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.