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The Muskegon Access Health "Three-Share" Plan: A Case History

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- Access Health, in Muskegon, MI, is generally regarded as a successful community-based approach to expanding health care coverage to uninsured workers. While the program is located in a fairly typical Midwestern community with a faltering economy and a population with worse-than-average health outcomes, it was the stimulus for proposed legislation to federally fund related programs in all 50 states. Access Health is known as a "three-share plan": Employers and employees each pay 30 percent of the cost of the program, and the community pays the remainder.
- ***Origins of Access Health***: Access Health would not have evolved without the vision and financial support of the W. K. Kellogg Foundation of Battle Creek, MI. Following the demise of national health care reform in 1994, the Kellogg Foundation launched an initiative with the objective of increasing access to health care by encouraging community-based collaboration projects. The initiative led to the establishment of the Muskegon Community Health Project (MCHP), whose goal was to improve health care in the county by developing alternative, comprehensive, high-quality and affordable health services models. Access Health was the product of one of the initiatives at MCHP.
- ***Access Health Today***: By the end of 2004, Access Health was serving more than 420 employers and 1,150 employees and dependents. In 1999, the employee share of Access Health coverage was $38 per month for adult coverage. By 2003, the employee share was $46 per month, an average annual increase of 5 percent since 1999. Employee and employer premiums have not increased since 2003. The community share was $46 per member per month in 1999, and reached $62 in 2003.
- ***Benefits Package***: Access Health is a unique health plan that covers a comprehensive array of health care services, but with exclusions. Inpatient and outpatient services are covered, as are primary and preventive care services, emergency room care, and prescription drugs. Health care services are provided only within Muskegon County. Among the services not covered are routine dental, vision, and hearing exams; neonatal care outside of Muskegon County; injuries as a result of an automobile accident; work-place injuries; or treatment for organ transplants and certain treatments for burns.
- ***Lessons Learned***: This detailed analysis of the emergence of Access Health and the program's experience since it was formed paints neither a rosy nor a bleak picture, and certainly not a simple one. However, considering the big picture, it is remarkable that Access Health has prevailed when one considers the paucity of viable programs that help to cover the uninsured population.
- ***Sustainability***: Today, Access Health's greatest financial vulnerability rests on the uncertain continued availability of the monies it uses to subsidize the program. Increasingly, the federal government is scrutinizing mechanisms used by some states to obtain federal matching funds. As a result, the largest of the three shares—the community share that is subsidized by federal DSH funds—could be reduced or redirected in the future. In addition, state fiscal problems could result in fewer federal matching dollars, which has the potential of affecting Access Health sustainability.

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Introduction

Despite years of attempts to address the issue of the uninsured, 44.7 million U.S. residents—17.7 percent of the population under age 65—have no health insurance, up from 36.5 million or 15.9 percent of the nonelderly population in 1994 (Fronstin, 2004). The lack of coverage has consequences for families, communities, and the nation as a whole. Recent studies have concluded that the uninsured do not receive the care they need; they suffer from poorer health and development; and they are more likely than the insured to die early (Institute of Medicine, 2004).

Employers offer health benefits to attract and retain qualified workers based on the generally accepted view that most employees desire them more than equivalent cash compensation and evidence that they outrank every other employee benefit in importance (Helman and Fronstin, 2004). They also offer health benefits in order to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury, to promote health, and to increase worker productivity.

However, employers provide health benefits voluntarily. They generally regard health benefits as a voluntary compensation arrangement dependent on business priorities, and their level of commitment to this benefit fluctuates in response to a variety of economic pressures. Public programs, such as Medicare and Medicaid, have been aimed at those farthest from the reach of employment-based coverage—particularly the elderly, disabled, and families with no or very low income. Yet, the problem of the uninsured is closely tied to the work place. About 83 percent of the 44.7 million uninsured are in a family with a worker (Fronstin, 2004).

In the absence of employment-based or government-based solutions to address the growing number of uninsured in the United States, it is useful to consider the seeds of change taking root in public/private initiatives at the local level. In fact, across the country, some communities have come together to fill a void in health coverage: workers employed by small businesses that do not offer health insurance.

