Michigan Family Impact Seminars

Innovative State and Local Approaches to Health Coverage for Children

Briefing Report No. 2003-1

MICHIGAN STATE UNIVERSITY

WAYNE STATE UNIVERSITY

Innovative State and Local Approaches to Health Coverage for Children

Michigan Family Impact Seminars
Briefing Report No. 2003-1

Edited by

Esther Onaga, Acting Director
Laura Bates, Research Associate
Institute for Children, Youth, and Families
Michigan State University

December 2003

Michigan Family Impact Seminars are sponsored by

The Skillman Foundation
Detroit, Michigan
Families and Communities Together Coalition
Michigan State University
Institute for Children, Youth, and Families
Michigan State University
Institute for Public Policy and Social Research
Michigan State University
School of Social Work
Wayne State University

Copies of this report are available from
Institute for Children, Youth, and Families
Michigan State University
Suite 27 Kellogg Center
East Lansing, MI 48824
Phone: (517) 353-6617
Fax: (517) 432-2022

Webcast available at www.ippsr.msu.edu

An electronic version is also available at
www.icyf.msu.edu or www.ippsr.msu.edu

Contents

Executive Summary 1
Laura Bates

Introduction 2
Laura Bates

A Profile of Uninsured Children in Michigan 3
Claudia Wallen

Michigan Residents' Views on Children's Health Issues 6
Carol S. Weissert

Michigan's State Children's Health Insurance Plan (SCHIP) 11
Emily Tamlyn and Laura Bates

SCHIP Turns Five: Gaining Ground, But Not Enough 18
Ian Hill

Breaking Down Barriers to Enrollment in Public Health Insurance:
Eastside Access Partnership 28
Richard Lichtenstein and Penni Johnson

Health Care Access and Community Partnership: Muskegon's
Access Health Program 33
Vondie Moore Woodbury

Policy Alternatives 38

Policy Alternatives and Recommendations 39

Snapshots of Local Innovative Programs 43

Glossary 46

Additional Resources 48

Acknowledgments 51

About Family Impact Seminars 52

References 53

Executive Summmary

Laura Bates

Today in Michigan, some 8.1% of children are without health insurance coverage. Ethnic minority children are disproportionately represented in this group, and approximately 136,000 children from low-income families remain uninsured, despite the fact that virtually all of them are eligible for public insurance. These data indicate that Michigan still has work to do to ensure that all children have access to the benefits of health insurance coverage. This briefing report explores in more detail the question of access to health coverage for children, some of the possible reasons for the continuing gaps in coverage, and what states, including Michigan, and local communities are doing to address the problem of lack of insurance. It describes the ongoing evaluation of program effectiveness for various options and presents policy alternatives from the experts.

The first three articles and the insert handout present background information to help us understand who is uninsured, what Michigan citizens believe about the issue, and how the federal and state governments are responding to the problem. **Profile of the Uninsured in Michigan**, presents the latest data on how many children are uninsured, and who they are. **Michigan Citizen's Perspectives on Children's Health** and the insert produced by the Skillman Foundation, present results from two surveys of Michigan residents asking them about the importance of various health issues for children. These surveys, one of the entire state and the other of Southeast Michigan, indicate that Michigan residents view access to health care for children as an important issue overall, but that regional differences emerge over specific aspects of the problem. The third article, **The State Children's Health Insurance Program (SCHIP)**, describes the major federal-state initiative to expand insurance coverage to more children in low-income families, with particular emphasis on the Michigan program, ***MIChild/Healthy Kids***.

The next three articles by national and state experts describe state and local initiatives to enhance health coverage for children. In **SCHIP Turns Five: Gaining Ground but Not Enough**, Ian Hill, Health Policy Analyst, presents information from the national evaluation of SCHIP. This study of 13 states, including Michigan, indicates that progress is being made in reducing rates of uninsurance among "near-poor" children, who are the target of SCHIP, and that states have used the flexibility of the program to address unique needs of their communities. However, challenges remain. The uninsurance rate among poor children is stagnating and states are facing record budget deficits that may place recent gains in jeopardy. In **Breaking Down Barriers to Enrollment in Public Health Insurance: Eastside Access Partnership**, Dr. Richard Lichtenstein and Ms. Penni Johnson describe the development of an innovative community-based outreach and enrollment initiative that uses a combination of public education and customer service training to reduce barriers to enrollment. Finally, in **Health Care Access and Community Partnership: Muskegon's Access Health**, Vondie Moore Woodbury describes a promising initiative to expand health coverage to low-income working families and small businesses in Muskegon County using public and private funding. Both of these initiatives, while promising, are still being evaluated as to their effectiveness.

Finally, **Policy Alternatives and Recommendations** presents policy alternatives derived from the experts in this briefing report and includes information on other localities that are experimenting with these alternatives.

Snapshots of Promising Programs presents brief summaries of the local initiatives in Michigan, including the two described in this brief.

Additional Resources offers sources for obtaining more detailed information or in depth analysis of material presented here.

Glossary defines technical terms used in this report.

Introduction

Laura Bates

"Bobby," a preschooler, was bitten by a mosquito – a common enough childhood experience. When Bobby scratched the bite, though, it became infected. His parents, wanting to do the right thing for their son, took him to a physician, who prescribed an antibiotic. Bobby's father worked, but his family was poor and money was too tight for them to be able to buy the medication right away, especially after paying the cost of a doctor's visit.

While they waited, the infection grew dangerously out of control. As a result, Bobby required three days of hospitalization, including administration of intravenous antibiotics.

The total bill for Bobby's mosquito bite was approximately $2,500 – more than 100 times the cost of the prescription medication his family could not afford to purchase on their limited income. In Bobby's case, as in thousands of others like it, an ounce of prevention (in the form of state health care assistance to families with children) could have gone a long way toward reducing child suffering – and unnecessary taxpayer expense.[1]

Access to health care for children is a continuing concern of policymakers, with good reason. As the above anecdote illustrates, failure to get timely medical care can lead to unnecessary illness and greater expense in the long run. While access to health care is a complex issue, insurance coverage is one important factor linking children with health care. A number of studies indicate that children who have health insurance have better access to health care, whether access is measured by having a usual source of medical care, a regular physician or by having made at least one visit to a doctor or dentist in the past year.[2] Low-income uninsured children are more likely to have an unmet medical need than are their insured counterparts.[3] Because children are rapidly developing organisms, regular monitoring and timely intervention to identify developmental or health problems is necessary to prevent minor problems from having major developmental consequences. By improving access to care, health insurance is one critical factor in identifying and addressing health problems in children.[4]

In this report, experts in research and policy discuss what we know about increasing health coverage for low-income children, what we don't know, and how state and local communities are working to increase coverage for children. The last article discusses the policy implications of information presented by the expert speakers. Finally, brief snapshots of promising local programs and a resources section direct the interested reader to additional sources of information.

A Profile of Uninsured Children in Michigan

Claudia Wallen

The Problem: Uninsured Children

In 2001, 8.1%, or approximately 200,000 Michigan children ages 0-17 were without health insurance.[5] Unfortunately, this represents an increase of 1.4% from the previous year (see Figure 1), possibly as a result of the 2001 Michigan economic slowdown.[6,7] In addition, some groups of children are at greater risk of being uninsured than others. Racial and ethnic minorities and children living in low-income families are more likely to lack health insurance coverage than any other group of children.[8]

Racial/Ethnic Minority Children are More Likely to be Uninsured in Michigan

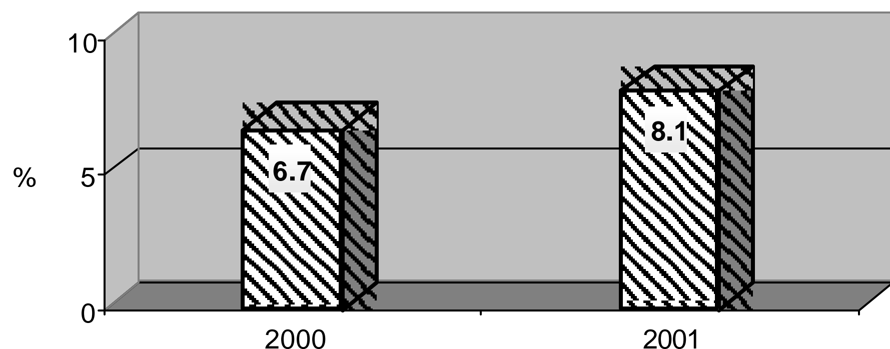
A disproportionate number of children from racial and ethnic minority groups are without health insurance statewide and ... Hispanic children run the greatest risk of being without coverage

Figure 2 shows that a disproportionate number of children from racial and ethnic minority groups are without health insurance statewide and that Hispanic children run the greatest risk of being without coverage.[9] Hispanic children represent only 4.3% of Michigan's total child population, yet they comprise 10.3% of all uninsured children statewide[10] – indicating a disparity in coverage. African American children account for 17.3 % of all children in Michigan; however, 20.9 percent of all uninsured children are African American.[11]

As *Figure 3* indicates, uninsurance rates differ for children from different ethnic/racial groups, and Hispanics are much more likely to be uninsured:

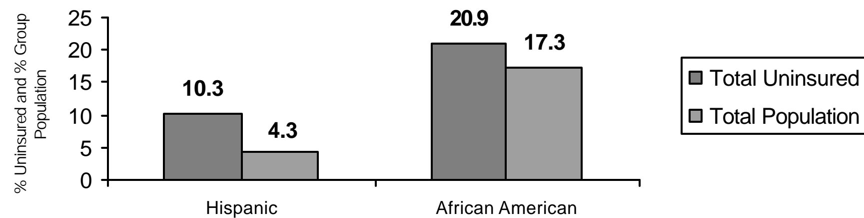
- ✓ 7.1 % of White children are uninsured in Michigan,
- ✓ 9.9 % of African American children are uninsured,
- ✓ 19.9 % of Hispanic children lack insurance, and
- ✓ 10.3 % of Michigan children whose race is defined as 'other' are uninsured.

Figure 1 - Percent Uninsured Michigan Children Ages 0-17 (2000 and 2001)



Source: 1999-2001 CPS Data Files, Employee Benefit Research Institute.

Figure 2 - Uninsurance Rates Among Racial/Ethnic Minority Children Relative to Population (1999-2001)



Source: 1999-2001 CPS Data Files, Employee Benefit Research Institute.

Children from poor and near poor (0-199% FPL) families represent approximately 52% of the uninsured children in Michigan,[13] even though the majority of them are eligible for public health insurance

Poor and Near Poor Children are More Likely to be Uninsured

Children in families with incomes less than 200% of the ***Federal Poverty Level*** [(FPL) – *see glossary for definitions*)] run the greatest risk of being uninsured in Michigan.[12] Children from poor and near poor (0-199% FPL) families represent approximately 52% of the uninsured children in Michigan,[13] even though the majority of them are eligible for public health insurance.

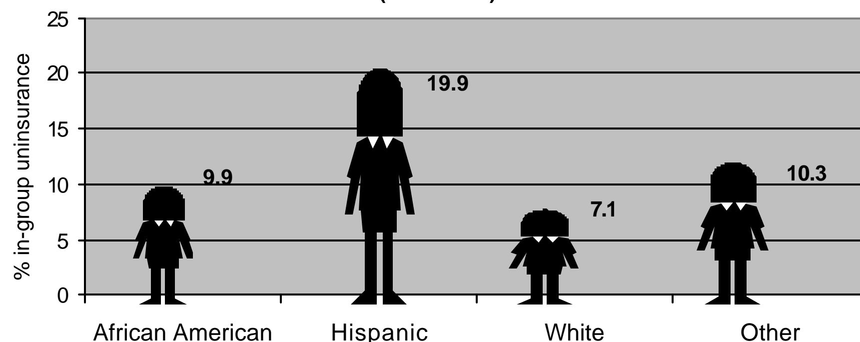
As Figure 4 illustrates, in Michigan:

- ✓ 14.5 % of children from poor families (0-99 % FPL) are uninsured.
- ✓ Almost the same number (14.9 %) of children from families with incomes between 100-149 % FPL are uninsured.
- ✓ With incomes at 150 % of FPL or above, the rates of uninsurance gradually diminish.

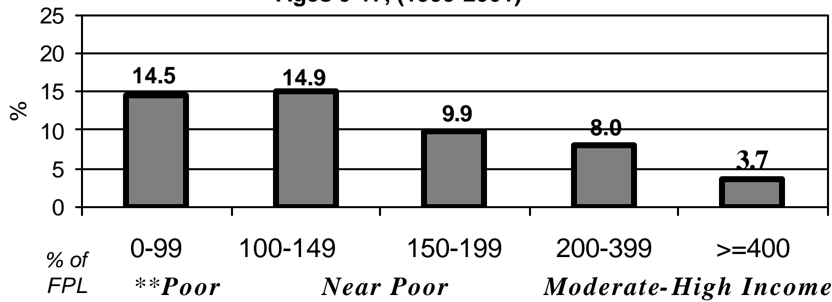
Conclusion

Lack of health insurance continues to be a barrier to quality health care for some 200,000 Michigan children. Hispanic and African American children are at greater risk for uninsurance, as are children whose families are poor or near poor. A recent rise in the number of children who are uninsured, coinciding

Figure 3 - Uninsurance Within Specific Racial/Ethnic Groups Michigan Children Ages 0-17 (1999-2001)



Source: 1999-2001 CPS Data Files, Employee Benefit Research Institute.



Source: 1999-2001 CPS Data Files, Employee Benefit Research Institute.
***Using definitions from The Kaiser Commission on Medicaid and the Uninsured, Poor is defined as 0-99% FPL, Near Poor is 100-199% FPL, Moderate is 200-299% FPL, and High is 300%+ FPL.*

with an economic downturn in the state, indicate that efforts must continue to ensure that all children living in Michigan receive quality, affordable health insurance coverage.

A recent rise in the number of children who are uninsured, coinciding with an economic downturn in the state, indicate that efforts must continue to ensure that all children living in Michigan receive quality, affordable health insurance coverage

Report limitations

The statistics used in this report are based on 1999-2001 United States Census Bureau Current Population Survey (CPS) data, as reported for the state of Michigan. Readers should note there is some concern among researchers that the estimates for Michigan's uninsured may be high in some areas due to the measurement and analysis techniques employed by CPS.

Carol S. Weissert, Ph.D. was formerly the Director of the Institute for Public Policy and Social Research (IPPSR) at Michigan State University. Since the summer of 2003 she has been The Leroy Collins Eminent Scholar in the Department of Political Science at Florida State University. Her areas of research interest are health policy, intergovernmental relations and federalism.

Michigan Residents' Views on Children's Health Issues

Carol S. Weissert

Introduction

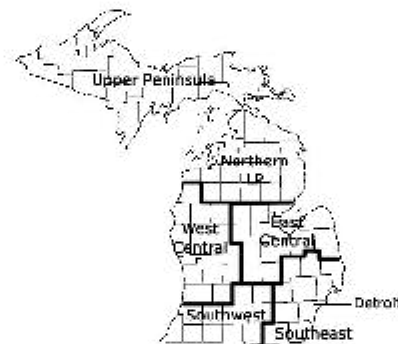
In 2003, several studies examined the attitudes of Michigan residents on issues of health care for children. Concerning Kids, a study funded by the Skillman Foundation and conducted by the Center for Survey Research at the University of Connecticut, focused on the perceptions of residents of Metropolitan Detroit toward issues of health and health care for children and youth. A summary of this study is enclosed as a pull out sheet. The study can also be found on the Skillman Center website at www.skillman.org. The second study examined perceptions of residents statewide on issues of health care coverage and access. The results are summarized in the following article by Dr. Weissert.

Summary of State of the State Survey

In early 2003, over 1,000 Michigan residents were asked their opinion of key health-related issues as part of a quarterly State of the State survey conducted by the Michigan State University Institute for Public Policy and Social Research. Funding for the health questions was provided by the Skillman Foundation. A response rate of 39% was achieved with a margin of sampling error of ± 3.1%. Responses have been grouped into 7 regions, illustrated in the map, below. A summary of results follows.

Health insurance and affordability of health care

One in five (20%) of all Michigan residents viewed access to health care as the policy issue of most importance for children and youth at this time



- Health insurance and the affordability of health care were identified as the most important health care issue for children and youth by the largest percentage of respondents statewide (39%).

- The distribution of those who shared this view was relatively evenly spread across the state except for those residents in the Northern Lower Peninsula where it was higher. There the rate rose to over one in every two persons (57%) (See figure 1)

- The importance of health insurance and the affordability of health care was a non-partisan issue. There was no significant difference in the percentage of Republicans (31%) and Democrats (29%) citing health insurance as the most important health care issue for children and youth.

