Michigan State Planning Project for the Uninsured

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 insure 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 health consequences of being uninsured are well documented, and the costs associated with care 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 include: a randomized Michigan Household Health Survey (Household Survey) of over 13,000 households, with focused questions for those residents without health insurance; a randomized mail survey of over 1,200 Michigan employers; focus groups with small and mid-size employers, insurance brokers and the uninsured; town hall meetings; and key informant interviews with policy makers to elucidate their attitudes about the strategies and models being considered by the project.

The structure for the Michigan State Planning Project for the Uninsured includes 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 in: designing data acquisition approaches and reviewing data; reviewing and assessing models; reviewing and assessing plan components as they are developed; 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.

Each workgroup member does not actively support every option, suggestion, or activity in every phase, but all are willing to let the document go forward in support of our overall goal…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 a set of options that builds upon each other, with the initial phase providing health insurance for individuals and families with income up to 100% of poverty, the second phase adding individuals and families living up to 200% of poverty and the later phases providing 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 of this MDWG proposal is to reduce the cost of health care so that employers in Michigan can better afford to provide health insurance to their employees. In today's system, 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:

Currently, Michigan has an employer-based health insurance system that, according to the Household Survey, 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. 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.

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 Michigan, $730/year is added to the cost of a family policy and $274/year to an individual policy, to cover health care costs of the uninsured. [1] 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 streamlining and consolidating authorization and billing systems, and lowering administrative costs, are advantageous to health insurance purchasers.

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). [1]

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. The good news is that 7.8% is lower than the national uninsured average. The bad news is that continued loss of

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

manufacturing jobs, combined with a sluggish economy, is eroding employer-based coverage in Michigan, especially for workers' dependents.

This loss of jobs and dependent coverage means that 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, an increase of nearly 400,000 people. 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[3] adults below the age of 65, who are not parents of minor children. (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.

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 threatens the financial viability of providers whose patient-base is disproportionately on Medicaid. Any reduction in the numbers of Medicaid providers would exacerbate rather than alleviate 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.

- Employer-based insurance is a critical component of health coverage in Michigan. Expansion options must minimize further erosion of employer-based coverage and support its growth. Any expansion of public coverage must be designed in a manner that minimizes incentives for reductions in private coverage, known as "crowd-out". If we are to increase the number of individuals with insurance, it is important that low-income individuals and families who currently

[3] For purposes of this discussion, "non-disabled" means individuals who do not meet the Social Security Administration's stringent 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.

have employer-based insurance retain that coverage so that we can concentrate on insuring the uninsured rather than simply shifting the currently insured from employer-based coverage to public coverage, with no net increase in the number of individuals insured. 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 appendix for a chart detailing federal poverty levels for various family sizes.)

Michigan continues to have a higher rate of employer-based insurance coverage than the rest of the United States; however, 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%. The 6% reduction in employer-based coverage in Michigan between 2000 and 2004 represents almost 350,000 uninsured individuals.

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. In fact, 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 temporary. 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 know 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.

Currently, 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.[4] 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.

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

For fiscal year 2006, no new sources of state general funds have been identified to extend health care coverage to low-income uninsured individuals[5] whose income exceed current Medicaid levels. 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[6] programs, but who are not enrolled. 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

[4] The Wayne County program can only accommodate 5,000 individuals and several 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.

[5] 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.

[6] 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.

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 so 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 some minimal funding, however it is possible that savings from simplification could cover most of these costs.

Through outreach and educational activities, Michigan should strive for enrolling 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 regarding 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 up" employer offered coverage.

Develop a General Educational Campaign Regarding the Economic Impact of Uninsurance

It is important to develop a statewide public education campaign to 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 various ways in which uninsurance affects us individually and collectively.

Establish a Health Care Commission (FY 2006)

A health care commission would develop implementation strategies to insure that all Michigan residents are covered. The commission would also develop on-going 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 that are aligned with evidence-based medicine.
- A pay-for-performance system based on the above protocols.
- Incentive systems for Michigan residents to increase healthy behaviors (a public/private partnership).
- 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/fund 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

- ***Low-Income 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 who live 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 choice to extend coverage to additional low-income parents and young adults. Under this approach federal funds would pay 56% of the additional costs 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 limit on assets, Michigan could offer Medicaid coverage to more low-income parents.[7] To expand coverage to young adults, the State could change the definition of "child" to include individuals age 19 and 20 years old.

As explained above, 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.[8]

According to the Department of Community Health, the average monthly cost of Medicaid coverage for a non-pregnant parent is about $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.

The coverage could be through a pool managed by the state, the current Medicaid managed care network, or some other combination of providers.[9]

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[7] The "name" of the program could be something other than "Medicaid" and enrollment could occur through sites and processes other than through Department of Human Services offices.

[8] The Budget Reduction Act of 2005 may allow different coverage and cost-sharing options for certain groups of parents on Medicaid.