This *Issue Brief* tells the story of the origin, development, birth, and evolution of Access Health, in Muskegon, MI. Access Health is generally regarded as a successful community-based approach to expanding health care coverage to uninsured workers at small firms. While the program is located in a fairly typical Midwestern community with a faltering economy and a population with worse-than-average health outcomes, it was the stimulus for proposed legislation to federally fund related programs in all 50 states.[1] Access Health is known as a "three-share plan": Employers and employees each pay 30 percent of the cost of the program, and the community pays the remainder.

The story of Access Health provides important lessons for employers and policymakers across the country and for all stakeholders in other communities who wish to provide increased access to health care for those among them who fall between the cracks of public and private coverage. In order to tell this story, extensive interviews were conducted in Muskegon and Lansing, MI; board minutes were examined; relevant literature was reviewed; and numerous follow-up conversations were held with program staff. This took place between summer 2003 and spring 2004. The remainder of this report discusses the origins of Access Health and the vision of its sponsor, the W.K. Kellogg Foundation; identifies key issues in the plan's evolution; and describes the program today. The discussion ends with a review of lessons learned and sustainability issues facing the program.

Origins of Access Health

Access Health would not have evolved—certainly not when it did or how it did—were it not for the vision and financial support of the W. K. Kellogg Foundation of Battle Creek, MI. Following the demise of national health care reform in 1994, the Kellogg Foundation launched the Comprehensive Community Health Models (CCHMs) of Michigan Initiative, a partnership with three community foundations, with the objective of increasing access to health care by encouraging community-based collaboration projects. Through this partnership, the Kellogg Foundation provided information, technical assistance, and training to help communities develop and implement a Community Health Investment Plan to improve health through an inclusive community decision-making process.

A central purpose of the initiative was to increase access to health care by encouraging networking, coordination, cooperation, and collaboration among community residents and organizations. CCHMs helped establish a framework for providers, consumers, and purchasers to assess health care resources and needs, identify priorities, and initiate rational health system change at the local level. The goals were ambitious; grantees were encouraged to think big and not to be afraid to fail.

The purpose of the CCHMs Initiative was to "[i]mprove the public's health care by developing alternative, comprehensive, high quality, and affordable health services models and [to inform] . . . policymakers of project results."[2] It was believed that existing health care systems were wasteful and inefficient—the result of compounding irrational responses to fierce market competition. By focusing on communities with sub-par health outcomes, the CCHMs Initiative was designed to initiate change from within. The aim was to encourage all major stakeholders in a community—consumers, providers, and payers—to redirect the flow of resources to broaden coverage and increase health care quality by creating a more efficient and effective health care system.

The W.K. Kellogg Foundation awarded a planning grant of $397,444 to the Community Foundation of Muskegon County for the 1994–1996 period. Given the Foundation's desire to encourage change from within communities, the Community Foundation of Muskegon County was a natural partner. As the primary charitable organization in the county, it had more than three decades of experience investing in community-based health and human services, community development, education, and arts programs. It had a demonstrated ability to convene the most senior leaders in community and business organizations and thus would have no problem attracting high-level, influential community members to its board of directors. Moreover, as the major local benefactor of organizations that respond to community needs, it could bring together a cross-section of the community to focus on the problems of the county's health care system.

The Muskegon Community Health Project

In 1993, when the Kellogg Foundation approached the Community Foundation about its interest in becoming a CCHMs site, the Community Foundation formed a preplanning committee to gauge local interest. The committee sponsored public forums involving some 900 residents and determined that there was sufficient interest and need to merit county participation.

In 1994, using the CCHMs planning grant, the Community Foundation established the Muskegon Community Health Project (MCHP) to improve health care in the county by developing alternative,

comprehensive, high-quality and affordable health services models. A steering committee, or Governing Board of Directors, was established with 28 community members representing the major health care provider organizations, business, labor, and consumer advocacy organizations. Initially, Kellogg believed a facilitator would be sufficient to direct community members who would shoulder the major effort. However, soon thereafter, a more traditional staffing structure was adopted by hiring a local resident with extensive political experience and well-honed leadership skills as the MCHP project director, and numerous work groups were formed to conduct planning activities. As one board member observed: "There were committees for everything! The initial strategy was to build grassroots support for the effort." There were, in fact, 14 different planning groups focused on issues as diverse as access to health care, youth violence, diabetes, and oral health. In various capacities, city council members, the mayor, corporate Muskegon, and the local unelected power elite were involved from the start.[3]

The Governing Board agreed on five guiding principles for the planning process: 1) Involve all major stakeholders in the community in a collaborative process, 2) Create a mechanism for broad community participation, 3) Assess and prioritize community health needs, 4) Develop a vision for health which emphasizes healthy citizens, and 5) Develop and implement a plan that fulfills this vision.