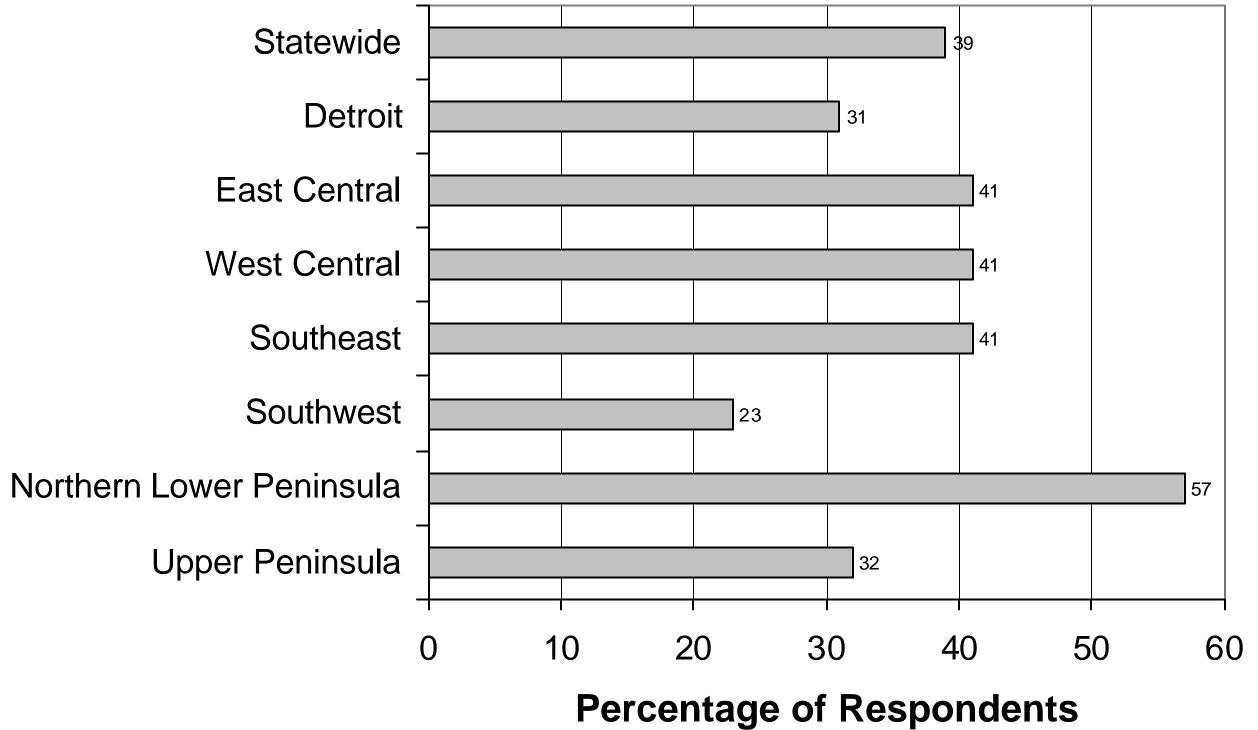


Figure 1: *Percentage of members in communities in Michigan who think health insurance is the most important health care issue for children and youth in their community.*

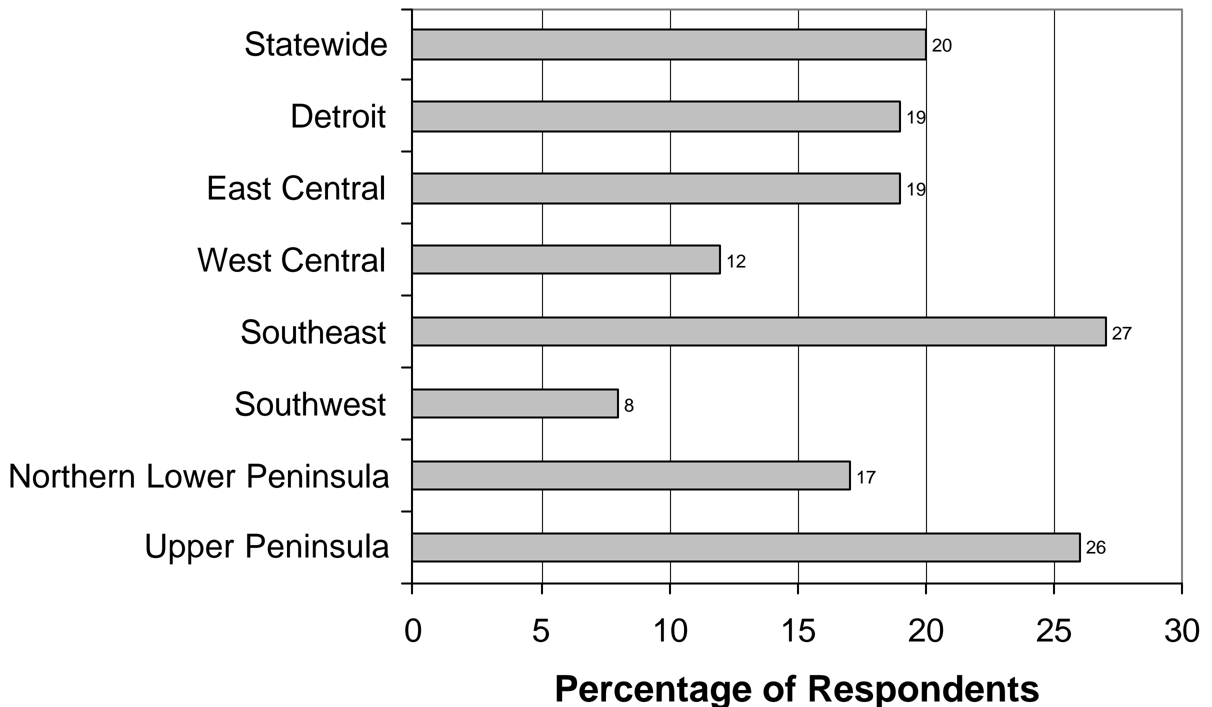


Figure 2: *Percentage of members in communities in Michigan who think access to health care is the most important health care issue for children and youth in their community at this time.*

Access to health care

- One in five (20%) of all Michigan residents viewed access to health care as the policy issue of most importance for children and youth at this time.

- When respondents were analyzed by region, some differences emerged. Only 8% of those living in the Southwest cited access as the most important issue compared to over one quarter of respondents (27%) in the Southeast and the Upper Peninsula (26%). (See figure 2)

- Partisan differences emerged in those feeling that access to health care was a top priority. Nearly twice as many Democrats (33%) as Republicans (17%) considered the issue of access to health care to be the most important health care issue for children and youth in their community.

Families who are uninsured

- Over three in four (76%) of all residents across the state perceived families without health insurance as a major problem (compared to a minor problem or no problem at all).

- This view was held relatively consistently across the state although it was more prevalent in the Southwest (85%) and Detroit (82%) and less so in the Northern Lower Peninsula (66%).

Quality of health care for children

Residents were asked to rate the quality of health care for their children and youth on a scale of 0 to 10 with 0 being extremely poor quality and 10 being excellent quality. The statewide average was 6.0.

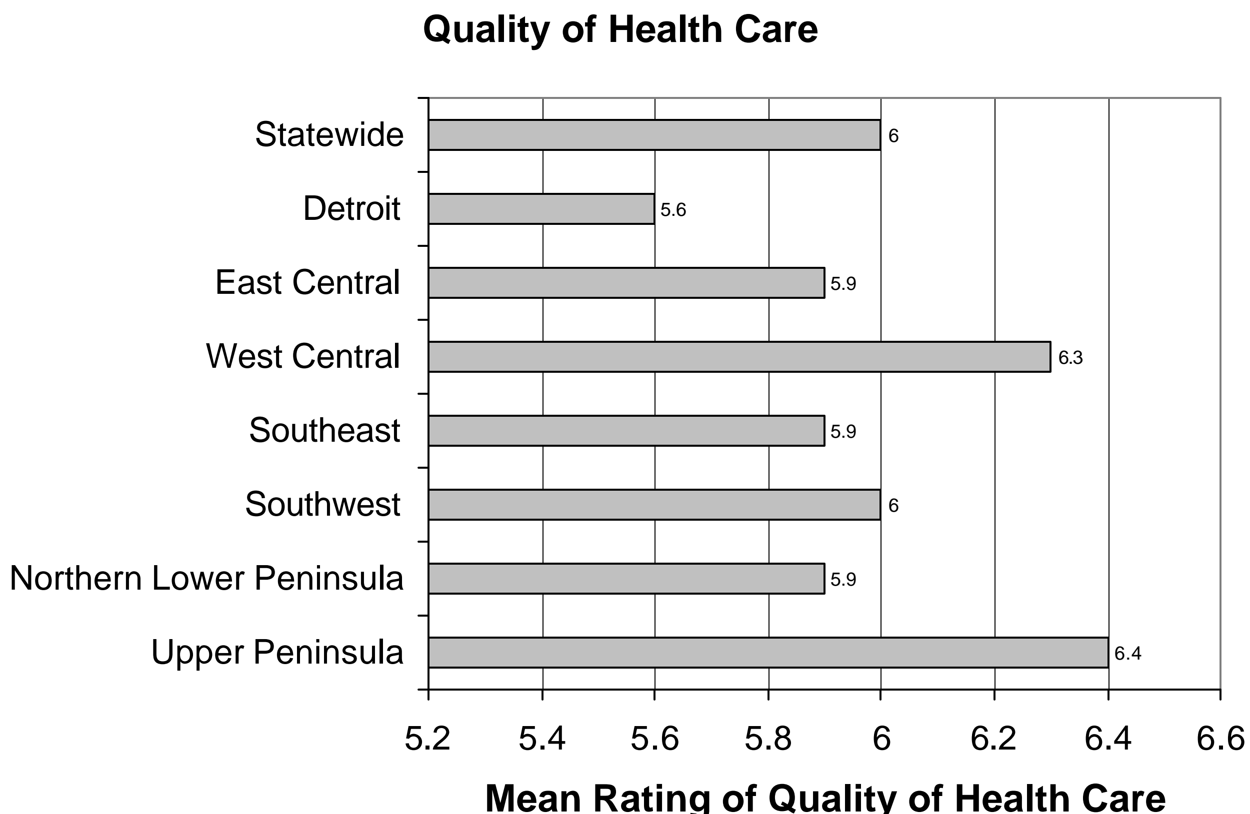


Figure 3: *Mean rating of the quality of health care for children in different communities in Michigan.*

- Detroit residents rated quality there lower than that found elsewhere in the state (5.6).

- In contrast, residents of the Upper Peninsula (6.4) and West Central (6.3) rated quality higher.

Affordability of health care

- The cost of health care was seen as "very" or "somewhat" affordable by over half of all residents statewide (56%).

- A majority of residents (72%) in the Southwest thought that health care was "very" or "somewhat" affordable.

- In contrast, only 46% of residents in the Northern Lower Peninsula and 45% of those in West Central felt that health care was "very" or "somewhat" affordable.

- There were apparent differences between Republicans and Democrats in their perceptions of the cost of health care. Nearly 3 out of every 4 Republicans (72%) viewed health care as "very" or "somewhat" affordable; fewer than half of the Democrats (47%) thought this.

Familiarity with MIChild health insurance

- Familiarity with MIChild insurance across the state was generally low. Approximately two out of three residents were "not familiar at all" or "not too familiar" with MIChild health insurance (See figure 5).

- Familiarity with the program was highest among residents of Detroit (43%) and the East Central Region (41%).

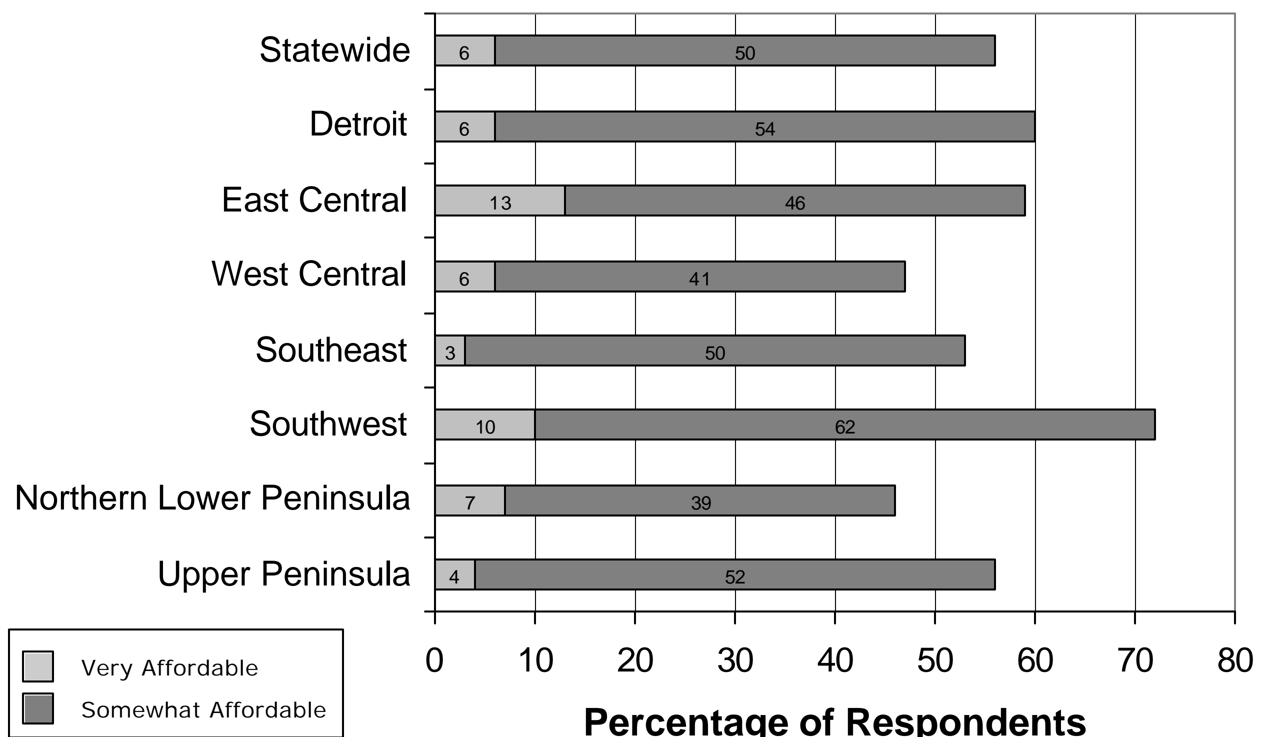


Figure 4: *Percentage of respondents who thought the cost of health care is "very" or "somewhat" affordable.*

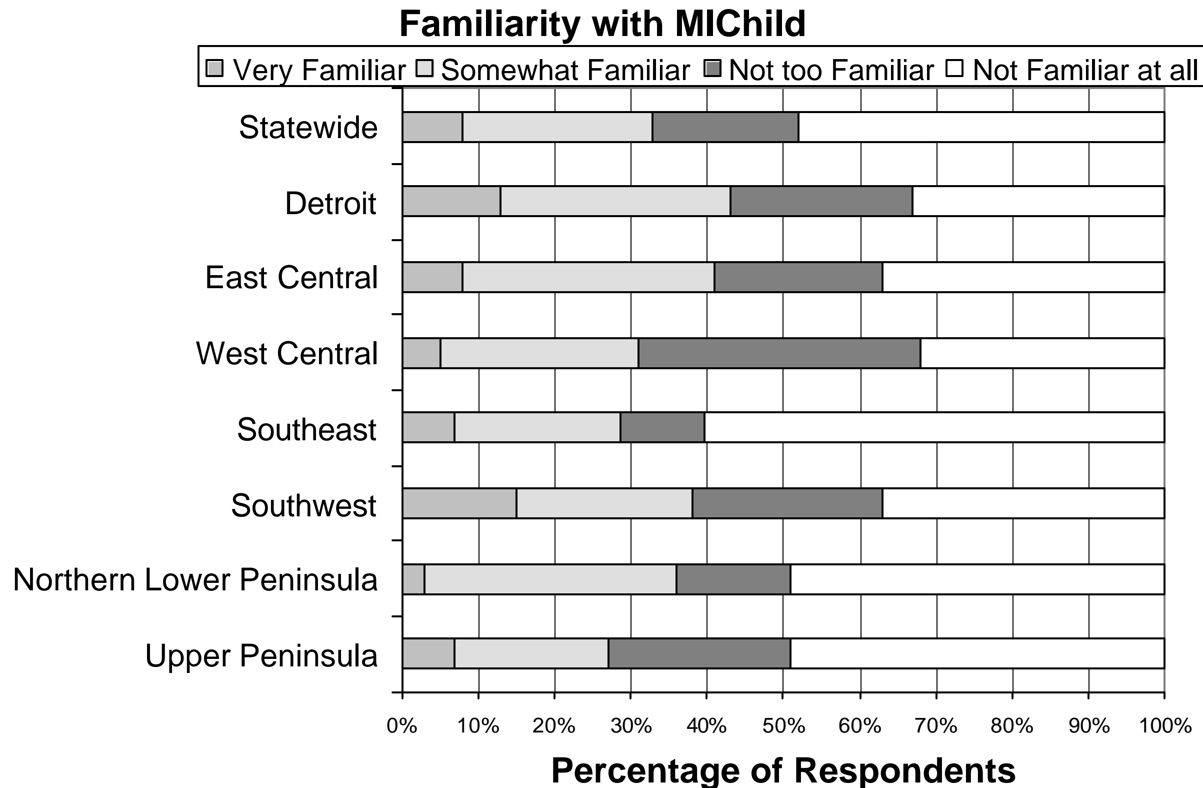


Figure 5: *Percentage of respondents who were familiar with the MIChild health insurance program for uninsured children of working families in the state of Michigan.*

Expansion of coverage through state government programs

- A substantial majority of residents (86%) across the state supported expanding state government programs for low income people such as Medicaid and MIChild, to provide coverage for people without health insurance
- Level of support ranged from almost all Detroit residents (96%) to three in four of the residents in the Northern Lower Peninsula (75%)

Summary

The picture for Michigan policymakers is decidedly mixed. On the positive side, affordable health care and access are viewed as important issues by residents across the state, and Michigan residents are supportive of state policy to expand health coverage. However, few residents are well informed about MIChild—a major program to provide health care coverage for children—and some important regional variations in defining health problems emerged. Access to health care is much more likely to be viewed as a problem in the Southeast and Upper Penninsula, but the costs are viewed as less affordable in the Northern Lower Peninsula and West Central parts of the state.

For more information:

Carol S. Weissert, Eminent Scholar, Department of Political Science, Florida State University.
Phone: (850) 644-7320 Email: cweisser@fsu.edu
The State of the State survey results can be found on the Institute for Public Policy and Social Research (MSU) website: www.ippsr.msu.edu

Michigan's State Children's Health Insurance Plan (SCHIP)

Emily Tamlyn and Laura Bates

The Problem

Most recent figures (1997-99) indicate that approximately 136,000[14] children from low-income families in Michigan are not covered by any form of health insurance, despite the fact that virtually all are eligible for public insurance programs. In addition, barriers to enrollment for some families still exist, access to care for those who are covered is uneven, and cuts in outreach funding mean that community organizations are under-utilized as means for reaching out to uninsured children and their low-income families. Unless these problems are corrected, Michigan will lose ground in its efforts to ensure that all children have health insurance coverage.

Approximately one-fourth of children in Michigan benefited from public health insurance coverage in 2001. Of these:

- 647,644 (23.6%) were enrolled in ***Medicaid*** and
- 26,065 (1.0%) were enrolled in ***MIChild***[15]

The State Children's Health Insurance Program (SCHIP) extends health insurance coverage to children in low-income families who are not eligible for Medicaid, using a combination of state and federal funds

While public health insurance has contributed to the well-being of Michigan's low-income children, more remains to be done to ensure that all Michigan's children have access to health care. The State Children's Health Insurance Program (SCHIP) is one program seeking to reduce the number of children without health insurance.