[9] 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.

Note: 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% of the current enrollees in what is know 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 limits 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.

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 up 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 figure represents only 12% of Michiganians with employer-based insurance, but accounts for more than 50% of the individuals in this income band. 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 income. 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 conducted as a part of this project, 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 8% 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. This data from the Household Survey was not analyzed according to the respondents' income levels.

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.[10]

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 costs 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 of 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 5% of a recipient's income. However some level of crowd-out can still be expected even with such cost-sharing strategies.

It should be noted that shifting costs to Medicaid recipients through co-payments would reduce the federal contribution toward the costs 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 costs for employer-sponsored insurance.[11] For families without access to employer-based coverage, a commercial insurance benefit package could be offered. Families at this income level would be expected to contribute less than 5% of their annual income to the cost of health care. Under this option, employers that do not offer health insurance benefits could still assist their workers by withholding health insurance premiums from pre-tax dollars.

[10] 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 very stringent disability standard used for Medicaid eligibility.

[11] There are several options for the mechanics of the 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.

One concern is that purchasing employer-provided insurance could leave workers underinsured, depending on the benefits of the policy, 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.

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, in combination with funds currently spent on the Adult Benefits Waiver might be enough to provide a comprehensive benefit package to childless adults up to 100% of poverty. This would allow the 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 could 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 5% of their annual income to the cost of health care.

Phase IV: Capitalize/Fund the Healthcare System

The phases described above 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. These families and individuals comprise 63% of the state's uninsured according to the Household Survey.

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 path to equalization would be to require employers that do not provide a certain level of health care coverage to their employees to contribute to a pool for providing coverage to the uninsured. The pool would have been developed by the commission in Phase I and would already be partially capitalized/funded by savings realized and captured from the cost reduction measures introduced in earlier phases. The Commission could also combine 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. Further, the State has other taxation tools at its disposal that could increase the amount in the fund prior to Phase IV. Options for consideration by the commission might include:

- Taxes on luxury goods, such as tobacco, alcohol, and other items.
- If auto medical coverage is ended, some of the current premiums could be captured in the form of fees from auto owners and placed in the fund
- If workers' disability medical coverage is ended, some of the premiums currently paid by employers could be captured by a tax and placed in the fund
- If there are measurable savings to providers then a tax on providers could be utilized to add to the fund
- Sales tax on services
- Income tax dedicated to the health care system
- Scaled business or employer fee/tax
- Means-tested premiums for insurance
- Capture additional savings from the system

The Commission would 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 for individuals who do not have employer-based insurance. The insurance would be purchased from private sector health plans approved by the Commission.

Phase V: A Multiple Payer System

General Description:
This phase of the proposal ensures health care coverage for all Michigan residents by making coverage 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 in 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 would pay any additional premium out of pocket.

Standard Benefit Package:
A standard benefit package would be available to everyone. The Commission would be responsible for annually reviewing the benefit package and premiums.

Supplemental Coverage:
Anyone, individuals or employers, could buy supplemental coverage from insurers to expand their benefits beyond those available in the standard plan. Policies covering these supplemental benefits 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 premium (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 recently relocated 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.[12]

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

Cost Containment:
The Commission would have responsibility for negotiating contracts with health plans and insuring that the total cost for all enrollees was no more than the revenue collected through taxes and fees.

Health plans could 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.

[12] 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 time 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.

Funding Issues

This document does not address all of the funding strategies needed to provide coverage to all residents. Once the model has been refined, development of funding alternatives will be a key step. Further study is necessary to determine the amount of savings that can be expected 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 what is 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.

Another set of considerations is to quantify the savings that can be generated through coverage for all Michigan residents. Here are some examples:

- Elimination of the burden for uncompensated care would result in lower payment rates for those with health insurance.
- Streamlined/simplified administration (reduction in multiple billing, for example) would result in cost savings to health care providers and insurers.

Employers would 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 health 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 period. Encouraging healthy lifestyles is a key component to reducing health care costs and can by impacted by:

- Incentives for healthy lifestyles, 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' Compensation Program that may potentially be used to help fund the comprehensive program in a more efficient manner.

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 insures 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
This workgroup coordinates town hall meetings and external communications for the state planning project.

Community-Rated
When rates 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
This workgroup develops research methodology and analyzes data, along with fulfilling 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. Many governmental programs use different percentages of the FPL to define eligibility for benefits or services.

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 healthcare coverage for the disabled and/or adults aged 65. 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. In 2006 this program is funded in Michigan with about 56% federal funds, through an open-ended match of state expenditures on the program.

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

Models Development Workgroup (MDWG)
As part of Michigan's State Planning Grant, this workgroup uses information from the Data Synthesis and Community Interface Workgroups to develop a plan to provide health care coverage to all Michigan residents that is 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)
SCHIP is 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 utilizes 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
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 in 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.