A broad educational process was begun. Forums (symposia, town hall meetings, public hearings, focus groups, opinion surveys, and media campaigns) were created that encouraged public dialog about defining community needs and developing strategies to address them. Community groups involved in the educational process included business, labor, human services agencies, physicians, hospitals, providers, substance abuse and mental health programs, religious groups, educational and cultural organizations, voluntary agencies, and consumer advocacy groups. The MCHP appears to have placed a looking glass over the county's entire health care infrastructure; the resulting view was unsettling to some.

The ensuing dialog among community stakeholders proved challenging for two reasons. First, there was a lack of common vocabulary about—and great unevenness in participants' understanding of—the Muskegon health care system. As a result, much of what was accomplished during the CCHMs planning phase was primarily educational in nature. As one key respondent said, "We discovered lots [of problems] that we felt existed but did not know for sure. We found out a lot of hard truths." Second, outside experts were brought in who, though highly qualified, ultimately contributed little to building and enhancing a common vision for health care reform from the inside out. This was largely due to their lack of experience in grassroots reform, but may also be explained by the fact that they were, simply, outsiders. In the end, MCHP used local people for key assignments.

Obstacles

During the planning stage, the first three guiding principles proved challenging enough, but the board nearly deadlocked in its effort to develop a vision and a plan to implement the vision. As might be expected, the clash of interests among board members was resounding. Significantly, several important stakeholders from the provider community—and in particular one of the county's two hospital systems—were highly skeptical about Kellogg's vision for the CCHMs Initiative.

Perhaps it is not surprising that the greatest resistance to reform of the health care system arose from some of the board members most invested in its current structure. The Foundation's goal—to rationalize the local health care system—implied all was not right with the status quo. In effect, the very creation of the CCHMs Initiative signaled to providers and hospital officials that their performance was not satisfactory, which inevitably put many on the defensive. Interviews for this report with key board members revealed strongly held beliefs that the Foundation wanted to see nothing less than radical reform, which meant bypassing existing market dynamics and redistributing resources to reduce duplication, inefficiency, and waste. These board members seemed to have felt they were being asked to agree on a way to reduce overcapacity in a manner that was not in their self-interest and/or in a manner that they did not agree with philosophically.

There are some facts about the market for health care services in Muskegon County that appear to have added fuel to the fires of resistance, according to many respondents. First, there are only two hospital systems in Muskegon, each of which has a wholly owned subsidiary network of primary care physicians. Each system competes with the other, and in this competitive (rather than cooperative) culture, one system's

loss is the other's gain. Moreover, most of the care received by residents of Muskegon is provided within the county (except tertiary care, which typically is provided in Grand Rapids or the greater Detroit metropolitan area). Therefore, most of the supply and demand for health care services in Muskegon fit neatly within the county's boundaries. This fact exacerbated the "zero-sum" nature of the competitive relationship between the two hospital systems within the county.

Finding a Common Purpose

After receiving its initial planning grant, the MCHP Governing Board submitted to the Kellogg Foundation its Community Health Investment Plan (CHIP) for the implementation phase of the CCHMs Initiative (Naierman, date unknown). However, in its search for consensus around a vision for reform, the MCHP Board decided to focus on such broad social reforms as affordable housing, consumer advocacy, and reducing crime and violence rather than on reforming the health care system. In short, the governing board avoided its internal divisions by swerving away from the medical model of health care reform that was of utmost importance to the Kellogg Foundation. Predictably, the Foundation required a revision to the CHIP—asking for a plan more closely aligned to the CCHMs Initiative medical model of reform. Kellogg also concluded that Muskegon's implementation plan was not innovative enough. Moreover, they expressed concerns about the ability of the Governing Board to function effectively. *The Foundation was quite explicit in recommending that a revised implementation plan include a proposal for extending health care coverage to the uninsured.* Board minutes indicate that this was a welcome message to business members who wanted the fundamental issues of the uninsured and cost shifting addressed.