The Federal SCHIP Program

What is SCHIP[16]?

The State Children's Health Insurance Program (SCHIP) extends health insurance coverage to children in low-income families who are not eligible for Medicaid, using a combination of state and federal funds. Authorized by Congress in 1997 under Title XXI of the Social Security Act, SCHIP was the first major federally funded health program to be established since Medicare and Medicaid in 1965.

Unlike Medicaid, SCHIP is not an ***entitlement program*** but instead comes to states in the form of a ***block grant.*** Once the federal allocation has been spent, the state may choose to pick up the total cost of services, cap enrollment, or reduce benefits. However, the ***federal match rate*** is higher than it is for Medicaid. Prior to SCHIP, Michigan had piloted the Caring Program for Children, which offered insurance to children not eligible for Medicaid. In 1998, this program was incorporated into Michigan's SCHIP program.[17]

What is the target population for SCHIP?

SCHIP extends coverage to children who:

- Are under age 19 years,
- Are uninsured,
- Are not eligible for Medicaid, and
- Live in families whose incomes are at or below 200% of the ***Federal Poverty Level (FPL)***.[18] [FPL was $18,400 for a family of four in 2003].

To ensure that states did not use SCHIP funds to supplant existing funding for child health programs, they are required to maintain eligibility for Medicaid at the level in effect on June 1, 1997, and must maintain the same level of spending on child health programs that was expended in 1996.[19]

How may states implement SCHIP?

The legislation allows states to have considerable flexibility in structuring their program. States may use SCHIP funds to either:

- Expand the state's Medicaid program
- Create or expand a separate state program with certain benefit criteria
- Use a combination of the above options

SCHIP funds were used to expand eligibility for* Healthy Kids*, Michigan's Medicaid program for children, and to establish* MIChild*, a program modeled after the state employees' health plan

This structure allows states electing to develop separate programs to adopt certain features of private insurance such as deductibles, premiums, and cost sharing; however, the legislation places strict limits on how much money families may be required to pay. About one third of the states opted to use a combination model, while an additional third created a separate program.[20] Michigan chose the combination model, creating a Medicaid expansion program and a separate state program.[21]

How is SCHIP funded?

Congress authorized funding of approximately $40 billion over 10 years with the minimum allocation to a state being $2 million in any year.[22] States receive a federal match for state funds expended. Within certain limits, states choosing the separate program option may impose cost sharing. Michigan's SCHIP Plan, which was approved by the US Department of Health and Human Services on April 7, 1998, was one of the first combination models approved.

Is SCHIP an effective program?

In 1999 the Balanced Budget Refinement Act mandated the US Department of Health and Human Services (DHHS) to conduct an evaluation of SCHIP programs in ten states. Included in the evaluation are rates of SCHIP enrollment and disenrollment, SCHIP and Medicaid enrollment practices, and coordination between SCHIP and Medicaid. The complete results are due to be released to Congress in 2004. The most recent data from the evaluation is discussed in the following article, **SCHIP Turns Five: Gaining Ground, but Not Enough**.

Michigan's SCHIP Program: MIChild/Healthy Kids

Michigan used the combination SCHIP option to expand Medicaid and to establish a separate program. SCHIP funds were used to expand eligibility for ***Healthy Kids***, Michigan's Medicaid program for children, and to establish

MIChild, a program modeled after the state employees' health plan. The similarities and differences between these programs are described in this section and summarized in Table 1.

The enrollment process is coordinated for* MIChild *and* Healthy Kids*, and the family completes a joint application for coverage

Similarities

The two programs share common objectives and a common enrollment process. These will be described first.

Objectives

To increase the number of children in low-income families covered by insurance, Michigan has established four performance objectives for the program:

1) Enrolling the estimated 136,000 low-income uninsured children in either *Healthy Kids* or *MIChild*;

2) Obtaining accurate data regarding the quality of care providers are giving;

3) Facilitating enrollment by involving community organizations in outreach and educational activities; and

4) Providing a user-friendly application process.[23]

Enrollment process

The enrollment process is coordinated for *MIChild* and *Healthy Kids*, and the family completes a joint application for coverage. This process makes it easier for families to apply, as they do not have to know ahead of time which program they are eligible for.

To facilitate enrollment, Michigan has a "no wrong door" application process. This means that families can apply in a variety of places, including Family Independence Agency offices, local health departments, and other community sites. Families can also complete an electronic application online and receive an immediate temporary eligibility determination (see glossary - ***presumptive eligibility***). Re-enrollment forms for *MIChild* are preprinted and sent out to families for verification and signature before the end of the enrollment period (12 months for both programs).

Comparison of programs

Eligibility

Healthy Kids Medicaid expansion extends Medicaid coverage to children 16 to 18 years old with family incomes between 100% and 150% of FPL, a group previously not covered by Medicaid.

MIChild enrolls children from birth to 18 years living in families with incomes between 150% and 200% of FPL.[24] Many of those eligible for *MIChild* live in working families who do not have health insurance. When an application is approved, a child is eligible for 12 months for both programs.

Cost sharing

Healthy Kids imposes no premiums or co-payments for consumers, as they are not allowed by Medicaid rules. Families may have other coverage (e.g., employer-sponsored insurance) and still be eligible for *Healthy Kids*. The other coverage is billed first.[25]

Families in ***MIChild*** pay a $5 per family monthly premium, with total cost sharing not to exceed $60 per year. There are no co-payments for *MIChild*-covered services. Other coverage disqualifies the child for coverage under *MIChild*.[26]

	Healthy Kids Medicaid Expansion [28]	MIChild State-Designed Program
Eligibility		
Age of Child	16-18 Years	Birth-18 years [29]
Family Income	100-150% FPL	150-200% FPL
Time Covered	12 months	12 months
Retroactive Eligibility	Yes, for previous 3 months	No
Residency	State resident or migrant worker family	State resident or migrant worker family
Cost-sharing		
Premiums	None	$5 premium per family per month up to $60 per year
Co-payments for covered services	None	None
Access to other coverage	Ok - other coverage billed first	Other coverage disqualifies
Benefits		
Included	Standard Medicaid coverage	Similar to coverage of state employees
Type of Program	Entitlement	Capped enrollment is possible
Service Providers	Medicaid Qualified Health Plans, all of which are health maintenance organizations (HMOs), and fee-for-services	Managed care system through HMOs and licensed health insurerers/dental providers who offer a preferred provider product

Table 1: Comparison of Healthy Kids Medicaid and MIChild Programs

Benefits

Those enrolled in ***Healthy Kids*** Medicaid expansion, receive the standard Medicaid benefits package, including mental health, dental, substance abuse and vision services.

Benefits in ***MIChild*** resemble the state employees' health care plan and include mental health, dental, substance abuse, and vision services.

Service model and service providers

Healthy Kids services are delivered by Medicaid Qualified Health Plans, all of which are health maintenance organizations (HMOs), and through fee-for service providers.

MIChild services are delivered through a capitated managed care service delivery system by HMOs and licensed health insurers/dental providers who offer a preferred provider product. With 89.84% of beneficiaries (30,460 children) currently enrolled in a Blue Cross/Blue Shield Program, they are the largest provider in the state.[27]

Enrollment to date

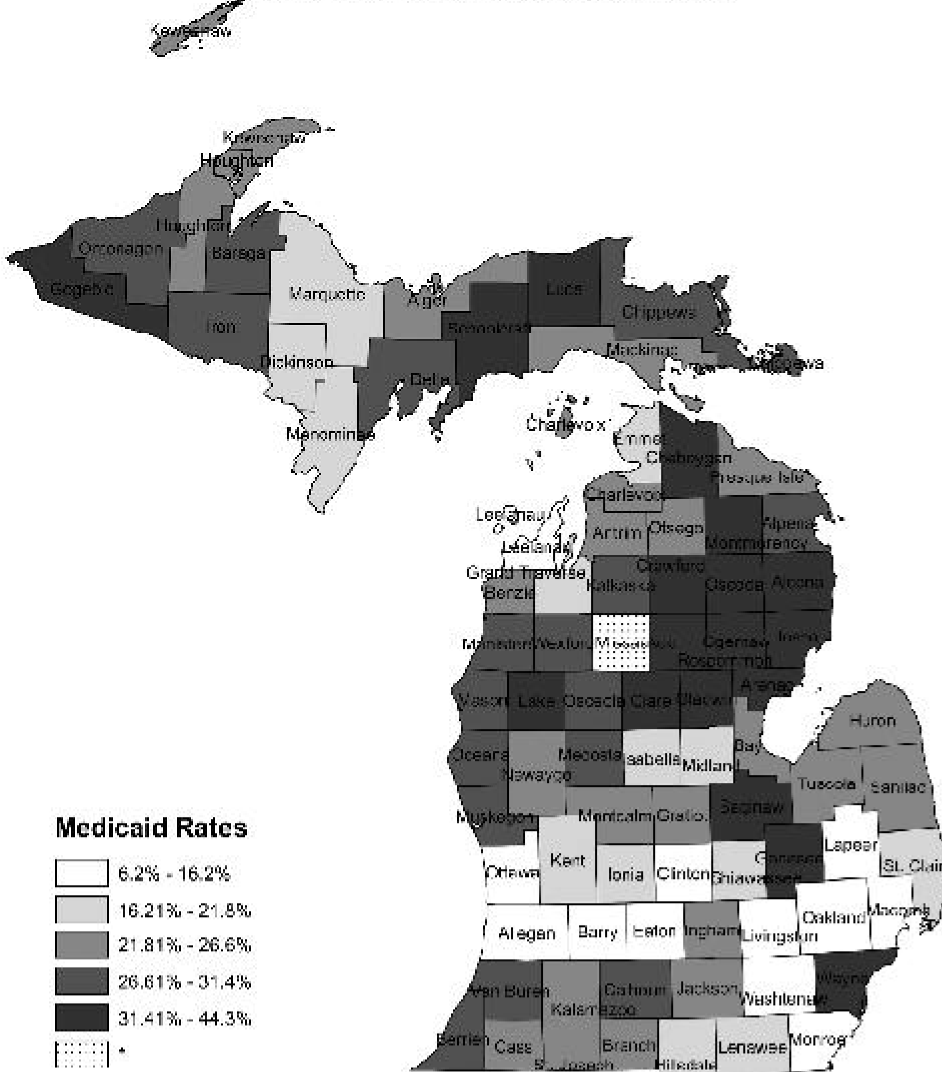
Between FYs 1998 and 2002, enrollment grew from 6,226 to 45,105 children.[30] Outreach activities for *MIChild* have also identified many uninsured children who are actually eligible for Medicaid. Between May of 1998 and September of 2002, 229,581 children who applied for *MIChild* were determined to be eligible

for public insurance. Of this total, 67,044 children (29.2%) received health insurance through the *MIChild* program, and the other 162,537 (70.8%) were transferred to the Medicaid program.[31]

How are *MIChild* and *Healthy Kids* funded and how much do they cost?

Michigan uses the general fund to finance the state's share of SCHIP and receives matching federal dollars.[32] In FY 2003, total expenditures for *MIChild* were $49,214,104, and the state's share was $15,359,646. For the *Healthy Kids* expansion portion of SCHIP, total expenditures were $25,992,204 with state's share being $8,112,167.[33] The federal match rate for SCHIP in FY 2003 was 68.79%, which is higher than the match for Medicaid dollars.[34] Total state expenditures for the SCHIP program represent only about one half of one percent of the state budget for FY 2003.

2001 Michigan Medicaid Rates

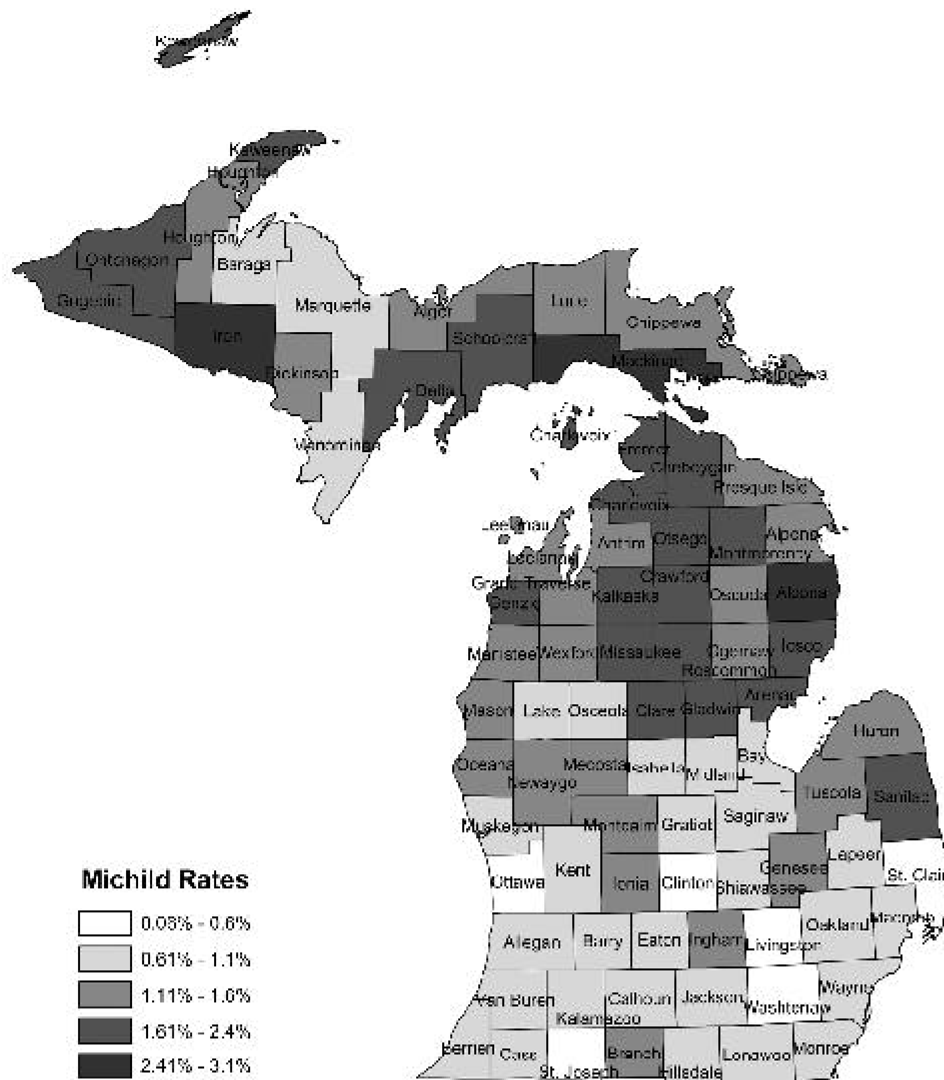


*: Rate not calculated because of low incidence of events or unavailable data

Source: Kids Count in Michigan 2002 Data Book

The counties with the highest proportion of children enrolled in* MIChild *are not in the major urban areas but rather in the rural counties of the Northern Lower and Upper Peninsulas. On the other hand the major urban counties of Southeast Michigan, as well as portions of the Northern Lower and Upper Peninsulas have the highest proportion of children enrolled in Medicaid

2001 Michigan Michild Rates



Source: Kids Count in Michigan 2002 Data Book

Public health insurance coverage in Michigan in 2001

Although many more children are enrolled in Medicaid than in *MIChild*, the rates of enrollment for each program vary by region of the state. Figure 2 illustrates the rates of enrollment of children in Medicaid by county and Figure 3 illustrates the rates of *MIChild* enrollment. Counties with the highest rates of enrollment of children in Medicaid are found in the Northern Lower Peninsula, urban counties in Southeast Michigan (Wayne, Genesee, and Saginaw) and in parts of the Upper Peninsula. Counties with the highest proportion of children enrolled in *MIChild* are found in the Northern Lower and Upper Peninsulas.

Implications for policy

As noted, the counties with the highest proportion of children enrolled in *MIChild* are not in the major urban areas but rather in the rural counties of the Northern Lower and Upper Peninsulas. On the other hand, the major urban counties of Southeast Michigan, as well as portions of the Northern Lower and

Upper Peninsulas have the highest proportion of children enrolled in Medicaid. Some possible explanations for these distributions are presented in this brief. Some of these possible explanations are:

- Employers in rural areas may be less likely to offer employer-sponsored health insurance to low-income workers;
- The greatest proportion of very poor (Medicaid-eligible) families live in areas of concentrated urban or rural poverty in Michigan;
- Outreach efforts are not reaching the working poor families in some areas;
- Poor families in some areas of the state are less likely to want to enroll in "welfare" (i.e., Medicaid) programs;
- Some other unidentified factors.

Each of these explanations would have implications for policy. However, more data on family income and employment patterns, and family health care enrollment and utilization patterns will be needed to make policy decisions about effective strategies to reduce uninsurance rates among the poor and near-poor families of Michigan.

Public awareness about *MIChild*

A recent survey conducted by The Institute for Public Policy and Social Research at Michigan State University[35] asked residents if they were familiar with the *MIChild* Program. Almost half the respondents were not at all familiar with *MIChild*, especially those in Southeastern Michigan and the Upper Peninsula.[36]

These findings suggest that expanded outreach efforts are needed to accomplish Michigan's SCHIP enrollment goals.

Conclusion

Healthy Kids and *MIChild* constitute an important step toward providing health insurance coverage for *all* children in Michigan. More work remains to be done, however. Most recent available figures indicate some 136,000 poor children still have no health insurance in our state. In addition, access to children's health services is uneven, enrollment processes and services are not always user-friendly, and outreach efforts remain insufficient. Other articles in this report provide information relevant to these concerns, as well as policy alternatives to address these problems.

Ian Hill, M.P.A., M.S.W., is a senior research associate in the Health Policy Center of the Urban Institute, a nonprofit, nonpartisan public policy research and educational organization. Hill directs the qualitative component of the Institute's evaluation of the State Children's Health Insurance Program (SCHIP) and oversees the development of a series of cross-cutting papers on states' implementation of SCHIP. He is a nationally recognized expert in maternal and child health policy and programs. Hill can be contacted at www.urban.org.

