states, such as Maine, expect to indirectly receive federal matching funds on employer contributions to their subsidized health care system. Perhaps Michigan could do the same.

Savings that can be generated through covering all Michigan residents also should be considered:

- Eliminating the burden for uncompensated care will result in lower payment rates for those with health insurance.

- Streamlined/simplified administration (reduction in multiple billing, for example) will result in cost savings to health care providers and insurers.

Employers will benefit from a healthier work force and may realize long-term savings from reductions in avoidable diseases and individuals could realize a better quality of life if they engage in healthy lifestyles. However, with individuals frequently moving in and out of insurance and between insurance plans, insurers have little incentive to invest in long-term health programs since in general, disease management and care management are more likely and effective when individuals are part of the same system for a longer time. Encouraging healthy lifestyles is a key component to reducing health care costs and can by impacted by:

- Incentives, such as reduced premiums or enhanced benefits, for those who engage in healthy lifestyles.

- Pay-for-performance strategies that would give health care providers incentives to better monitor and manage chronic diseases.

When all Michiganians have health care coverage, there will be several significant sources of health care funding, such as the medical component of auto insurance, casualty insurance, and workers' disability that could fund this program.

Glossary

Advisory Council
Comprised of a group of stakeholders from across Michigan, Advisory Council members were appointed by the Director of the Department of Community Health to create a plan that ensures all Michigan residents have access to health insurance.

Childless Adults
Non-disabled adults below the age of 65 who are not parents of minor children who live with them.

Community Interface Workgroup
Workgroup that coordinated town hall meetings and external communications for the state planning project.

Community-Rated
Rates that are based on the risks of the population at large (i.e., not individually risk-rated – see below).

County Health Plans (CHPs)
Community-based health plans that provide limited benefits for low-income individuals.

Current Population Survey (CPS)
An annual survey of 50,000 households nationwide, conducted by the U.S. Census Bureau, which gathers labor and employment data.

Crowd-out
The substitution of publicly-funded coverage for employer-based insurance. This occurs when there are incentives for purchasers of insurance (employers, as well as employees) to drop private health insurance in favor of publicly-funded coverage. It results in the expenditure of public funds, but no increase in the number of individuals insured.

Data Synthesis Workgroup
Workgroup that developed research methodology, analyzed data, and fulfilled data requests from the other workgroups.

Disproportionate Share Hospital Funds (DSH)
Supplemental federal payments that compensate hospitals for their losses incurred in caring for Medicaid and uninsured individuals. DSH funds are separate from the federal matching funds that are paid based on state expenditures for covering Medicaid recipients. DSH funds are capped by the federal government. A portion of Michigan's DSH funds are used to partially fund County Health Plans.

Federal Poverty Level (FPL)
FPL is the official income level for poverty in the United States. Having income below the FPL may qualify an individual for various social/federal programs.

2006 HHS Poverty Guidelines

Persons in Family or Household	Annual Income for 100% of Poverty.	Monthly Income for 100% of Poverty
1	$ 9,800	$817
2	13,200	1,100
3	16,600	1,383
4	20,000	1667
5	23,400	1,950
6	26,800	2,233
7	30,200	2,517
8	33,600	2,800
For each additional person, add	3,400	283

SOURCE: *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Low-Income
Individuals that earn up to twice the FPL for their family size, or "200% of FPL," are generally considered low-income. Governmental programs that serve low-income individuals have varying income and asset limits.

Medicare
Government-funded health care coverage for the disabled and/or adults aged 65 and over. Medicare is entirely federally funded, except an amount paid by the state for the Medicare Part D prescription coverage for Medicare recipients who also have Medicaid, which began on January 1, 2006.

Medicaid
Government-funded health care coverage for low-income children, pregnant women, parents of minor children, or disabled individuals. Michigan funds Medicaid with about 56% federal funds, through an open-ended match of state expenditures on the program (2006 figure).

Michigan Health Fund (MHF)
State pool whose creation is recommended as a vehicle through which citizens can purchase health insurance.

Models Development Workgroup (MDWG)
Workgroup that used information from the Data Synthesis and Community Interface Workgroups to develop a plan to provide health care coverage to all Michigan residents that was subsequently recommended to the Advisory Council.

Provider Reimbursement Rates
The amount of money providers are reimbursed for providing care.

Risk-Rated
When insurance rates are based on the expected risk of each individual to be covered.

State Children's Health Insurance Program (SCHIP)
A federal funding source that covers health insurance for children in families up to 200% of poverty. Michigan's SCHIP program has two components called Healthy Kids and MIChild. This program is funded with 70% federal funds, but the total amount of federal funding available is capped.

State Planning Grant (SPG)
Project that used funding from HRSA to create a plan to provide health insurance to all Michigan residents. Also known as the State Planning Project for the Uninsured.

Third Share Plan or Three-Share Program
A health plan wherein the employer, employee, and a third party (usually a County Health Plan) each share in the cost of an insurance policy.

Waiver
There are many different kinds of Medicaid waivers a state can request. A waiver asks the federal government to waive the limits or requirements of specific federal Medicaid laws. For example, states need a waiver to cover childless adults because childless adults are not one of the allowable covered populations under Medicaid laws.

Wrap-Around Coverage
Services for people that are dually eligible for both Medicare and Medicaid, or employer-based insurance and Medicaid; Medicare or the private insurer serves as the primary payer, and Medicaid "wraps around" that coverage to fill gaps in Medicare or employer-based insurance coverage. It also protects the recipient from having to pay deductibles and most co-payments or co-insurance amounts under Medicare or the private insurance, because providers accept the Medicaid payment as payment in full.