As the MCHP attempted to shift from planning to implementation, it was under the directorship of a board that was handicapped by strains of skepticism toward its funder's intent and torn by internal divisions over a vision for its future. In the summer of 1997, the board was still refining its Statement of Purpose.[4]

In the summer of 1997, after the Foundation requested a revised CHIP, a key Kellogg staff member attended a MCHP Board meeting. This meeting is noteworthy because a number of concerns that had been grinding away at some board members were aired. One member asked what must have been on the minds of many: What criteria were used to evaluate the implementation proposals?[5] They were told that five themes—or key features—of the CCHMs initiative provided the framework for evaluating the implementation proposals:

- A "community governing board" that would be "responsible for establishing local priorities and allocating health resources."
- A "comprehensive, integrated delivery system" that would "build the medical care system" with "new organizational arrangements and financial incentives."
- An "integrated administrative structure" that allows for a "single set of rules and regulations" and that would allow for better monitoring of health-care system performance.
- A "health information system" that would allow health-care providers and human service agencies to share information and would allow the community governing board to "monitor quality of care, its costs and benefits and consumer satisfaction."
- "Community-wide coverage" of medical care for all residents.

One may assume that bringing these evaluation criteria to light did little to assuage the concerns of the most skeptical board members. Within the constraints of the evaluation criteria, however, the Kellogg Foundation staff member also made it clear during this meeting that the review of the CCHMs implementation proposals was to be an *open process* with *no prescribed solutions*. MCHP was told to devise a model without fear of failure, according to our respondents. The Kellogg officer reiterated that the CCHMs Initiative is unique in its attempt to bring together purchasers, consumers, and providers to engage in a community-driven decision-making process about the allocation and structure of health care resources. He emphasized that *current trends indicate that access to health care will become a problem for increasing numbers of people*. He said that the Kellogg Foundation's intention was to facilitate solutions to this issue by bringing community members together to develop answers for their own communities.

In a statement that must have put the severest critics at least somewhat at ease, he said that there was "no great design on the part of Kellogg to implement a single-payer system or single board controlling all health care services. Kellogg's intent is to offer a partnership, with the MCHP Board taking the lead to develop local solutions."[6] A board member with deep-seated reservations about the CCHMs Initiative asked point blank whether it was the intent of the Foundation to establish in the MCHP a local certificate of need (CON) process (i.e., to turn it into an organization that would determine how many of what kind of health care services should be permitted within the community). "No," he was told. There were other important breakthroughs at this meeting as well, though still at a high level of abstraction.

Another important catalyst for change came on Oct. 27, 1997, when an article was published in the *Muskegon Chronicle*, the community's main newspaper, entitled "Questions Plaguing Health Project." The lengthy article questioned whether health care reform had progressed in the county, despite four years of funding that totaled $1.5 million. The article also brought into the open a number of the issues that had stymied the MHCP Board. Key sources for this report said the article embarrassed many board members.

As a result, they agreed to hold a retreat with an outside facilitator to work through their disagreements.[7] The watershed outcome of the retreat was a one-page document entitled "Board of Directors' Purpose Statement." The statement consists of six carefully crafted pronouncements, three stating what the MCHP Board *will* do, and three stating what the MCHP Board *will not* do:

- The Muskegon Community Health Project Board *will* facilitate community identification and resolution of health issues.
- The Muskegon Community Health Project Board *will* oversee the evaluation and coordination of activities to improve health outcomes.
- The Muskegon Community Health Project Board *will* initiate health-related projects, providing support and oversight when other community resources are not available.
- The Muskegon Community Health Project Board *will not* be involved in Certificate of Need recommendations.
- The Muskegon Community Health Project Board *will not* function as a financial intermediary for health care services.
- The Muskegon Community Health Project Board *will not* interfere with the governance of community health providers.

Even after this Purpose Statement was drafted, one of the local hospitals remained a reluctant participant. According to key respondents outside the hospital system, the hospital agreed to participate in MCHP (and later in Access Health) because "it did not want to be left behind." MCHP had money and a strong will to succeed whether all hospital systems were on board or not. Moreover, the hospital may have decided that it was better to be in the discussion than left out of it. And given the hospital's mission and obvious concern for the uninsured, it would have been a poor marketing tactic to fail to participate in a community program targeting uninsured workers. In contrast to this information (disclosed to us in anonymous interviews), hospital leaders reported to us that it participated in MCHP in keeping with its mission as a community, not-for-profit hospital to serve the needs of the community and to assist with the medical needs of a potentially vulnerable population.