SCHIP Turns Five: Gaining Ground, But Not Enough

Ian Hill, The Urban Institute

Introduction

In 1997 Congress enacted the State Children's Health Insurance Program (SCHIP) with bipartisan support, as Title XXI of the Social Security Act. The program allows states to extend health insurance coverage to children not eligible for Medicaid, provides a higher federal match than Medicaid, and was funded for 10 years at $40 billion.

Five years into SCHIP, evaluations have provided early positive evidence regarding SCHIP's success, and rates of uninsurance among children appear to have been reduced

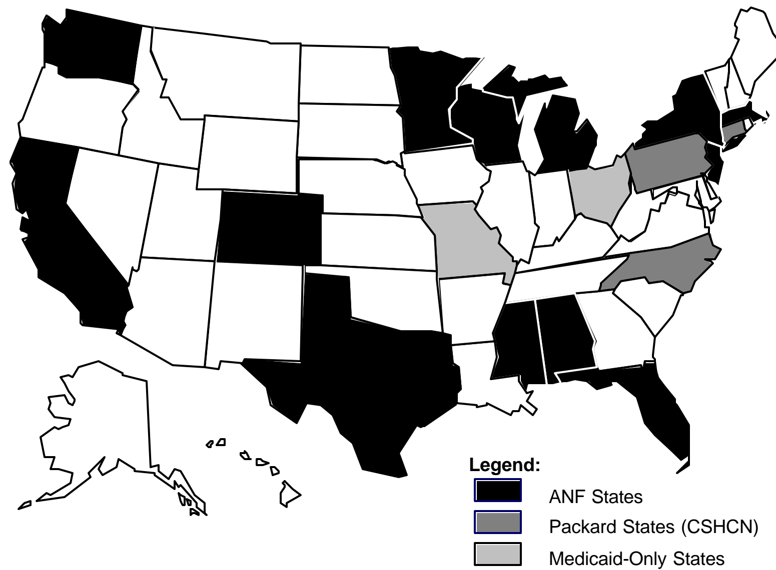
SCHIP gives states the opportunity to expand insurance coverage to uninsured children whose family income is too high to qualify for Medicaid. States may cover these children by expanding Medicaid (in which case they must extend open-ended "entitlement" to eligible children), creating a separate program, or using a combination of the two methods. Five years into SCHIP, evaluations have provided early positive evidence regarding SCHIP's success, and rates of uninsurance among children appear to have been reduced. This report will review the evidence to date of program accomplishments, barriers encountered, and challenges that lie ahead.

The Urban Institute's SCHIP Evaluation

Since SCHIP's inception, the Urban Institute has been engaged in an evaluation of the program as part of its Assessing the New Federalism (ANF) Project. This multi-year evaluation, which is jointly funded by the Robert Wood Johnson Foundation, the David and Lucille Packard Foundation, and the Kaiser Commission on Medicaid and the Uninsured, looks at Medicaid and SCHIP nationally, but examines program implementation more closely in 13 "focal" states, including Michigan (see Figure 1, map of study states).

The qualitative component, directed by the author, relied on site visits to the focal states[37] conducted between 1999 and 2001, as well as periodic telephone interviews with state and local officials. The quantitative component, directed by Lisa Dubay and Genevieve Kenney, relies on the National Survey of America's Families and the Current Population Survey.

Figure 1: Study States for the UI/SCHIP Evaluation



What has been accomplished?

States have taken advantage of SCHIP's flexibility to expand health insurance coverage.

The Title XXI statute creating SCHIP afforded states great flexibility in designing their child health programs, and within approximately two years, all 50 states and the District of Columbia had implemented programs.[38] States also had the option to:

1. Choose program models (Medicaid expansion, separate program, or combination approach),
2. Set eligibility limits up to 200% of ***Federal Poverty Level*** (FPL) or higher,
3. Engage in outreach and recruitment activities, and
4. Simplify enrollment procedures.

The Title XXI statute creating SCHIP afforded states great flexibility in designing their child health programs, and within approximately two years, all 50 states and the District of Columbia had implemented programs[38]

Those who used Medicaid expansion programs were required to adopt the full benefit package mandated under Medicaid, but states that created separate programs could adopt a more limited benefit package, as long as it met any one of several federally-identified "benchmark" plans. Separate programs could also impose cost sharing at significantly higher levels than those allowed by Medicaid, cap enrollment, and adopt various strategies to prevent SCHIP from "crowding out" existing private health insurance.[39]

How states have used this flexibility

Eligibility has included the near poor. Two thirds of the states set their income eligibility thresholds at 200% of FPL or above; 27 (including Michigan) adopted expansions to 200% of FPL. Thirteen states chose to cover children in families with higher incomes, the highest being New Jersey at 350% of FPL. Importantly, SCHIP has generally equalized eligibility for coverage across

children of different age groups[40] because historically Medicaid has had more generous coverage policies for younger children. [This is true of Michigan's SCHIP program, which expands the *Healthy Kids* Medicaid program to include children 16-18 years old whose family incomes are between 100% and 150% of FPL.]

Medicaid-Separate Program Options. Sixteen states opted to expand Medicaid, and thirty-five chose to create separate programs, either alone or in combination with Medicaid expansions. Policymakers in states that chose Medicaid expansions generally held high opinions of their Medicaid programs, and saw them as the most efficient and effective means for increasing coverage.[41] Those who chose separate programs were spurred by a desire to create programs that were "more like private insurance." Those who adopted "combination" programs [as did Michigan] tended to begin with small Medicaid expansions followed by adoption of much larger separate programs.[42]

Outreach and enrollment has been emphasized. In response to encouragement from the federal Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) states have invested unprecedented resources in outreach and enrollment simplification. They have employed strategies such as:

- Statewide public education campaigns
- Targeted community-based efforts to reach and enroll families
- Streamlined enrollment with many states using
    - Short and simple application forms to jointly determine eligibility for SCHIP and Medicaid
    - Application by mail
    - Dropping assets tests
    - Reducing the documentation families must submit with the application.

[Michigan allows online application for MIChild and concurrently screens for Medicaid eligibility. Documentation requirements are reduced.] While simplification of Medicaid enrollment has not kept pace with SCHIP, there has been significant "spillover" of these policies to Medicaid.[43, 44]

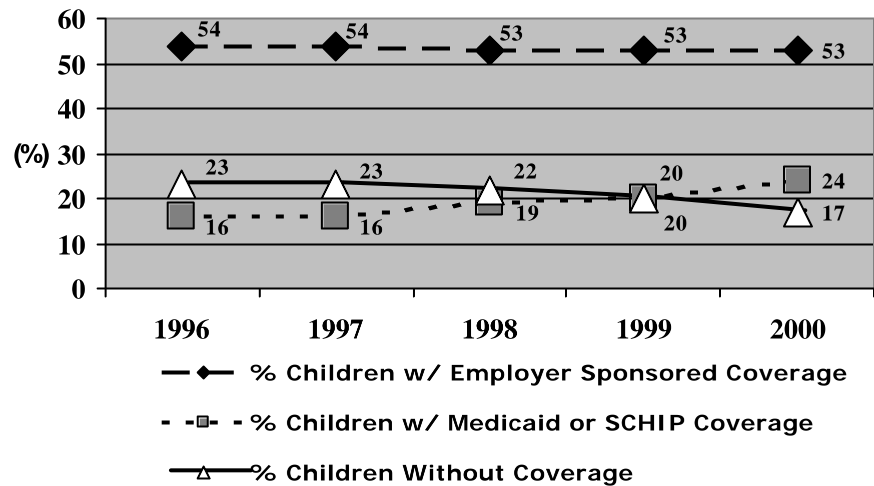
States have adopted generous benefits coverage. Although states creating separate programs had the option to provide a narrower benefit package than that offered by Medicaid, evidence indicates that SCHIP separate programs cover a broad range of preventive, primary and acute care services.[45] One-third of states with separate programs cover the full benefit package of Medicaid, and six others ensure that Medicaid-equivalent coverage is extended to children with special health care needs. In other states, the benefits most often left out are those often needed by children with special health care needs, suggesting that gaps may exist in services for this group.[46, 47]

Use of managed care is nearly universal and is often credited with helping to achieve "good" access to care.[48]

Cost-sharing, where used, appears to be affordable for most families. In general, cost sharing for separate programs, such as premiums and copayments, are well below the maximum allowable limit of 5% of total family income. Qualitative data from focus groups suggest cost sharing measures are "affordable."[49]

"Crowd-out" does not appear to be a problem. States creating separate programs were required to take measures to prevent "crowd-out" of existing employer-based coverage. The majority used initial waiting periods (usually three or six months) for enrollment of those children who were previously insured by private insurance. Exceptions were made for job loss. [In Michigan,

Figure 2 - Coverage Gains Have Occurred for Children
Uninsurance Rate Dropping for Near Poor Children



Source: 1997 through 2001 Current Population Survey
Near poor defined as 100 to 200% FPL
Chart does not include CHAMPUS/Medicare and other insurance

the waiting period is 6 months, except in the case of job loss.] These waiting periods were intended to reduce substitution.

Since SCHIP was enacted in 1997, rates of uninsurance have dropped among children, especially among children in low-income households.[50] In particular there have been substantial declines in the rates of uninsurance among children in "near poor" [100-200% of FPL] families[51]

Following SCHIP, coverage gains have occurred for children.

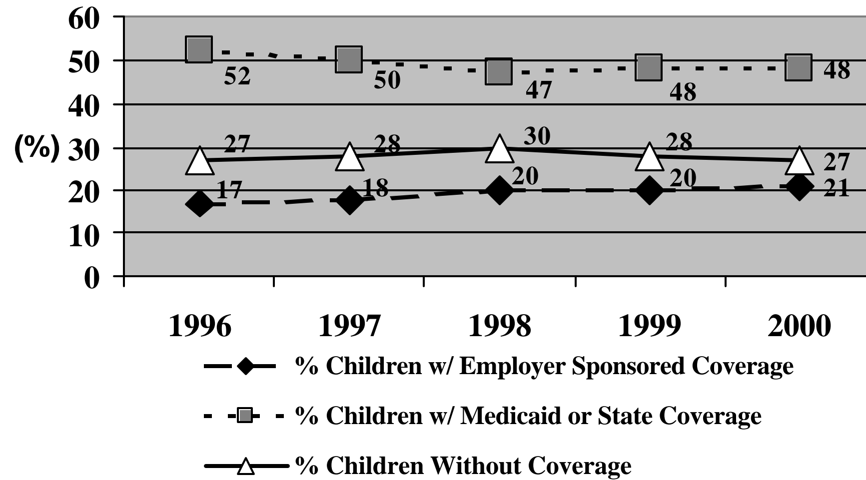
Since SCHIP was enacted in 1997, rates of uninsurance have dropped among children, especially among children in low-income households.[50] In particular there have been substantial declines in the rates of uninsurance among children in "near poor" [100-200% of FPL] families.[51]

Between 1996 and 2000 the rate of uninsurance among this group declined 33% nationally from 23.3 to 17.5 %, probably reflecting increased participation in Medicaid and new SCHIP enrollment as a result of outreach activities and eligibility simplification. During this period, the share of near-poor children covered by SCHIP or Medicaid increased by 7.6 percentage points while the rate of those covered by employer, CHAMPUS/Medicare and other private insurance remained constant. Since 2000, the economic slowdown has resulted in more individuals lacking health insurance because of job losses; however, data from the Current Population Survey indicate that between 2000 and 2002, the rates of insurance coverage for children have held steady.

However, too many children in the United States still are uninsured. Nationally, some 2.7 million near-poor children remain uninsured. The vast majority of these children are eligible for SCHIP or Medicaid.

Awareness of public health insurance programs is increasing. Recent data indicate that low-income families with uninsured children are becoming more familiar with public insurance programs. A significant increase occurred nationally between 1999 and 2002 in the number of these families who had heard of their state's SCHIP program ($p<.10$); in addition among those who had heard of public insurance programs, more understood that a child can participate in the insurance programs without receiving welfare.

Figure 3 - Uninsurance Rate Stagnating for Poor Children



Source: 1997 through 2001 Current Population Survey
Poor defined as below 100% FPL
Chart does not include CHAMPUS/Medicare and other insurance

What has not been accomplished?

In spite of early positive trends in increasing health coverage among near-poor children, the target group for SCHIP, there are signs that the program is not helping to reduce the rates of uninsurance among poor children.

The rate of uninsurance among *poor* children is stagnating.

While the increasing rates of insurance coverage among children in near-poor families is a major accomplishment of SCHIP, the situation for poor families (those with incomes below 100% of FPL) is much less encouraging. In fact, from 1996 to 2000 the uninsurance rate in this group stagnated at 24.9 % for children who were citizens, despite the fact that all were eligible for Medicaid or SCHIP in 2000 (see Figure 3).[52]

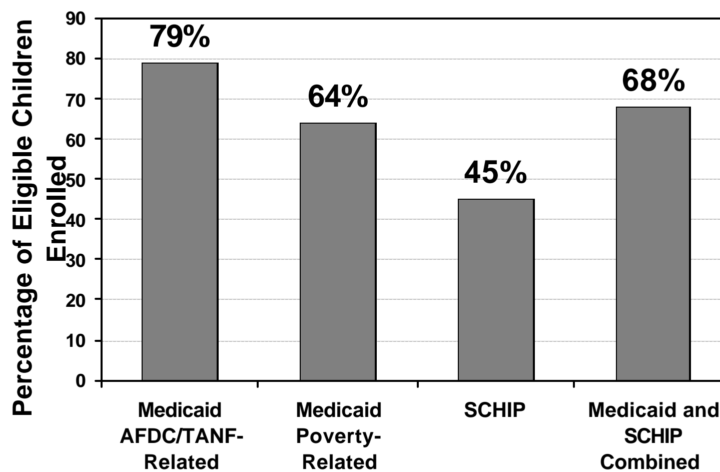
Poor children constitute 21% of all children, but almost 46% of uninsured children.[53] Since states have used SCHIP to make many more uninsured children eligible for public health insurance, only 23% of all uninsured children and only 16% of poor children are not eligible for public insurance.[54]

Importantly, many more uninsured children are eligible for Medicaid than for SCHIP. Of the 8.9 million uninsured children in the US in 1999, for example, 52% were eligible for Medicaid but only 25% were eligible for SCHIP. The highest participation rates among eligible children were among those children who received Medicaid because of their participation in the Temporary Assistance to Needy Families (TANF) program, while rates were lower among higher income children not receiving TANF who were Medicaid-eligible or those who were eligible for SCHIP (see Figure 4).

It is evident that accomplishing further reductions in uninsurance rates will require increasing participation in Medicaid as well as SCHIP.

Figure 4: Participation in Public Health Insurance Programs Varies Across Program Type

(Citizen Children Age 0 to 17, Excluding Private Coverage, 1999)



Source: 1999 National Survey of America's Families.

Note: Simulation uses income and insurance distribution from the 1999 NSAF and Medicaid and SCHIP eligibility rules in place as of July 1999.

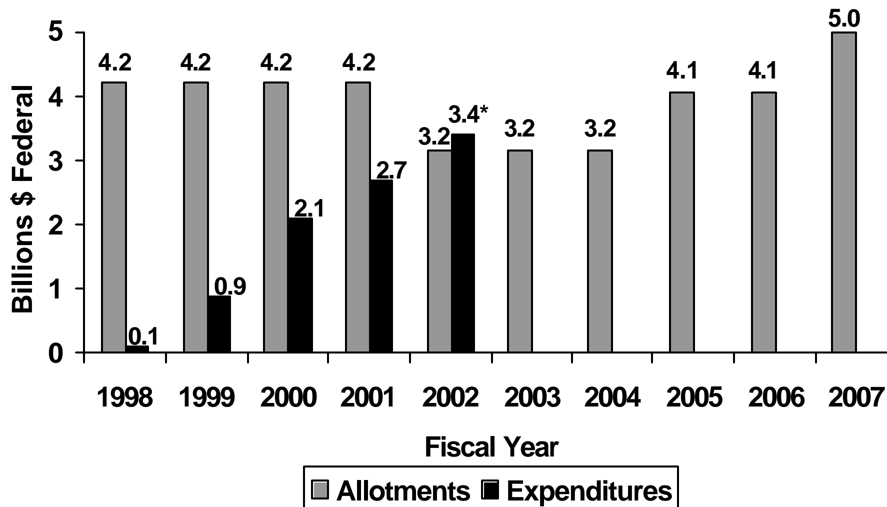
Continuing barriers to participation

Reasons for nonparticipation. Recent analyses indicate that the causes of uninsurance among eligible children who are not enrolled are complex.[55, 56]

Parents give various reasons for not enrolling their children, including:

- Knowledge gaps, such as:
    - Lack of awareness of the program
    - Not knowing their children are eligible
    - Believing that participation in welfare is required for Medicaid/SCHIP enrollment
- Administrative hassles, including:
    - Complicated application forms and documentation requirements
    - Lack of transportation
    - Language barriers
- Not wanting public insurance or believing it is not necessary

Retention and re-enrollment of eligible children. Despite recent gains in SCHIP enrollment, states are struggling to retain families once enrolled. Retention rates of less than 50% are not uncommon. Enrollment/re-enrollment processes may pose particular problems for poor families. Recent research[57] indicates that the families of many eligible children without coverage have experience with the programs. For example, one study found that 29% of low-income uninsured children had either recently disenrolled from public coverage or had begun, but not completed, the enrollment process during the previous year. Increasing participation may require further simplifications to Medicaid



SCHIP expenditures for FY '02 based on projections

enrollment and use of community-based outreach workers [see snapshots of the Eastside Access Partnership and Covering Kids, for local outreach examples].

What challenges lie ahead?

SCHIP funds may run short.

SCHIP was funded with approximately $40 billion in federal funds for fiscal years 1998 to 2007. Although an average of $4.0 billion per year was allocated, the allotment started at $4.2 billion (see Figure 5), then dipped to $3.1 billion for FY 2002, 2003, and 2004, returning to the higher level for the last years. In addition, states were given 3 years to spend each year's allotment, after which time unspent funds would be redistributed to states whose spending outstripped their allotments. This policy had the effect of fully funding the program shortly after start up and then reducing funds just as most programs were fully implemented. As shown in Figure 5, spending in the first 3 years was far below the allotments, but by FY 2002 it had caught up.

The Congressional Budget Office projects that there will be federal funding shortfalls in SCHIP in the coming years due to lower allotments and the fact that, after three years, unspent funds can be redistributed to other states.

States are facing the first fiscal crisis in a decade.

As the US economy has encountered the first downturn since the early 90's many states, including Michigan, are facing severe budget shortfalls. Few states are considering revenue enhancements as a solution to the crisis, but spending cuts are a major strategy for budget balancing.[58]

How has SCHIP fared as states face budget crises?

As part of the ongoing qualitative evaluation of SCHIP, the Urban Institute conducted telephone surveys of SCHIP directors in the 13 ANF states (see Figure 1) during the summer/fall of 2002 and again in the fall of 2003. These interviews explored whether states were enacting or considering changes in SCHIP that would reduce eligibility, outreach, or benefits, or increase cost sharing by families.

Last year, the evaluation team found that SCHIP had "dodged the first budget axe." **This year, preliminary analysis of the data indicates that more cuts have been enacted, but SCHIP has fared relatively well.** In 2003 the following changes were made in response to budgetary restraints:

- One third of the study states reduced the upper income thresholds or capped eligibility
- Over half the study states imposed more restrictive enrollment procedures, such as:
  - Reinstating assets tests
  - Reducing enrollment periods from 12 months to 6 months
  - Shortening the renewal grace period
- One quarter of the states reduced outreach even further (this was already occurring in 2002)
  - Some states, including Michigan, eliminated the application assistance fee provided to community groups who help enroll children
- One quarter cut benefits, such as dental, vision and hearing services
  - Texas, Alabama, and Florida used this option
  - Texas made the most severe cuts
- Over half the states raised cost-sharing amounts
- One state imposed more stringent crowd-out prevention safeguards
- Half the states froze or reduced provider reimbursement

Overall, the cuts that were made to SCHIP programs tended to "chip at the edges" rather than make drastic changes in eligibility or benefits. States tended to cut coverage to parents first, while keeping benefits to children relatively intact

[Michigan had originally considered folding the MIChild separate program into Medicaid Healthy Kids because of a large premium increase requested by Blue Cross/Blue Shield of Michigan (BC/BSM), the largest provider of MIChild. In late summer of 2003 the state and BC/BSM reached an agreement to partner in subsidizing MIChild for two years].

Overall, the cuts that were made to SCHIP programs tended to "chip at the edges" rather than make drastic changes in eligibility or benefits. States tended to cut coverage to parents first, while keeping benefits to children relatively intact. In many cases states viewed these changes as "choosing the lesser of evils." Many "cuts" were described as small and reasonable, and must be placed in context. For example, while several states increased premiums, the increases were proportionally much smaller than those of private insurers during the same period.

On the other hand, some state chose to freeze enrollment rather than erode other aspects of the program. These states believed that it was more important to preserve the integrity of the program by temporarily closing the program to new enrollments rather than make changes to the package. Enrollment caps were designed as temporary measures to reduce enrollment to target levels.

In spite of the budget difficulties, some states continued to enhance their SCHIP programs.

In spite of difficult economic times:

- **Half of the study states continued to simplify enrollment, for example:**
  - Michigan is expanding its electronic enrollment process and developing preprinted renewal forms
  - California is instituting "***express lane" eligibility*** and ***presumptive eligibility*** for all children receiving free/reduced lunch
- **Two states increased outreach**
- **Two states added new benefits:**
  - Minnesota instituted a mental health benefit
  - New York added emergency transportation and hospice care
- **One state reduced crowd-out prevention safeguards**

Why is children's health coverage so resilient?

In spite of states' fiscal crises, reductions in SCHIP have been relatively mild. There are a number of reasons that states give for the resilience of these programs:

- **SCHIP (and Medicaid for children) are viewed as successfully addressing a critical need**
- **SCHIP is protected by its small size relative to Medicaid**
- **Policymakers like programs they can control (rather than entitlement programs)**
- **The high federal match rate for SCHIP makes it hard to justify cuts**
- **Policymakers do not want to cut programs that explicitly benefit children**

Further progress will be dependent on the ability of states to enroll additional children

How can we maintain or enhance our progress?

As the Urban Institute's SCHIP evaluation has demonstrated, much progress has been made in increasing health coverage of children, particularly children of the near-poor. This progress can be attributed to active outreach for SCHIP that has also identified many children eligible for Medicaid. However, many eligible children remain without public insurance coverage.

Further progress will be dependent on the ability of states to enroll additional children. Toward that end, we make the following general **recommendations**:

- **States should maintain or increase efforts to help families enroll more easily in the program.**
- **States should enhance education programs to help families understand the benefits of preventive health care, and of the available health programs for low-income families.**

Also, it is important to note that health coverage is merely one means to reach our ultimate goal: healthier children. More research is needed to investigate the complex relationship of health coverage to issues of access, quality and health outcomes.

Additional policy alternatives are discussed in the Policy Alternative and Recommendations section of this brief.

Richard L. Lichtenstein, Ph.D., M.P.H., is an Associate Professor in the Department of Health Management and Policy in the School of Public Health at the University of Michigan. He is the Interim Principal Investigator of the Detroit Community-Academic Urban Research Center (URC), a Community-Based Participatory Research Program that includes several community-based organizations, the Detroit Health Department, the Henry Ford Health System, CDC and the University of Michigan. He is also the Principal Investigator of the "Eastside Access Partnership."

Penni Johnson brings 15 years of community experience to the Eastside Access Partnership (EAP) where she serves as its Program Coordinator. She is employed with Neighborhood Service Organization (NSO), a multi-faceted human service agency in Detroit that has been in the forefront in developing new initiatives to address the unmet and changing needs of persons in Southeastern Michigan. At EAP, Mrs. Johnson works to increase the participation of eligible children on Detroit's eastside in public health care programs.

Breaking Down Barriers to Enrollment in Public Health Insurance: Eastside Access Partnership

Richard Lichtenstein and Penni Johnson

The Problem

Approximately 3,000 uninsured children live in Eastside neighborhoods in Detroit, virtually all of whom are eligible for public health insurance. Comprehensive outreach efforts to enroll children from these neighborhoods in MIChild and Healthy Kids Medicaid (the program for which the vast majority of these children are eligible) have not been completely successful.

The Partnership

In 2000 the *Eastside Access Partnership (EAP)* was organized to identify barriers to enrollment in these neighborhoods and to develop strategies to reduce these barriers. EAP is part of a larger university-community partnership known as the Detroit Community-Academic Urban Research Center (URC). The URC brings together Detroit community organizations, the Detroit Health Department and the University of Michigan Schools of Public Health and Nursing to address factors affecting the health and well being of residents of Detroit neighborhoods. The URC focuses on neighborhoods on the East and Southwest sides of Detroit and seeks to develop policies and interventions that address these factors in ways that build upon and enhance the strengths and resources of the communities.

In 2000 the* Eastside Access Partnership (EAP) *was organized to identify barriers to enrollment in these neighborhoods and to develop strategies to reduce these barriers

The URC initiative has three priority issues:

1) Health care access and quality;

2) The environment as it affects health; and

3) Violence, particularly intimate partner and teen violence.

EAP includes Neighborhood Service Organization and other community-based organizations working on the East side, the University of Michigan School of Public Health, the Detroit Health Department, and three local offices of the Family Independence Agency (FIA). The FIA offices are the major point of contact for persons enrolling in Medicaid, so their involvement was integral to the success of the project.

Identifying Barriers to Enrollment

During its first year, EAP focused its activities on building the partnership and collecting data identifying barriers to enrolling eligible children in Medicaid. As part of the data collection process, EAP conducted a series of focus groups with community residents and agency staff.

A total of 45 community residents and 20 FIA staff participated in 7 focus groups that considered issues related to 5 target populations:

- Community residents with children;
- Grandparents responsible for raising young children;
- Community advocates from other URC projects;
- Family Independence Agency (FIA) customers, past and present;
- FIA staff.

Community members and advocates identified barriers to health coverage in three areas: (1) the enrollment process, (2) eligibility requirements for public insurance programs, and (3) eligibility and/or affordability of employer insurance

Qualitative analysis techniques identified common themes across groups. Although these themes may not be representative of all people in the community, they do indicate a range of perceptions commonly held in that community.

Commonly-held Perceptions

Community members and advocates

Community members and advocates identified barriers to health coverage in three areas: (1) the enrollment process, (2) eligibility requirements for public insurance programs, and (3) eligibility and/or affordability of employer insurance.

- **Problems with Medicaid Enrollment Processes**
    - Complexity of the application process (e.g., the need for detailed documentation of income)
    - Poor customer service by FIA offices (e.g., intrusive questions, lack of interest in customers as persons, inadequate explanation of reasons for denials)
    - Negative characteristics of FIA caseworkers (e.g., rudeness, anger, feelings of being overworked)
    - Inconvenient office hours
    - Poor quality care received under Medicaid (e.g., customers indicated they had previously had bad experiences with the program, or they believed service would be poor)
- **Problems with Eligibility Requirements for MIChild and Medicaid**
    - Lack of accurate information or understanding of who is eligible for Medicaid or MIChild

- A perception that, because parents are working, their children no longer are eligible for Medicaid (a perception that is not always true)

- **Eligibility and/or Affordability of Employer Insurance**
  - As a matter of business policy, children may not be covered by employer insurance
  - Coverage, if offered, may be too expensive for families to purchase

Perceptions of FIA Staff

Focus group participants from FIA staff agreed with community members regarding some barriers to enrollment, but new themes also emerged from their discussions. FIA themes focused on enrollment issues and eligibility requirements.

- **Problems with Enrollment in Medicaid**
  - Poor customer service
  - Negative characteristics of FIA caseworkers (e.g., FIA employees were aware that some staff members did not always provide accurate information or did not identify all programs for which a customer was eligible)
  - Inadequate staff training
  - Inappropriate administrator demands (e.g., supervisors sometimes insisted that staff respond to a customer who called the supervisor rather than paying attention to a case the worker had been servicing)
  - Caseworkers inappropriately serving as "gatekeepers" (e.g., incorrect decisions by a caseworker may shut customers out of a program for which they might have been eligible)
  - Caseworker response to negative participant characteristics (e.g., caseworker might not respond sufficiently to a customer who has a substance abuse or mental health problem)
  - Participant perception of a stigma associated with participation in a "welfare" program such as Medicaid
  - Poor quality of care under Medicaid
- **Problems with Eligibility Requirements for Medicaid**

In addition to agreeing with community members about major barriers, FIA staff also discussed barriers internal to the agency:

- Lack of understanding of eligibility requirements by caseworkers discourages participant enrollment
- Under welfare reform, FIA's priority is to move people off assistance rather than to engage in outreach and enrollment

Developing and Implementing Strategies for Change

The information obtained from the focus groups provided a base of knowledge about barriers to enrollment that EAP used to design targeted strategies to create change. Focus groups revealed that eligible families not only lacked knowledge and understanding of eligibility and enrollment processes, but also

that negative perceptions they held concerning FIA policies, procedures, and staff discouraged some families from applying.

Therefore, an effective strategy to increase the number of children enrolled in public health insurance required a two-pronged approach. First, EAP developed better strategies to educate the public about eligibility for public insurance programs and how to apply. Second, EAP devised strategies to reduce the organizational and attitudinal barriers that previously had impeded enrollment. These methods focused on improving relationships between community residents and local FIA offices.

First, EAP developed better strategies to educate the public about eligibility for public insurance programs and how to apply

Public Education Strategies

First, to enhance community understanding of available programs, several new outreach and community education strategies were implemented. The centerpiece of the community education effort was the **Learning Map**®, a technology developed by Root Learning, Inc. The map is used to teach families about the multiple programs available at FIA and other community agencies and their eligibility criteria. This system, designed for education of small groups, promotes self-learning through the use of interactive dialogue and eye-catching visuals understandable to individuals with low reading levels. Dialogue cards promote interaction and retention of learning and make complex concepts more accessible to average people. This learning tool was first implemented in the community during the summer of 2003.

Companion strategies for public education and enrollment include distribution of a **user-friendly information booklet** for community residents and establishing a **network of health advocates** to help identify uninsured children.

Organizational Change Strategies

To reduce organizational and attitudinal barriers to enrollment, the partnership implemented organizational change in FIA offices to enable staff to provide excellent service and to function more effectively in their interactions with agency customers. The principal strategy for creating change is a four-part customer service training program:

1) **What is Excellence?** FIA staff identify the barriers to excellent customer service and learn ways to influence or change them.

2) **Maximize the Moment.** Because agency staff carry large workloads, efficiency is essential to providing excellent service. Better time management and organization of workspace help staff increase productivity.

3) **Dealing with Stress.** Because heavy work loads also lead to feelings of being overwhelmed and constantly stressed, training focuses on overcoming stress through the use of problem-solving, social support, and personal stress relief techniques.

4) **Relationship Management.** Building positive relationships with peers, supervisors and agency customers can lead to reduced conflict and stress, improved work efficiency and increased customer satisfaction. Training addresses how to work with different types of customers and techniques for adapting to the personalities and work styles of peers and supervisors.

Training was completed with staff of two FIA offices (Forest/Ellery and Medbury/Concord) in July, 2003.

To reduce organizational and attitudinal barriers to enrollment, the partnership implemented organizational change in FIA offices to enable staff to provide excellent service and to function more effectively in their interactions with agency customers

Evaluating the Impact

To evaluate the effect of project activities, the team will be looking at three key outcomes:

1) Increased enrollment rates over time in focal ZIP codes as compared to ZIP codes with similar characteristics but without program interventions.

2) Improved perceptions and attitudes of FIA customers and staff of offices that received the staff training compared with offices that did not receive training. Attitudes will be assessed before program initiation and six months after full implementation.

3) Increased knowledge and improved behavior of participants using the Root Learning Map®.

So far, 609 FIA customers and 115 FIA staff have completed pretest surveys and all staff in the test sites received training. Final data collection on program activities will be completed in the spring of 2004. To promote organizational change in Michigan FIA, meetings to disseminate results have been held with District managers, as well as County and State Directors. In addition, reports of the evaluation will be disseminated through policy reports, academic journals, and reports to funding sources, such as the Robert Wood Johnson Foundation, the Blue Cross/Blue Shield of Michigan Foundation, and the Detroit Empowerment Zone.

Policy Implications

Based on preliminary data from the focus groups, EAP has developed several recommendations for policy, which are included in the policy alternatives section of this report. As additional data is analyzed from the program evaluation, other policy issues may arise.

Where can I get more information?

Evaluation data: Richard Lichtenstein, Ph.D., MPH, School of Public Health, The University of Michigan, 109 S. Observatory, Room 3124, Ann Arbor, MI. Phone: 734-936-1316; E-mail: lichto@umich.edu.

***Eastside Access Partnership* and its managing organization, Neighborhood Service Organization:** See program **Snapshot** at end of this report.

Vondie Moore Woodbury, M.P.A., has been Director of the Muskegon Community Health Project since October 1995. Under her direction, the Health Project has initiated *Access Health* and undertaken local management of health care for over 2,000 indigent community members (Muskegon Care). MCHP has implemented a variety of community-based health improvement programs, including a dental initiative for low-income children, a diabetes screening effort, a mentoring program for African American youth, and a new CDC-supported initiative to reduce the inappropriate use of antibiotics in treating viral infections. Woodbury is active in several organizations that support communities addressing access to care issues and is a co-author of "Out of the Box and Over the Barriers" a book describing Muskegon's community driven process to develop its own health plan.

Health Care Access and Community Partnership: Muskegon's *Access Health* Program

Vondie Moore Woodbury

The Problem

Access Health .... *grew out of a community-based initiative to address the problem of uninsured people in Muskegon County.* **Access Health *designed its program by examining the types of program models that have worked successfully for other communities*[59]**

Approximately 8% of Muskegon County's 172,000 residents lack health insurance. A community survey revealed that 17,000 children and adults in families working for relatively low wages ($11.50/hour on average) in 500 small businesses in Muskegon County did not have access to health insurance. Their incomes were too high to be eligible for public insurance, yet their employers did not offer coverage because it was considered too costly. However, community polls showed that 97% of Muskegon residents believed that all children should have access to health care, regardless of a family's circumstances.

What is *Access Health*?

Access Health is a nonprofit corporation, designated by the Internal Revenue Service as a 501(c)3 organization. It grew out of a community-based initiative to address the problem of uninsured people in Muskegon County. *Access Health* designed its program by examining the types of program models that have worked successfully for other communities.[59]

Access Health provides health **coverage**, not health **insurance**.[60] It does not deliver services directly; rather it contracts with and pays the providers in the community. The organization contracts directly with local providers, including both local health systems and most local physicians; therefore, *Access Health* does not contract with a health maintenance organization (HMO) as a 3rd party intermediary.

Access Health covers most physical and some mental health outpatient and inpatient services delivered in Muskegon County. Health services delivered outside of the county are excluded, as are certain specialized catastrophic care conditions typically covered by Medicaid.

Access Health has a community-based board composed of payers, providers and consumers of services. *Access Health* contains administrative costs by using an internet-based software package called i-Net, which manages claims payment locally.

Community Preparation for *Access Health*

In 1993, with a grant from the W. K. Kellogg Foundation, the community formed the **Muskegon Community Health Project (MCHP)**, one of three county projects chosen to test the Foundation's Comprehensive Community Health Models of Michigan Initiative. Operating on the assumption that solutions to complex problems are best when they come from collaboration within the community, MCHP convened meetings to discuss Muskegon County health care access issues. Community members then developed several health initiatives, including *Access Health.*

The typical small business without employee health coverage was a restaurant, childcare center, home health agency, or retail establishment

Access Health targets the 17,000 people in working families who do not have access to health insurance through their employers. This population was identified through a community assessment of insured, uninsured and under-insured populations. The community assessment identified subgroups of uninsured individuals: (1) working families without insurance and (2) indigent uninsured adults without children. Muskegon Care, another project of MCHP available through the State Medical Plan, covers indigent adults without children.

In 1999, EPIC-MRA, a Michigan-based research firm, conducted a survey of 200 businesses that did not provide health insurance for their employees. The typical small business without employee health coverage was a restaurant, childcare center, home health agency, or retail establishment.