The Uninsured Work Group and the Evolution of Access Health

After MCHP's planning grant expired, and while the board struggled to find a common purpose, the project director formed several key working groups that began the detailed work required to develop concrete proposals to the Kellogg Foundation and to flesh them out if approved. One of these, the Uninsured Work Group, held its first meeting in February 1997, well before the board had settled on a purpose statement. After the Foundation asked the Project to revise its CHIP proposal, and gave explicit direction to focus on increasing access to care, the activities of the Uninsured Work Group gained a new sense of importance.

Beginnings

The Uninsured Work Group convened monthly from February 1997 until March 1999 (when a newly formed Access Health Board of Trustees held its first meeting). A staff facilitator with extensive experience was appointed chair of the work group by the MCHP director and given considerable latitude and immediately began to provide leadership that set group members on a positive path forward. Initially, the work group focused on findings from local studies providing evidence of the extent of the uninsured population in the county and the absence of wellness programs of any kind. Subsequent surveys indicated that employers and employees felt they could pay as much as $50 per month for individual health care coverage. A study of local physician supply revealed that, although there was an adequate number of primary care physicians in the county, various factors inhibited access to them.

The April 1997 minutes of the work group indicate that members had begun the difficult task of specifying a benefit plan to submit for price estimates. They began with a list of 30 typical benefits and ranked them by priority. Their goal was to design a minimal benefit plan that "is a reasonable alternative to those people who otherwise would not buy any coverage at all (the unemployed, temporary workers, part-time workers, workers not covered by their employers) and would offer advantages in eligibility, enrollment, and premium payment terms."[8] However, actuarial estimates showed the product was 50 percent too expensive and a discussion ensued about whether to cut preventive or catastrophic services. According to the April minutes, MCHP staff informed the work group about a Michigan plan where the funding was split into thirds—one-third paid by the employer, one-third by the employee, and one-third by a foundation focused on improving access to health care.

By late spring, efforts to design a benefit plan led the work group to realize that their decisions should be based on information—which they did not have—reflecting the preferences of their target consumers regarding benefit limitations. They decided to do further survey work with consumers and employers (specifically, small employers that did not offer health coverage to their employees).

In June 1997, the chair of the work group met with the chief executive officers (CEOs) from the Muskegon hospitals to discuss broad ideas for the development of an "Uninsured Workers' Pilot" proposal. Concepts were presented and feedback received (as described in a memo to the MCHP director and chairman of the board and to the Kellogg Foundation). Hospital participation would be critical to the success of the pilot. The chair had floated the idea of global capitation of health care costs, but it was rejected by one of the hospital systems that was particularly uncomfortable taking the risk for health care costs generated through utilization of care outside of their direct control. She was told that without more detailed information on the project's benefit structure, nature of the population served, and financing mechanism, the risk of global capitation was too great.

Thereafter, the work group began to consider the creation of a benefit package that built upon (rather than duplicated) existing services, such as those that were provided by Planned Parenthood and through the Breast and Cervical Cancer Screening Program managed by the Muskegon County Health Department. In addition, the group entered into educational discussions about health underwriting and the use of narrower provider networks to reduce costs. The market appeal of the later was tested in a subsequent consumer survey.

By July, members of the work group had become interested in the funding strategies employed by the HealthChoice plan of Wayne County (Detroit, MI). HealthChoice paired money saved by managing the care of enrollees in public programs with a distinct revenue stream: federal matching funds channeled to hospitals that provided a disproportionate share of uncompensated care (known as DSH payments). Several hospitals pooled these funds to subsidize health insurance (through local health maintenance organizations, or HMOs) to thousands of previously uninsured working poor who were not eligible for Medicaid. Ultimately, this financing model became central to the launching of Access Health (see *Financing Access Health*, below, for more information).

Progress now occurred on multiple fronts simultaneously. In August, the work group reported advances on underwriting discussions, focusing on such issues as employee eligibility, contributions through payroll deduction, COBRA-like continuation of coverage, and the possibility of adverse selection if a bare-bones product were offered to those who could not afford more generous coverage.

Further Development

By September 1997, the work group was focused on finding an insurer to take the product to market. There were discussions about administrative costs and how to minimize them. And they had a deadline: They needed to prepare a proposal for the Health Project's revised CHIP submission to Kellogg later in the fall. The work group began to give structure to the still-unnamed pilot project by making decisions, such as limiting the project to three years, identifying enrollment targets, devising a marketing plan, further specifying the benefit design, and drafting a provider contract.