Access Health Target Populations

Access Health has targeted 500 businesses in the Muskegon area that have uninsured W-2 full-time employees with a median wage of up to $11.50/hour. *Access Health* contracts for health coverage for employees and their eligible dependents. Under certain circumstances, young adults ages 19-23 years who live in the family home are eligible for coverage. Many young high school graduates in Muskegon live at home and either do not attend college or attend the local business college and thus may be uninsured and eligible.

To avoid competing with the commercial insurance market, *Access Health* enrollment is limited to businesses that have not offered another insurance product for the past 12 months. *Access Health* checks with the small group

Businesses surveyed reported that:

- **75% had fewer than four full-time employees.**
- **45% paid $6 to $12 per hour to full-time employees.**
- **67% thought that offering coverage would reduce employee turnover.**
- **69% indicated that "cost of premiums" was the reason for not offering coverage.**
- **72% cited fear of future premium increases as another barrier to offering coverage.**
- **81% said they would offer coverage if it were affordable.**
- **95% indicated that they would be able to pay $35 to $50 per month per employee in premiums.**

Employees surveyed revealed that:

- **64% of employees considered health insurance coverage to be "extremely important."**
- **30% of employees said they had forgone treatment for illness because of lack of coverage.**
- **The typical uninsured person was a woman under age 40 with children, often working multiple part-time jobs.**
- **48% of those surveyed had not been offered coverage by their employers.**
- **16% of employees surveyed had been offered coverage but had refused it. [Cost can be an issue for some people and young men tend to turn down coverage.]**
- **About two-thirds of employees surveyed said they would be able to pay $35 to $50 per month in premiums.**

coverage program administered by the Chamber of Commerce and with local insurance brokers; if a business is found to have been involved with any commercial product within 12 months, it is not eligible for *Access Health*.

Business Enrollment

When enrollment began in 1999, *Access Health* developed a multi-pronged marketing strategy designed to reach the target population of 500 local businesses. First, *Access Health* launched a direct marketing initiative and a media campaign, including cable TV coverage. In addition, *Access Health* encouraged private insurance brokers to enroll businesses not currently able to purchase small market private insurance packages. Private brokers agreed to market *Access Health* without commission because they believed that many of the businesses would "trade up" to commercial insurance packages later.

Consumer Enrollment

Access Health's parent organization, Muskegon Community Health Project (MCHP), has an extensive outreach and enrollment effort for the programs they manage (see "Snapshot" below for details on other programs). As part of this effort, *Access Health* and Muskegon Community Health Project assess families for their eligibility for other programs. Dependent children of *Access Health* participants are automatically screened for MIChild and Medicaid eligibility and families of eligible children are encouraged to enroll. Many of these working families do have children eligible for MIChild; in fact, MCHP is ranked 5th in the state for number of online enrollments in MIChild.[61]

Financing *Access Health*

Access Health ***is a three-share program, which means that the business, the employee, and the community all share expenses***

Access Health is a three-share program, which means that the business, the employee, and the community all share expenses. Costs are shared in the following proportions:

- Employer pays 30%
- Employee pays 30%
- Community pays 40%

In addition, the provider community contributes 10% of reimbursements to *Access Health* for administrative overhead. Actual costs of coverage are listed in Table 1.

Table 1: Access Health Cost of Coverage

	Employer	Employee	Community	Total
Adult	$46.00/mo	$46.00/mo	$56.00/mo	$148.00/mo
	$552.00/yr	$552.00/yr	$672.00/yr	$1776.00/yr
Child	$29.00/mo	$29.00/mo	$37.50/mo	$95.50/mo
	$348.00/yr	$348.00/yr	$450.00/yr	$1146.00/yr

Consumers must make co-payments for services. The actual amounts vary by service but generally range from $5 to $50.

Reimbursements to providers are set at the Medicare rate + 20%, which is higher than Medicaid rates.

The community share of the costs is financed with local money and matched with state dollars from the ***Disproportionate Share Hospital (DSH)*** funds. The state has allowed Muskegon to use these funds to finance *Access Health*; in return, MCHP has agreed to serve the medically indigent population of the state (State Medical Plan consumers). This subpopulation of uninsured is served through "Muskegon Care," another program of MCHP.

What has *Access Health* accomplished?

Data collection and analysis still are in the early stages, as *Access Health* has been in effect for less than five years. To date, data have been collected on utilization and cost. In addition, *Access Health* plans to periodically assess patient and provider satisfaction and quality of services.

Enrollment and utilization

So far, *Access Health* has made significant progress in reaching its target populations:

- **Business**: Today, 420 small businesses participate in *Access Health*, with an average of 2.6 employees per business.[62]

- **Consumers**: *Access Health* served 1,500 people in 2003. Data indicate that young men are less likely to enroll and prefer to count on good health.[63]

- **Providers**: 97% of all local physicians participate, as well as both local health systems.

- **Health insurance for children**: *Access Health* has identified and enrolled hundreds of children in working families who are eligible for MIChild. MCHP is responsible for 60% of the MIChild enrollments in Muskegon County.

Stakeholder Satisfaction

A recent survey of 75 participating businesses conducted by the University of Illinois indicated early positive responses to participation in *Access Health*:

- 57% of respondents had not offered health insurance previously, which suggests that *Access Health* is not competing with the private insurance market.

- 49% of participating businesses now are likely to purchase commercial coverage and would prefer to buy through the agent who sold them *Access Health* .

- 49% of respondents indicated that *Access Health* helped employee morale and productivity.

- 33% indicated *Access Health* improved business profitability.

- 36% indicated *Access Health* helped them recruit and retain workers.

Policy Wins for the Community

So far, *Access Health* has been quite successful in serving its target populations and enjoys wide community support. A number of factors have contributed to the community buy-in that is so important to long-term sustainability of *Access Health*:

- Community stakeholders participated in designing the project; in addition, consumers, providers and payors all are involved in governance.
- *Access Health* is not an entitlement program but a shared public/private responsibility.
- *Access Health* moves people into the private provider market, saving safety net resources (e.g., free clinics, federally qualified health centers) for those with no other resource.
- *Access Health* gives a competitive advantage to businesses that can offer it as an employee benefit.
- *Access Health* can be used as an economic development tool to attract new businesses to the area.While these factors have a logical relationship with program effectiveness and long-term sustainability, systematic program evaluation over time is needed to establish program effectiveness. In the end, the community's hope is that health coverage will lead to more people using medical care appropriately, which will result in better health.

In the end, the community's hope is that health coverage will lead to more people using medical care appropriately, which will result in better health

Forthcoming Study of *Access Health*

Some questions about program effectiveness may be answered in the near future. In 2003 the Employee Benefits Research Institute received a grant from the W.K. Kellogg Foundation to conduct a study of *Access Health*, including how and why it was established; positives and negatives of the approach; impact on business; access to health care; and other factors. In addition to describing the project, the study will explore the business decisions that led to the plan and its preliminary impact on factors such as employee recruitment and retention, and will analyze significant community and financial factors affecting implementation.

Core components of the study include:

- Descriptive update on the program
- Exploration of the employer decision-making process
- Key stakeholder perspectives
- Funding and benefits issues
- Evidence related to risk selection
- Review of health and quality initiatives undertaken and their expected impact on health care spending

The report of initial findings is expected during the summer of 2004.[64]

Additional Information

For more information on *Access Health*, contact Vondie Moore Woodbury, Director, Muskegon Community Health Project, 565 W. Western Ave., Muskegon, MI 49440. Voice: 231-728-3201; E-mail: VWoodbury@mchp.org Website: www.mchp.org

Policy Alternatives

Introduction

In the previous two sections, we presented information on the parameters of the problem of uninsured children and what states and localities are doing to address this problem. In this section we discuss some of the policy implications of the information presented.

Policy considerations

When selecting which policy alternatives to adopt, it is important to consider whether a particular program or policy fits the unique characteristics of a specific state or locality. Programs or policies must be considered along several dimensions:

- **Promise**:
  - What benefits can we expect to gain from implementing this program?
  - Does its approach fit with our community values?
- **Efficacy**:
  - Is there research evidence that this program works and is appropriate for the population group to be targeted in a given community?
- **Feasibility**:
  - Does our state or community have the human, economic, and social resources to carry out this program?
- **Cost/Benefit**:
  - Can we afford to implement this program or policy?
  - Will the benefits the community gains offset the costs?
- **Sustainability**:
  - Does the community have the resources and will to sustain this policy or program over time?

The final article presents policy alternatives from the experts and information about localities where these policies have been implemented. For additional information on policy alternatives, we refer you to the Access to Health Care Coalition, whose series of reports entitled "Closing the Gaps: Access to Health Care in Michigan" present valuable infomation about insurance trends in Michigan, with a particular focus on Detroit and Southeast Michigan. Information about the coalition and how to contact them is included in the **Additional Resources** section at the end of this report. Information about cost estimates for covering the uninsured can be found on the web in the recent report: Hadley, J. & Holohan, J. (2003). Covering the uninsured: How much would it cost? *Health Affairs Web Exclusive.* June 4. Available online at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.250v1/pdf.

It is important to remember that many of the alternatives presented here still require validation by evaluation of their efficacy. For this reason, our primary policy recommendation is this: ***All funded program initiatives should be required to have a credible evaluation component with sufficient resources to carry it out.***

Policy Alternatives & Recommendations

The policy alternatives and recommendations presented here are summarized from material presented in previous articles. Many of these strategies have been implemented in other states or localities; where this is true, it is so noted. Some states and localities are experimenting with major changes in the health care system, taking one of two alternative approaches: (1) subsidizing private health insurance coverage or (2) expanding public coverage. A full discussion of premium assistance programs for private coverage and universal health coverage models can be found in *The Future of Children: Health Insurance for Children.*[65]

Policy Recommendation #1: Restore Funding for Outreach and Enrollment

A. Restore Funding for SCHIP Outreach

To address state fiscal crises resulting from the recent economic slowdown, a number of states, including Michigan, have significantly cut back on expenditures for outreach activities. For example, Michigan has discontinued payments to community organizations for enrolling children for SCHIP. As a result, recent data show that many children eligible for both SCHIP and Medicaid still are not enrolled and that retention of children in SCHIP continues to be a problem. ***If Michigan is to make significant progress in increasing the rate of insurance coverage among poor and near-poor children, adequately funded outreach activities must be restored.***

B. Adequately Fund Outreach and Enrollment Activities for Small Business Programs

Programs that recruit enrollees among low-wage employees, such as Access Health, are reaching a portion of the target population that is not accessible to many social service agencies. In addition, such programs can screen children for eligibility for MIChild and Healthy Kids. ***Therefore, outreach and enrollment activities for small business programs such as*** **Access Health** ***must be continued and adequately funded.***

Policy Recommendation #2: Streamline Enrollment and Renewal Procedures

A. Simplify Enrollment and Renewal Procedures

The complexity of enrollment/eligibility determination is sufficient to prevent some families from ever enrolling in public programs. The Urban Institute's evaluation of the SCHIP program indicates that reasons for non-enrollment include confusion about eligibility and administrative barriers such as complex enrollment forms, processes, and documentation requirements. As a result, retention rates in many states are 50% or less.

Michigan should be commended for simplifying the enrollment processes for MIChild by expanding online enrollment and sending out preprinted re-determination forms to encourage parents to keep their children enrolled. ***These processes should be maintained and expanded to Medicaid to reach more of the uninsured.***

B. Use One Form to Apply for Multiple Programs

In addition to health programs, low-income children often participate in other programs for low-income families, such as food stamps or the National School Lunch Program. One strategy used by states to increase enrollment in public insurance programs is to connect Medicaid and SCHIP with other programs for low-income children and families. These strategies, sometimes referred to as ***express lane eligibility***, allow health insurance programs to use information

families already have provided to another program to be used, with permission, to evaluate the child's eligibility for Medicaid/SCHIP. Here are some examples of experiments with express lane eligibility:

- **Vermont** has coordinated SCHIP enrollment with the Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program.
- **Los Angeles County** has initiated a similar program through the Food Stamp Program.
- **California** has gone a step further by instituting automatic enrollment, using a child's enrollment in an income-comparable program to qualify for Medicaid or SCHIP.

Although these strategies are promising, they face a number of challenges, such as differing eligibility rules and immigration requirements, and the technological and personnel resources needed to run the program effectively. In addition, these initiatives need to be evaluated to determine whether they are achieving their intended goals. A full discussion of state programs and the advantages and challenges of these strategies can be found in "The Future of Children: Health Insurance for Children."[66]

C. Presume Eligibility for Medicaid and MIChild Among Certain Groups

Presumptive eligibility allows states to extend coverage to children in families with gross incomes at or below the eligibility level for Medicaid or SCHIP while waiting for a full eligibility determination to be completed. Under this option, states may receive federal Medicaid or SCHIP match for funds expended for services during the presumptive eligibility period. The state may train and qualify certain entities – such as FIA, Head Start or Medicaid providers – to determine presumptive eligibility so that they can tie outreach activities to actually enrolling children, at least on a temporary basis. This process has the advantage of allowing children to receive immediate care for existing conditions and perhaps reduce the need for more expensive care later.

Massachusetts, Mississippi, New Jersey, and New York are experimenting with presumptive eligibility for both Medicaid and SCHIP. For a more complete discussion of this option refer to "The Future of Children: Health Insurance for Children."[67]

Currently, Michigan has presumptive eligibility for MIChild but not for Medicaid. Most students who are eligible for free/reduced lunch or who live in geographic areas characterized by high poverty rates are eligible for Medicaid or MIChild. ***Expanding presumptive eligibility to Medicaid, targeting enrollment to certain groups, and focusing on community-based outreach/ enrollment in high poverty census tracts could be cost-efficient ways to enroll children eligible for public insurance***.

Policy Recommendation #3: Improve Customer Services

A. Provide Community-Based Support in Navigating Public Systems

Good models exist for improving customer service through streamlining enrollment and renewal procedures and assisting families to navigate the social services system. For example, Covering Michigan's Kids, an initiative funded by the Robert Wood Johnson Foundation, has demonstrated that community-based enrollment can be successful in increasing health coverage for low-income children (see **snapshot** of Covering Michigan's Kids after this article). Similarly, Neighborhood Services Organization and their partners educate families about the various health insurance options available to them and the benefits of having health insurance. The centerpiece of their community education effort is the **Learning Map**®, which is used to teach families about the multiple programs available at FIA and other community agencies and their eligibility criteria (see Lichtenstein & Johnson).

In the past, Michigan provided an application-assistance fee to community-based groups to supplement the resources they devote to education/ enrollment. However, this fee was discontinued in the 2004 budget.

Michigan needs to replicate and adequately fund successful models for improving customer service through community-based support systems.

B. Enhance Customer Service at FIA Offices

Family Independence Agency (FIA) staff determine eligibility for Medicaid as well as for other assistance programs such as Temporary Assistance to Needy Families (TANF). However, community residents and parents who participated in focus groups in Detroit indicated that having to deal with FIA was a deterrent to enrollment in health insurance programs. Focus groups of both customers and FIA staff also indicated that agency caseworkers do not always provide high quality or friendly services to agency clients. By improving customer service, more families would be referred to all services for which they are eligible and the agency's image in the community could improve. Therefore, Michigan needs to:

- **Create "health insurance only" forms and expedited procedures to enroll more eligible children in health insurance programs.**
- **Institute maximum caseload standards for Family Independence Specialists and provide quality improvement training to FIA supervisory staff.**

Policy Recommendation #4: Increase Public Awareness

A. Increase Awareness and Understanding of Available Programs

A recent State of the State Survey in Michigan found that 48% of Michigan residents still do not know of MIChild, in spite of outreach efforts and media campaigns. In addition, low-income families remain confused about program eligibility rules and enrollment procedures.[68] ***Michigan needs to fund a pilot program to test the effectiveness of different approaches for educating low-income families about programs, eligibility requirements, and enrollment procedures.***

B. Increase Awareness of the Benefits of Preventive Care for Healthy Children

Research indicates that some families who are aware of public health insurance programs choose not to sign up because they believe the coverage is not needed. This attitude is particularly prevalent among parents of healthy children. Parents who understand the benefits of preventive care for long-term good health are more likely to enroll their children in health insurance programs and to remain enrolled.

The *Eastside Access Partnership* (Lichtenstein & Johnson) has developed attractive and interesting materials for family learning in an interactive format. Copies of the materials can be obtained by contacting Penni Johnson, the Eastside Access Partnership (EAP) director (see **snapshot** of EAP for contact information). ***Michigan needs to fund a pilot program to test the effectiveness of different approaches for educating families about the benefits of preventive care for all children.***

C. Administer* MIChild *as a Program Separate from "Welfare" Programs to Retain a Separate Identity for Health Coverage for Working Families

Working, low-income families who are eligible for children's health coverage sometimes do not enroll in programs for the poor, such as Medicaid, because, as taxpayers, they are reluctant to accept "welfare" (See previous articles, Eastside Access Partnership & Access Health). By retaining *MIChild* as a separate program, families receive a standard health care card (a "Blue Cross" card for the majority of children), which outreach workers report is more palatable to families. ***Michigan should administer* MIChild *as a program separate from programs perceived as "welfare."***

Policy Recommendation #5: Support Local Management of Programs

A. Foster and Support Local Decision Making About Health Care Issues

Locally managed programs are more likely to garner the necessary community support for sustainability than are top-down strategies.[69] Each community has its own unique character, provider networks and problems, so some flexibility in state policy will enable communities to adapt programs to address their own health care issues. Although health care policies often are made on the state or national level, people actually receive their health care locally and this shapes their experience.[70] ***Like politics, all health care is local. Michigan's health care policies should foster and support local decision making.***

B. Support Local Financing and Management of Services

Local funding is a benefit to the state, as each state dollar is matched by two local dollars. Locally-focused management can enter into contracts with providers and monitor services in ways that large management organizations cannot. For example, Access Health has saved administrative costs by managing its own contracts with providers. ***Michigan should reward local management of health care services for low-income families.***

Policy Recommendation #6: Fund Research and Evaluation Efforts

A. Collect Systematic Data on Health Indicators

Organizations that contract to provide services should be required to collect and report data on service utilization that will enable state planners to gauge the reach and success of programs. Sometimes, however, the data collected are neither systematic nor comprehensive. ***Michigan should require contractors to regularly collect and report comprehensive data that can be used in planning for future needs and more efficient use of state and local health care dollars.***

B. Investigate Issues of Access, Quality, and Health Outcomes to Ensure that Programs Achieve their Intended Goal: **Healthier Children**

Health insurance is an important component of improving health care. Research indicates that children with health insurance are more likely to have a regular source of health care, to get more preventive care, and are less likely to use emergency rooms.[71]

However, as noted in Chapter 2, health insurance is only one aspect of insuring better health for children. Access and quality in health care for children are perceived as continuing problems in some areas of the state. Research is needed to establish the role of health insurance in improving health outcomes for children. ***As Michigan funds health insurance programs, a portion of each allocation should be designated for program evaluation.***

Snapshots of Innovative Local Programs

This section provides brief descriptions of innovative local programs to increase health coverage for children, including the two programs presented in this brief. While these programs appear promising, none have been fully evaluated as to their effectiveness at this point in time. Where evaluations are in process, we have indicated the contact information for the evaluator.

EASTSIDE ACCESS PARTNERSHIP

Primary focus: Outreach and enrollment in public health insurance

Program Description

This university-community partnership focuses on increasing the number of eligible children who are enrolled in MIChild and Healthy Kids using a number of innovative strategies. It has developed strategies to reduce barriers to enrollment identified through community focus groups. They provide education to families on the benefits of health insurance coverage using an interactive learning tool called the Root Learning Map® and enrollment assistance through community based workers. Because poor relationships with local Family Independence Agency (FIA) offices are another perceived barrier to enrollment in Healthy Kids, the project also offers customer service training to local FIA staff.

Target population

- Primary targets are children and pregnant women who are eligible for MIChild or Healthy Kids Medicaid.
- A secondary target population are FIA Specialists and clerical staff.

What has been the impact?

Hundreds of children have been enrolled as a result of the project. The staff have also conducted a series of customer service excellence workshops for all FIA staff in two local offices. A formal evaluation of this program and its effectiveness is in process; preliminary results are expected in the Spring of 2004.

For more information:

Program Services
Penni Johnson, Program Coordinator
Neighborhood Service Organization
9641 Harper Avenue
Detroit, MI 48213
Phone: 313.923.5050
Fax: 313.571.9866
Email: penjohnus@sbcglobal.net

Evaluation
Richard L. Lichtenstein, MPH, Ph.D.
Associate Professor
School of Public Health
The University of Michigan
109 S. Observatory, Room M3124
Ann Arbor, MI 48109-2029
Tel: (734) 936-1316
Fax: (734) 764-4338
Email: lichto@umich.edu

COVERING MICHIGAN'S KIDS

Primary focus: Outreach and enrollment of children in public health insurance coverage.

Program Description

The *Covering Michigan's Kids* program began in 1999 as a three-year demonstration initiative sponsored by the Robert Wood Johnson Foundation. The program supports local efforts to identify and enroll hard-to-reach populations of children in public health insurance programs such as Medicaid and *MIChild*. Programs are active in Detroit-Wayne County, Muskegon County, and the Upper Peninsula. Each community identified specific target populations and developed strategies unique to that population. The following snapshot summarizes the three initiatives.

Muskegon County: Muskegon Community Health Project

Who are the target populations?

- Hispanic children
- Children of part-time workers

Impact

- Program enrolled 81% of its target population.

Detroit-Wayne County: Detroit/Wayne County Child Health Care Coalition

Who are the target populations?

- Eligible children of undocumented parents
- High-risk adolescents
- Arab-American children
- Latino families

Impact

- Detroit-Wayne County successfully enrolled 202% of its proposed target population

The Upper Peninsula (Marquette): Upper Peninsula Coalition

Who are the target populations?

- Native American children
- Homeless youth
- Children of the working poor

Impact

- The Upper Peninsula Coalition enrolled 117% of its proposed target population

Michigan Covering Kids & Families Initiative

Because *Covering Michigan's Kids* demonstrated effectiveness, the Robert Wood Johnson Foundation has awarded to the state lead agency, Michigan Public Health Institute (MPHI), a new four-year grant entitled *Covering Michigan's Kids and Families*. This grant will expand the program to find and enroll eligible families, simplify enrollment and renewal processes, coordinate health care coverage programs, and involve private and volunteer organizations. The second phase of the initiative will maintain current partnerships as well as expand to additional areas throughout the state.

For more information:

Ann McMillan, MSW
Michigan Public Health Institute
2438 Woodlake Circle, Suite 200
Okemos, MI 48864
(517) 324-8311
amcmill@mphi.org

Ingham Health Plan (IHP)

Primary focus: Health coverage for uninsured low-income children and adults.

Program Description

IHP provides health coverage to uninsured individuals in Ingham County with incomes less than 250% of FPL who cannot obtain coverage under Medicaid, Medicare, MIChild, employer-sponsored or other health insurance programs. The program pays for primary care, some specialist visits, outpatient X-rays and laboratory work and prescriptions. It does not pay for inpatient hospital services, substance abuse or mental health services. Families pay $5 to $10 per covered service.

What has been the impact?

- Approximately 100 children are enrolled in the Ingham Health Plan, most of whom are not eligible for Healthy Kids or MIChild due to citizenship status.
- About 15,000 persons are enrolled in the IHP at any given time, representing 55% of the approximately 27,000 uninsured persons in the county.
- In 2002, a total of 1,956 children were seen at the Healthy Smiles Dental Clinic for a total of 4,306 visits.

For more information:

Bruce Miller, Deputy Director for Health Services
Ingham County Health Department
P.O. Box 30161
5303 South Cedar Street Lansing, MI 48909 (517) 887-4311
Fax (517) 887-4310
bmiller@ingham.org

Access Health, Inc., Muskegon, Michigan

Primary focus: Affordable, workplace-based health coverage for uninsured families.

Program description

Access Health provides health coverage to uninsured working families in Muskegon County through a community-based program that utilizes a small business model. It covers a wide range of health services delivered in Muskegon County, including, physician services, inpatient, outpatient and emergency room services, behavioral health, prescription drugs, and lab and x-ray. Access Health also covers pre-existing conditions, such as diabetes.

Costs are shared by the employer, the employee and the community (state and local funds). Premiums for the family are $46/month for adults and $29/month for each child. Co-payments for services range from $10 for a physician office visit and $5 per prescription to a maximum of $300 for hospitalization.

Target population

- Small businesses in Muskegon County with W-2 full-time employees whose average hourly wage is $11.50 or less and who have not been offered health insurance in the past 12 months.
- Individuals and families who work for eligible businesses and do not have health insurance.

What has been the impact?

Access Health has been successful in recruiting small businesses, health providers, and uninsured families into the program:

- 420 of the 500 small businesses targeted for inclusion have participated since enrollment began in 1999.
- Both health systems and 97% of area physicians participate in *Access Health*.
- In 2003, Access Health served approximately 1,500 people.

The initiative has targeted four outcomes: (1) reductions in the number of uninsured persons in the community, (2) reductions in employee turnover and absenteeism, (3) reduced need to shift costs of care to charitable care, and (4) improved community health status. Approximately half the participating businesses recently surveyed said the program improved employee morale and productivity; half also indicated they now are likely to purchase commercial coverage. About one-third said the program improved their profitability and helped them recruit and retain workers.

The Employee Benefits Research Institute is conducting a study of the initiative, including the process by which it was developed and its impact on health care spending in the community. Findings from this study are scheduled to be published in the summer of 2004.

For more information:

Services
Vondie Moore Woodbury, Director
Muskegon Community Health Project
565 West Western Ave.
Muskegon, MI 49440
Phone: 231-728-3201
E-mail: info@mchp.org

Policy Study
Paul Fronstin, Ph.D., Director,
Health Research and Education Program
Employee Benefit Research Institute
2121 K Street, NW, Suite 600
Washington, DC 20037
Phone 202-775-6352
E-mail: fronstin@ebri.org

Glossary

Block Grant:	An intergovernmental transfer of Federal funds to states and local governments for broad purposes such as health, education or community development. A block grant holds few requirements for how the money is to be spent, instead offering state and local discretion within general guidelines established by Congress and the executive branch. Annual program plans or applications are normally required. Source: Delaware Healthcare Association - http://www.deha.org/Glossary/GlossaryB.htm
Disproportionate Share Hospital Funds (DSH):	Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining which hospitals qualify for DSH payments and how much they receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in statute. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#C
Entitlement Program:	A program that creates a legal obligation on the federal government to any person, business, or unit of government that meets the criteria set in law. Federal spending on an entitlement program is controlled through the program's eligibility criteria and benefit and payment rules, not by the appropriation of a specific level of funding in advance. Entitlement programs such as Medicare and Medicaid are also referred to (for federal budget purposes) as "direct" or "mandatory" spending. Medicaid is both an individual entitlement and an entitlement to the states that elect to participate. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#E
Express Lane Eligibility:	A variety of strategies and models with the goal of establishing connections with programs that have similar income eligibility rules to Medicaid and SCHIP such as Food Stamps, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and the National School Lunch Program (NSLP) to find and more quickly enroll uninsured children in health insurance programs. Source: The Children's Partnership - http://www.childrenspartnership.org/expresslane/overview.html
Federal Match Rate:	The Federal Match Rate is the share of the costs of Medicaid or SCHIP services or administration that the federal government bears. The Federal Medicaid Assistance Program (FMAP) - the statutory term for the federal match rate for Medicaid - varies from 50 to 83% depending upon a state's per capita income; on average, across all states, the federal government pays at least 57% of the costs of Medicaid. The federal match rate for SCHIP is higher - on average 70%, but the federal allotment for SCHIP services is capped at a specific amount each year. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#F and http://www.nmha.org/shcr/articles/glossary.cfm#W
Federal Poverty Level (FPL):	The Federal Poverty Level refers to the federal government's working definition of poverty that is used to determine eligibility for certain federal and state programs. The more precise term is the Federal Poverty Guidelines, which are measures of poverty that are simplified for administrative use. Adjusted annually for inflation and published by the Department of Health and Human Services, the FPL in calendar year 2003 was $18,400 for a family of 4 in the continental U.S., $23,000 in Alaska, and $21,160 in Hawaii. [See poverty guidelines at end of glossary].
Federally Qualified Health Centers (FQHCs):	FQHC services are primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the Public Health Service Act, as well as by "look alike" clinics that meet the requirements for federal funding but are not actually receiving federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#E

Healthy Kids:	Healthy Kids is the Medicaid program for low-income pregnant women, infants, and children up to age 19. SCHIP expanded Healthy Kids coverage to include children, age 16 through 19 years, whose family income is below 150% FPL. Source: Michigan Department of Community Health - http://www.michigan.gov/documents/HealthyKids_10324_7.pdf and Center for Advancing Community Health -http://www.cachlink.org/projects/coveringkids.html
Heath Maintenance Organization (HMO):	An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are three basic models of HMOs: group model, individual practice association (IPA) and staff model. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#E
Managed Care:	A term used to describe a set of tools to control health care costs primarily through resource allocation, volume discounts and service utilization limitations. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#E
Medicaid:	A nationwide health insurance program, adopted in 1965, for eligible disabled and low-income persons. It is administered by the Federal government and participating states. The program's costs, paid for by general tax revenue, are shared by the Federal and state governments. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#E
MIChild:	MIChild is a Michigan program to provide health insurance to previously uninsured children whose family income is above 150% and at or below 200% of FPL. Children under 19 years of age, who are not Medicaid eligible, and meet the financial guidelines, may be eligible for MIChild. It is funded with a combination of state and federal funds, with federal funds coming from the State Children's Health Insurance Program (SCHIP). Source: Michigan Department of Community Health - http://www.michigan.gov/documents/MIChildflyerEnglish_11845_7.pdf and Center for Advancing Community Health - http://www.cachlink.org/projects/coveringkids.html
Presumptive Eligibility:	States provide immediate coverage to children in families with gross incomes below Medicaid or SCHIP eligibility levels, instead of waiting for a full determination of eligibility. To keep coverage, families must be found eligible through the regular application process by the end of the month following the initial application, or the temporary coverage will expire. States receive federal matching funds for the costs of covering children who are presumed eligible, even if the child is later found to be ineligible. Source: The Future of Children - http://www.futureofchildren.org/information2827/information_show.htm?doc_id=17-5529
Safety Net Providers:	Defined as those organizations and programs, in both the public and private sectors, which have a legal obligation or a commitment to provide direct health care services to the uninsured, underinsured, and other underserved groups. Examples include public and private hospitals that provide a disproportionate share of services to underserved groups; community and migrant health centers, and; federally qualified health centers (FQHCs). Source: Opens Minds Industry Resources Library - http://www.openminds.com/indres/michiganspotlight.htm
State Children's Health Insurance Program (SCHIP):	Authorized in 1997 as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health insurance for uninsured low-income children whose family incomes are too high to qualify for Medicaid. In contrast to Medicaid, SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Source: National Mental Health Association - http://www.nmha.org/shcr/articles/glossary.cfm#C

2003 HHS Poverty Guidelines[72]

Size of Family Unit	1	2	3	4	5	6	7	8	For each aditional person, add
48 Contiguous States and D.C.	$8,680	12,120	15,260	18,400	21,540	24,680	27,820	30,960	3,140
Alaska	$11,210	15,140	19,070	23,000	26,930	30,860	34,790	38,720	3,930
Hawaii	$10,330	13,940	17,550	21,160	24,770	28,380	31,990	35,600	3,610

Additional Resources

Access to Health Care Coalition

The mission of the Access to Health Care Coalition (AHCC) – an organization of health care provider, purchaser, and consumer groups — is to identify where access to health care is lacking and develop strategies to improve coverage and services for the uninsured and underinsured. The AHCC has released a series of reports detailing the state of access to care in Michigan and making recommendations for improving access. The most recent report, "Closing the Gap: Improving Access to Health Care in Michigan," was released in March, 2003. This report can be accessed at http://www.bcbsm.com/blues/sm/pdf/access_rpt_full_0303.pdf.

For more information contact:

Tyffany Shadd-Coleman
Health Policy and Social Mission
Blue Cross Blue Shield of Michigan
600 Lafayette E (MC J756)
Detroit, MI 48226
phone: (313) 225-8971
fax: (313) 225-0283
tshadd@bcbsm.com

American Academy of Pediatrics

www.aap.org

The American Academy of Pediatrics (AAP) and its member pediatricians dedicate their efforts and resources to the health, safety and well being of infants, children, adolescents and young adults. The research arm of AAP compiles research on a number of issues related to the health of children and youth. Research reports on SCHIP and Medicaid, as well as other health topics, are posted on their Website at www.aap.org/research.

For more information contact:

National Headquarters
The American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
phone: (847) 434-4000
fax: (847) 434-8000

The Children's Defense Fund

www.childrensdefense.org

The Children's Defense Fund (CDF) advocates for America's children, particularly poor and minority children, and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investment before they get sick, get into trouble, drop out of school, or suffer family breakdown. To access research reports regarding specific health topics or to join the CDF Child Health Listserv, go to www.childrensdefense.org.

For more information contact:

25 E Street NW
Washington, DC 20001
phone: (202) 628-8787
cdfinfo@childrensdefense.org

The Commonwealth Fund

www.cmwf.org

The Commonwealth Fund is dedicated to helping people become more informed about their health care and improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. A variety of research publications on health care quality and improvement are available at www.cmwf.org.

For more information contact:

One East 75th Street
New York, NY 10021
phone: (212) 606-3800
fax: (212) 606-3600

The Future of Children

www.futureofchildren.org

The Future of Children promotes effective policies and programs for children by providing policymakers, service providers, and the media with timely, objective information based upon the best available research. The Future of Children Website has a variety of publications regarding child health care. To access these resources, go to www.futureofchildren.org.

For more information contact:

The David and Lucile Packard Foundation
300 Second Street, Suite 200
Los Altos, CA 94022
phone: (650) 917-7110
fax: (650) 947-8616

Institute for Public Policy and Social Research (IPPSR)

www.ippsr.msu.edu

Michigan State University

The Institute for Public Policy and Social Research (IPPSR), a collaborator of the Michigan Family Impact Seminars, promotes and conducts research on issues of public policy while trying to build problem-solving relationships between the academic and policymaker communities. Information about current research projects, particularly IPPSR's annual State of the State Survey, which has an important child health care dimension, is located at www.ippsr.msu.edu.

For more information contact:

Douglas Roberts, Interim Director
Michigan State University
321 Berkey Hall
East Lansing, MI 48824-1111
phone: (517) 355-6672
fax: (517) 432-1544

The Institute for Children, Youth, and Families

www.icyf.msu.edu

Michigan State University

The institute engages in multidisciplinary research, outreach collaborations and policy development responsive to contemporary social issues affecting children, youth, and families. For the past four years the institute has co-sponsored the Michigan Family Impact Seminars, which present scholarly work on issues related to families in formats that are meaningful for state policy makers. The briefing reports from previous seminars can be found on the website.

For more information contact:

Esther Onaga, Acting Director
Michigan State University
Suite 27 Kellogg Center
East Lansing, MI 48824
Phone: (517) 353-6617
Fax: (517) 432-2022

Kaiser Family Foundation

www.kff.org

The Henry J. Kaiser Family Foundation is a non-profit, private operating foundation that is a source of facts and analysis regarding major health care issues facing the nation. The foundation has a series of reports and publications specific to child and adult health issues, and has a database of individual state health facts. This research and data is accessible at www.kff.org.

For more information contact:

Headquarters:
2400 Sand Hill Road
Menlo Park, CA 94025
phone: (650) 854-9400
fax: (650) 854-4800

Michigan Department of Community Health

www.michigan.gov/mdch

The Michigan Department of Community Health (MDCH) is responsible for health policy and management of the state's publicly funded health service systems. The Department also collects information on a range of health related issues and these reports and statistics can be obtained from their Website at www.michigan.gov/mdch.

For more information contact:

Lonnie D. Barnett
Health Policy, Regulation and Professions Administration
320 S. Walnut Street
Lansing, MI 48913
phone: (517) 241-2963
fax: (517) 241-1200

National Governors Association

www.nga.org

The National Governors Association (NGA) is the collective voice of the nation's governors. Among other services, NGA develops policy reports on innovative state programs and hosts networking seminars for state government executive branch officials. The NGA Center for Best Practices helps governors and their key policy staff develop and implement innovative solutions to governance and policy challenges in their states. Some timely NGA reports and issue briefs regarding health care can be accessed at www.nga.org/nga/1,1169,C_REPORTS,00.html.