Notwithstanding this progress, the work group was still unable to finalize and announce the cost of its product. Members were eagerly waiting for results from an employer survey to see whether the target premium cost of $70–$80 per month was feasible. And for the time being, financing discussions focused on the state and the possibility of obtaining funds from Medicaid or the State Children's Health Insurance Program, or S-CHIP (known as MIChild).

In the fall of 1997, the Uninsured Work Group suffered a temporary setback when the chair resigned to accept another job opportunity. In a memo to the MCHP director and president of the board, she summarized the work group's progress and looked to the future. Her main points were as follows:

- The pilot project aimed to provide coverage and easy access to primary preventive services with a minimal co-payment.
- It was imperative that each patient have a designated primary care physician.
- The target premium rate would be well below existing private insurance rates.
- Numerous health plans were contacted and proposals were solicited. BlueCross BlueShield Michigan (BCBSM) was the most receptive. The others either declined to offer a proposal or came in too high. However, once received, the BCBSM quote was higher than then current commercial premiums (approximately $400 per member per month (PMPM)).
- Looking ahead, the departing chair suggested that MCHP establish a legal entity that could hold contracts with providers. To subsidize the new product, she favored a global capitation rate that would incorporate a provider discount in proportion to the DSH pool contribution established by the hospitals of Detroit for HealthChoice. According to this argument, the capitation payment would be a source of payment for services that currently are not reimbursed. Moreover, the product would provide preventive care and thus reduce the costs of charity care by decreasing the number of patients treated in emergency departments for serious illnesses. She believed that providers could see that their self-interests would be served by this compensation method and that it would provide the solution to subsidizing the employer and employee contributions to the project.

At year's end, the search for a new chair of the Uninsured Work Group was under way. Moreover, a second business survey was fielded to assess employers' price sensitivity and their preference for a particular benefit package. And in a move that later would prove critical to attracting funding for the pilot project, an expert consultant was hired with rich experience in the development of health care coverage for uninsured Michigan residents by drawing down state and federal dollars for local purposes.

A New Start

In 1998, the year began with the appointment of a new work group chair. The board hired an individual with a wealth of local and national experience in health plan design, network development, funding, marketing, and sales. By early February, the new chair had reviewed the group's work to date and concluded that "it was clear that the pilot project could not be developed as a traditional insurance product, but should be viewed as a vehicle to get people into a preventive health care system." Moreover, for financial and political reasons, she believed that the project should not be designed to compete with existing [private or public] insurance products.[9] Several large tasks remained on the work group's agenda: complete the design of the benefit package; devise a feasible funding strategy; develop member, employer, and (importantly) physician contracts; and name the project, develop marketing materials, and prepare to roll it out.

To achieve these goals, the chair initiated organizational changes, primarily by creating smaller work groups comprised of individuals with similar interests and expertise, and by assigning each a very specific task. With strategic insight, a physician's advisory subcommittee was convened to review health protocols, select evaluation benchmarks and a screening tool, help design the benefit package, and most significantly, tackle the critical questions surrounding provider payment and provider participation. The leader of this subcommittee performed a highly significant role, aided in no small part by the fact that she had accumulated a great deal of local experience working with the local physician networks and hospital systems.

By late February, the work group divided into three subgroups, each assigned a central issue area: employers, members, and providers. These smaller, more homogeneous groups proved to be quite productive. They functioned as expert crucibles in which important details were identified and debated, and from which recommendations were developed and presented to the larger work group.

As winter wore on, discussions centered on the nature of the benefit package, which inevitably broadened to include financial and provider participation concerns. The minutes from the March meeting reflect considerable discussion about the marketing of the new project—but no agreement was reached on whether to narrow the scope of the message to target individual firms, or to broadcast to the community at large. The work group also had a lengthy discussion about the name of the product and decided to submit "Access Health" to the MCHP Board of Directors for approval.

The minutes also indicate that the mechanism of physician compensation had become a "pressing issue." The chair of the work group observed that she could not "define compensation until she knows the premium amount" and she would not know that until she talked with state representatives in April about subsidy options. "In any case," according to the minutes, "it is her opinion that the plan must be written to provide whatever it is the providers need to participate."[10] By adopting this orientation, the director kept physicians at the table. Although there was no concrete proposal yet, the work group would have to figure out how to fit the provider piece of the puzzle with a sufficiently attractive benefit package and a feasible financing mechanism in order to deliver an affordable product.