For more information contact:

Headquarters:
Hall of States, 444 N. Capitol St.
Washington, D.C. 20001-1512
phone: (202) 624-5300

National Institute for Health Care Management

www.nihcm.org

The National Institute for Health Care Management (NIHCM) conducts research, policy analysis and educational activities on a range of health care issues and promotes dialogue between the private health care industry and the government. Publications on maternal child health, the uninsured, and rural health, to name a few, can be found at the NIHCM Website at http://www.nihcm.org/pubsmain.html.

For more information contact:

1225 19th Street, NW
Suite 710
Washington, DC 20036
phone: (202) 296-4426
fax: (202) 296-4319
nihcm@nihcm.org

The Skillman Foundation

www.skillman.org

The Skillman Foundation is a private grant making foundation that applies its resources to foster positive relationships between children and adults, support high quality learning opportunities and to strengthen healthy, safe and supportive homes and communities. The Skillman Foundation's Concerning Kids studies with topics ranging from health care to violence can be accessed from their Website, www.skillman.org/resources.htm.

For more information contact:

600 Renaissance Center
Suite 1700
Detroit, MI 48243
phone: (313) 393-1185

Urban Institute

www.urban.org

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that provides information and analysis to public and private decision makers in order to help them address social, economic, and governance problems facing the nation. Publications on a variety of pertinent issues such as health insurance coverage for children and Medicaid/SCHIP enrollment can be accessed online at www.urban.org.

For more information contact:

Ian Hill
2100 M Street, N.W.
Washington, DC 20037
phone: (202) 833-7200

Acknowledgments

This brief was produced by the Institute for Children, Youth, and Families, Michigan State University; Esther Onaga, Ph.D. & Laura Bates, M.A., Editors.

For their generosity in supporting the Family Impact Seminars, we thank:

The Skillman Foundation

Michigan State University
Families and Communities Together (FACT) Coalition
The Institute for Children, Youth, and Families
The Institute for Public Policy and Social Research

Wayne State University
School of Social Work

We also are grateful to the following people for their assistance with this report:

Research assistants: Michael Mahaffey, Emily Tamlyn, Claudia Wallen, & Bethany Zimmerman.

Michigan Legislative Advisory Committee for assistance in topic selection.

The Honorable Stephen Ehardt, Chair, Health Policy Committee, Michigan House of Representatives, for his contributions to health policy education in Michigan.

Content advisory committee: Denise Holmes, College of Human Medicine, Michigan State University; Pamela Paul-Shaheen, Health and Human Services Policy Advisor, Office of the Governor; Patricia Sorenson, Michigan's Children; Jane Zehnder-Merrell, Michigan League for Human Services; Carol Weissert, Florida State University.

Karen Bogenschneider, Bettina Friese, Beth Gross, and Meg Wall-Wild of the Policy Institute for Family Impact Seminars, University of Wisconsin-Madison/Extension, for sharing their wealth of experience with us.

Douglas Roberts and **AnnMarie Schneider** of the Institute for Public Policy and Social Research, for their assistance with program development and organization.

Robert Stampfly, College of Human Medicine, Michigan State University, for sharing his technical expertise concerning health policy in Michigan.

Lonnie Barnett, Logan Dreasky, Nancy Grundel, and Daniel Ridge of the Michigan Department of Community Health for providing us with health and budget data.

Ann McMillan of Covering Michigan's Kids and **Bruce Bragg** of Ingham County FIA for assistance in developing the Snapshots of community programs.

Mae Platte of the Institute for Children, Youth, and Families for administrative support to the Family Impact Seminars.

Robin Christensen of the Institute for Children, Youth, and Families, for editorial assistance preparing the briefing report.

Vivek Joshi of University Outreach, MSU, for assistance with GIS mapping.

Betty Tableman and **Rosalind Kirk** of MSU and **Nancy Walker** of the Center for Youth Policy Research for their helpful editorial comments.

Marianne Udow and **Vernice Davis Anthony** of the Access to Health Care Coalition for sharing their expertise on health care issues.

About Family Impact Seminars

- Family Impact Seminars are nonpartisan educational forums on family issues for state policymakers.
- The seminars analyze the consequences to families of an issue, policy or program.
- The seminars provide objective non-partisan information on current issues. They do not advocate or lobby for particular policies.
- Briefing reports make scholarly findings available in an accessible format.
- A Legislative Advisory Committee selects issues for seminars based on emerging legislative need.
- National scholarly experts bring state of-the-art research on current family issues to policymakers.
- Webcasts make information available to those not able to attend the seminar.

For more information on Family Impact Seminars in Michigan, please contact:

Esther Onaga
Acting Director
Institute for Children, Youth, and Families
Michigan State University
Suite 27 Kellogg Center
East Lansing, Michigan 48824-1022
(517) 353-6617
onaga@msu.edu

Kristine Miranne
Director
Skillman Center for Children
Wayne State University
Detroit, MI 48202
(313) 872-7166
ag7821@wayne.edu

Michigan Family Impact Seminar Briefing Reports

No. 2000-1 *Child Care and Education*
No. 2000-2 *Children and Divorce*
No. 2001-1 *Promising Approaches for Reducing Youth Violence*
No. 2001-2 *Moving Families out of Poverty*
No. 2002-1 *What About Me? Children with Incarcerated Parents*
No. 2002-2 *Prostituted Teens: More than a Runaway Problem*

References

1. Children's Defense Fund. (1994). *Wasting America's Future.* Boston: Beacon (p. 45)
2. For example, Dubay, L. & Kenney, G. (2001). Health care access and use among low-income children: Who fares best? *Health Affairs, 20*(1), 112-121; Newacheck, P., Stoddard, J., Hughes, D., & Pearl, M, (1998). Health insurance and access to primary care for children. *New England Journal of Medicine, 338*(8), 513-519.
3. Newacheck, P., Hughes, D., Hung, Y., Wong, S., & Stoddard, J. (2000). The unmet health needs of America's children. *Pediatrics, 105*(4), 989-997; Newacheck, P., Stoddard, J., Hughes, D., & Pearl, M. (1998).
4. Halfon, N., Inkelas, M., & Wood, D. (1995). Nonfinancial barriers to care for children and youth. *Annual Review of Public Health, 16*, 447-72.
5. Michigan Department of Community Health. (2003). *Characteristics of the uninsured and select health insurance coverage in Michigan*. Lansing, MI: Michigan Department of Community Health. pp. 4 & 13.
6. Michigan Department of Community Health. (2003). p. 13.
7. Michigan Department of Treasury. (2003). *Michigan economic update*. Lansing, MI: Michigan Department of Treasury. p. 7.
8. Michigan Department of Community Health. (2003). p. 11.
9. Michigan Department of Community Health. (2003). p. 14.
10. L. Barnett (personal communication, February 2004). U.S. Census Bureau, CPS Data Files 1999-2001. Michigan Department of Community Health.
11. L. Barnett (personal communication, February 2004). U.S. Census Bureau, CPS Data Files 1999-2001. Michigan Department of Community Health.
12. Michigan Department of Community Health. (2003). p. 17.
13. Michigan Department of Community Health. (2003). p. 17.
14. The Urban Institute. National Survey of America's Families, Current Population Survey, 1997-99 data. According to Daniel Ridge, Michigan Department of Community Health, (personal communication), this is the most recent reliable data available on number of uninsured children eligible for public insurance in Michigan. However, the numbers are very fluid and may well have changed with the changes in the ecomomic situation in the state. Database available online at http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm
15. Michigan League for Human Services. (2002). *Kids Count in Michigan, 2002 Data Book*, p 36. Lansing, MI: Michigan League for Human Services.
16. Words and phrases that appear in *italics* can be found in the glossary.
17. National Governors Association. (2001). State health insurance program plan summaries. 9 February. Available online at http://www.nga.org/cda/files/MISCHIP.pdf.
18. For definitions of Federal Poverty Level, see Glossary.
19. American Academy of Pediatrics. (2003) State insurance program (SCHIP). 25 March. www.aap.org/advocacy/schipsum.htm.
20. Dubay, L., Hill, I., & Kenney, G. (2002). Five things everyone should know about SCHIP. Washington, DC: The Urban Institute. October 1. Available online http://www.urban.org/url.cfm?ID=310570.
21. National Governors Association (2001).
22. American Academy of Pediatrics (2003).
23. National Governors Association (2001).
24. Infants less than one year in families with incomes from 186-200% of FPL are eligible for MIChild; those with family incomes between 150% to 185% of FPL are eligible for Healthy Kids.
25. Michigan Department of Community Health. (2000). SCHIP evaluation and FY 1999 annual report. Lansing, MI: Michigan Department of Community Health.
26. National Governors Association (2001).
27. L. Dreasky (personal communication, 14 August 2003). Michigan Department of Community Health.
28. SCHIP funds were used to expand eligibility for *Healthy Kids*; benefits, cost-sharing, and other aspects of the program are the same for all *Healthy Kids* recipients.
29. Children under 1 year with family incomes up to 185% of FPL are eligible for Medicaid Healthy Kids.
30. National Governors Association (2001).
31. Healthy youth: An assessment of state investments in school-based/school linked health services. (2002). Lansing, MI: Michigan's Children: Budget Watch Project. Spring. Available online at http://www.michiganschildren.org/page.cfm/85/.
32. National Governors Association (2001).
33. N. Grundel (personal communication , January 15, 2004). Michigan Department of Community Health.
34. Howell, E. M., Hill, I., and Kapustka, H. (2002). *SCHIP Dodges the First Budget Ax*. Washington, DC: The Urban Institute. October 1. Available

online at http://www.urban.org/url.cfm?ID=900558.

35. Weissert, C. S. (2003). Michigan resident's views on children's health issues. Institute for Public Policy and Social Research. [Presentation made 29 July, Detroit, MI]. Available online at www.ippsr.msu.edu
36. Weissert, C.S. (2003).
37. The sample of 13 focal states was augmented by the inclusion of five additional states—Connecticut, Missouri, North Carolina, Ohio, and Pennsylvania.
38. Hill, I. (2000). Charting new courses for children's health insurance. *Policy and Practice, 58*(4): 30-38).
39. Weil, A. (1997). The New Children's Health Insurance Program: Should States Expand Medicaid? (From Series "New Federalism: Issues and Options for States" No. A-13). The Urban Institute. Available Online: http://www.urban.org/url.cfm?ID=307047
40. Ullman, F., Hill, I., & Almeida, R. (1999). CHIP: A Look at Emerging Programs. (*Assessing the New Federalism* Policy Brief A-35). Washington, DC: The Urban Institute.
41. Hill, I. (2000).
42. Hill, I. (2000).
43. Cohen Ross, D., & Cox, L. (2002, June). Enrolling children and families in health coverage programs: The Promise of Doing More. Washington, DC: The Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured.
44. Cohen Ross, D., & Hill, I. (2003). Enrolling Eligible Children and Keeping them Enrolled. The Future of Children. Vol. 13, No. 1, Spring. Los Altos, CA: The David and Lucile Packard Foundation.
45. Hill, I., Hawkes, C., & Harrington, M. (2003). Congressionally mandated evaluation of SCHIP: Final crosscutting report on findings from case studies of ten states. Washington, DC: U.S. Department of Health and Human Services.
46. Hill, I., Snow J. (In Press). Are Children Covered for the Benefits They Need? An Assessment of Service Coverage Under SCHIP. Washington, DC: The Urban Institute.
47. Rosenbaum, S., Markus, A., Sonosky, C., Repasch, L. (2001). State Benefit Design Choices Under SCHIP-Implications for Pediatric Health Care (George Washington University Center for Health Services Research and Policy. Policy Brief No. 2). Washington, DC.
48. Hill, Hawkes, & Harrington, 2003.
49. Hill, Hawkes, & Harrington, 2003.
50. Holahan, J., & Pohl, M. B. (2002). Changes in insurance coverage: 1994-2000 and beyond. *Health Affairs Web Exclusive*, April 3. http://www.healthaffairs.org/WebExclusives/2103Holahan.pdf
51. Dubay, L., & Kenney, G. (In Press). Coverage Improvements Found Among Low-Income Children Targeted by SCHIP. Washington, DC: The Urban Institute.
52. Dubay, L., & Kenney, G. (2002). Expanding Public Health Coverage to Parents: Effects on Children's Coverage Under Medicaid. Washington, DC: The Urban Institute.
53. Holahan, J., Dubay, L., & Kenney, G. (2003). Which Children Are Still Uninsured and Why. *The Future of Children, 13*(1). Los Altos, California: The David and Lucile Packard Foundation. Available Online: http://www.futureofchildren.org/
54. Dubay, L., Haley, J., & Kenney, G. (2002). Children's Eligibility for Medicaid and SCHIP: A View from 2000. (*Assessing the New Federalism* Policy Brief B-41). Washington, DC: The Urban Institute.
55. Kenney, G., & Haley, J. (2001). Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP? (*Assessing the New Federalism* Policy Brief No. B-35). Washington, DC: The Urban Institute;
56. Kenney, G., Haley, J., & Dubay, L. (2001). How Familiar Are Low-Income Parents with Medicaid and SCHIP? (*Assessing the New Federalism* Policy Brief No. B-34). Washington, D.C: The Urban Institute.
57. Hill, Hawkes, & Harrington (2003); Kenney, G., & Haley, J. (2001).; Kenney, G., Haley, J., & Dubay, L. (2001).
58. Feingold, K., Schardin, S., Maag, E., Steinbach, R., Merriman, D., & Weil, A. (2003). Social program spending and state fiscal crises. *Assessing the New Federalism Occasional Paper No.70*, November 12. Washington, DC: The Urban Institute. Available on line at: http://www.urban.org/url.cfm?ID=310888.
59. For examples of successful community models, see Woodbury, V., Struger-Fritsch, D., & Paul Shaheen, P. (2002). *Out of the Box and Over the Barriers.* Bloomington, IN: 1st Books (p. 78).
60. Insurance products are regulated by states and involve collecting premiums in exchange for providing a defined set of benefits, with guarantees to provide those benefits. Health coverage often is not covered by insurance regulations. In Michigan, the law allows municipalities to charge premiums for services without qualifying as "insurance."
61. Michigan Department of Community Health, Medical Services Administration.
62. Woodbury, Kruger-Stritch, & Paul Shaheen (2002), p 103.
63. Woodbury, Kruger-Stritch, & Paul Shaheen (2002), p 103.
64. For more information on the study, contact Paul Fronstin, Ph.D., Director, Health Research and Education Program, Employee Benefit Research Institute, 2121 K Street, NW, Suite 600, Washington, DC 20037. Voice: 202-775-6352; Fax: 202-775-6312; E-mail: fronstin@ebri.org
65. The future of children: Health insurance for children (2003), *The future of children:*

Health Insurance for Children 13(1). Los Altos, CA: The David and Lucille Packard Foundation. Available on line at www.futureofchildren.org

66. Horner, D., Lazarus, W., & Morrow, B. (2003). Express lane eligibility. *In The Future of Children: Health Insurance for Children, 13*(3), pp 224-229.
67. Klein, R. (2003).. Presumptive eligibility. In *The Future of Children: Health Insurance for Children, 13*(3), pp 230-237.
68. See Hill, I; and Lichtenstein, R. & Johnson, P., this brief.
69. For example, Melaville, A., Blank, M., & Asayesh, G. (1993). Together we can: A Guide for crafting a profamily system of education and human services. Washington, DC: US Dept of Education & US Department of Health and Human Services.
70. Woodbury, V., Struger-Fritsch, D., & Shaheen, P.P. (2002). *Out of the box and over the barriers: Community-driven strategies for addressing the uninsured,* p 11. Bloomington, IN: 1st Books.
71. For example, Dubay, L. & Kenney, G. (2001). Health care access and use among low-income children: Who fares best? Health Affairs, 20,(1), 112-121; Newacheck, P., Stoddard, J., Hughes, D., & Pearl, M, (1998). Health insurance and access to primary care for children. *New England Journal of Medicine, 338*(8), 513-519.
72. Chart is adapted from National Mental Health Association, available online at: (http://www.nmha.org/shcr/articles/glossary.cfm#E); and the U.S. Department of Health and Human Services, available online at: (http://aspe.hhs.gov/poverty/03poverty.htm).

Information for this report compiled by

Esther Onaga is Acting Director of the Institute for Children, Youth and Families, Associate Dean for Research for the College of Human Ecology and an associate professor with the Department of Family and Child Ecology. She has conducted numerous research projects on children, youth and adults with disabilities. She has co-authored a book, *Children with Special Needs.* She is currently working on a survey of parents of special education youth in Michigan and on the Inclusive Early Childhood Project.

Laura Bates is a research coordinator and writer at the Institute for Children, Youth, and Families. She is a member of the research teams for several statewide program evaluations and community research projects, as well as coordinating the Michigan Family Impact Seminars. She has written evaluation reports and numerous briefs for communities and policy makers on education and social policy issues related to children, youth and families.

Claudia Wallen is a graduate student in Family Community Services at Michigan State University. Claudia has helped collect research for ICYF in the areas of child abuse forensic interviewing protocols and disproportionate minority representation among Latino youth in the U.S. justice system. She gathered data for this briefing report and is currently conducting interviews with Michigan legislators regarding research utilization.

Emily Tamlyn graduated from James Madison College at Michigan State University in 2003 with a B.A. in Political Theory and Constitutional Democracy. She worked as a research intern at the Institute for Children, Youth, and Families in the summer of 2003. Currently she is working for the Americorps National Civilian Community Corps in the Southeast Region. She plans to attend law school after finishing her year of national service.

Bethany Zimmerman is an undergraduate research assistant at the Institute for Children, Youth, and Families. Her research interests include Early Childhood Education; she is currently working on a research project involving inclusion in early childhood and preschool programs. Bethany is pursuing a degree in Child Development and plans to teach in an early childhood program or elementary school upon graduation.

Mike Mahaffey is a 2003 graduate of the Master of Social Work program at Michigan State University. Previously he worked on the statewide evaluation of the All Students Achieve Program - Parent Involvement in Education (ASAP-PIE). Mike is currently working in the psychology department at MSU on an evaluation of a WK Kellogg Foundation-funded comprehensive community initiative in Battle Creek. Mike lives in Lansing with his beautiful wife, Teresa, and their 9 month old puppy, Murphy.