In April 1998, it was announced that the cost per member per month was estimated to be $100. Although there was much discussion about a source of funds for stop-loss insurance, there was no resolution of the issue at the time. The group did decide, however, that part-time employees (defined as those who work 200 or more hours over a three-month period, or approximately 40 percent or more of a full-time schedule) would be eligible to participate, and that only those employers that do not offer insurance would be targeted.

Planning ahead, the work group considered program evaluation issues. As noted previously, it was generally assumed that Access Health would last for approximately three years. The stated goal was to positively affect the health status of enrollees. Members designed a project that would measure provider and patient satisfaction, track health screenings, track Web site use, monitor costs, and collect measures of access and quality. The work group believed that an important long-term result of the pilot "is to develop a model that can be replicated in other communities."

Physician Advisory Subcommittee

As has been seen, the Uninsured Work Group began addressing important issues relating to physician contracting and benefits from the start. But when the new chair formed a Physician Advisory Subcommittee and gave it a capable and trusted leader, hard questions were raised and decisions made at a rate and with authority heretofore unseen. The fact that physicians and health care administrators were leading this work inspired confidence in the larger medical community and built the necessary support that ultimately led to 97 percent Muskegon County physician participation in Access Health.

By mid-1998, the subcommittee had met three times. An initial focus was on reducing barriers to provider participation. Two recurring concerns were how to limit providers' risk exposure and related questions about the health status of the target population. The subcommittee had also begun to address various aspects of the project's benefit structure, considering how much care could be provided at the primary care provider level and to what extent higher copayments associated with seeing specialists would be a disincentive to accessing care.

By late August, the subcommittee was about midway through reviewing the proposed benefit package. Subcommittee members were focused on the need to clarify what benefits were offered, to whom, and under what constraints. They also reviewed copayments associated with services, since high out-of-pocket costs could discourage enrollment.

And although they shared little appreciation for managed care reimbursement methods, being cognizant of the need to restrict costs, they focused on identification of health maintenance guidelines (or managed care protocols), development of behavioral health and ancillary networks, and determination of pharmacy needs. Moreover, they endorsed the identification and measurement of health outcomes, and the use of case management and care coordination.

Scrutiny of the benefit package continued as they considered Michigan Health Department coverage of immunization serum, cardiac and pulmonary rehabilitation guidelines, copayments for cancer radiation and chemotherapy, mental health medication management, and the extent to which oral health services would be offered.

In September, the board discussed the advantages and disadvantages of contracting with a third-party administrator (TPA) to process claims, or whether they should purchase software and process claims internally. They decided to use two TPAs, one to administer medical claims and one to administer pharmacy benefits. (In 2003, Access Health moved to an internally coordinated claims payment and case management system, which, according to the director, has helped reduce administrative costs.)

By fall 1998, the Physician's Advisory Subcommittee was nearly finished reviewing benefits. They needed to complete work on the payment schedule, confirm the stop-loss mechanism, and identify a pharmacy formulary and ancillary network. (In the end, providers—who were already providing uncompensated care to the uninsured—agreed to participate in Access Health without stop-loss insurance because they believed that it would be able to self-fund its own risk pool over time.) The work group would give the final benefit package to the hospitals to review.

As the subcommittee worked on drafts of employer and member contracts, they became concerned that the language used could prompt the Michigan Insurance Bureau to view Access Health as an insurance product rather than coverage per se, and thus be subject to state insurance commissioner regulation. This, of course, was to be avoided—primarily because of the significant added costs associated with state mandated health benefits and minimum capitalization requirements. To address these concerns, contract language was changed from "insurance" and "premium" to "coverage" and "payment for coverage."

The subcommittee also considered whether an employee with dependents could purchase dependent-only coverage, or whether an employer could offer an employee with dependents self-only coverage. Neither were options in the then-current draft contract. Other additions to the member contract included language that rendered the member accountable to meet with his or her primary care physician soon after enrollment, and language to reflect the member's commitment to follow a preventive care schedule (such as smoking cessation).

Clarification of the benefits package continued: Emergency services required prior authorization or would be reviewed for medical necessity; members would not be triaged to regional medical centers; copayments for chemotherapy and radiology were removed; the maximum copayment for all pre- and post-natal care was capped; hospice care was added as a case-management service. But perhaps most importantly, it was decided that only services *provided in Muskegon County* would be covered under Access Health. Moreover, explicit benefit exclusions were added, including infertility treatment, transplants, certain treatments for burns, and neo-natal care provided outside the county.

A key decision was physician compensation. While the first work group director had advocated global capitation at a level that would have been below Medicaid rates (on the theory that some remuneration is better than none), the new director gave the Physicians Advisory Subcommittee carte blanche to devise a compensation scheme. For some time, Muskegon physicians had been adapting to new managed care practices (and payment rates), and many were not pleased with the changes that had come about. Given the opportunity to design a reimbursement method on their own, the Physicians Advisory Subcommittee decided on a fee-for-service arrangement set at 122 percent of Medicare rates, with a 10 percent giveback to the community.[11] By October, this fee was under review by doctors in the community.

The subcommittee discussed pharmacy-related issues. Originally, only the two hospitals' pharmacies could be used. Later, they decided to expand access to local pharmacies (not part of a national chain) to constrain costs.[12] Consideration was given to excluding coverage of certain drugs, such as those used in the treatment of mental health conditions (which can exceed $10,000 per year). However, it was noted that removing such drugs from the formulary could result in higher hospital costs. Case management seemed warranted.

In November, pharmacy benefit discussions continued. The subcommittee had developed a limited formulary with a $5 copayment for generic drugs and 50 percent coinsurance for brand-name drugs. It was a sensitive issue, but the decision was made not to include birth control pills in the formulary, at least initially.

Financing Access Health

It is well known that the high cost of health insurance is the greatest barrier preventing small employers from offering health insurance and, when it is offered, preventing employees in small firms from taking it up. Cost barriers have stymied national efforts to enhance access to health care, and local efforts struggle with the issue as well. Thus, figuring out how to finance the Uninsured Work Group's new pilot project was a challenge from the first day forward.

The earliest discussions of financing options are discussed above. In the spring of 1997, the work group continued to discuss strategies for seeking a source to subsidize the cost of coverage, even before it knew exactly what would be covered, who would provide services, how much providers would be paid, and how much coverage would cost. Wayne County's HealthChoice depended on DSH funds, but the board believed that these funds were much less likely to flow to Muskegon and worried that the government could discontinue DSH payments (which had been the source of considerable controversy among federal policymakers) in the future. Thus, the work group began to discuss the possibility of seeking a coverage subsidy from the Kellogg Foundation. Two Michigan programs that used subsidies from the Robert Wood Johnson Foundation were considered as potential models, but it was determined that employers had been reluctant to buy into a program with a limited life span, and the uncertainty of grant funding concerned members of the work group. Given these considerations, they decided that the best approach to cost constraint was to restrict the benefits offered.

But restricting benefits could not be the sole answer. Realizing this, the Uninsured Work Group began to seriously consider the possibility of securing federal money to subsidize the cost of Access Health. According to minutes recorded in May 1998, "[t]he committee reviewed a chart illustrating the necessary flow of funds in order to obtain matching state and federal money." Soon thereafter, in a presentation of Access Health to the Muskegon County Board of Commissioners, the director proposed that the county "package" its various streams of funding for health programs (disease control, immunizations, mammography, the Women's, Infants and Children program, teen pregnancy, the county dental program, funding to enroll people in prescription discount programs, and other health programs funded by the local United Way) to qualify for matching federal/state funds. The legitimacy of the mechanism was questioned, but skepticism was set aside while the external consultant prepared a report discussing potential funding mechanisms.

On another front, the director intended to ask the Kellogg Foundation to fund Access Health for the first three years, with a commitment from the community to continue supporting it for three subsequent years. Group members' concerns about community funding focused on costs associated with plan administration, carve-outs for special services (e.g., neonatal care not available in the county), risk from adverse selection, and pent-up demand from previously uninsured individuals. Concerns about community financing paralleled the global capitation concerns expressed by providers.

In July, the MCHP director gave a report to the board on the Access Health presentation she gave to the Kellogg project officer. The MCHP asked Kellogg for $360,000 per year for Access Health operating costs and a first-year-only grant of $250,000 for marketing and information systems costs. Three months later, the director announced that the Kellogg Foundation would be unable to fund the one-third share of the premium.

Moreover, even though the state had expressed interest in covering adults with children enrolled in MIChild, this potential funding source appeared less and less likely, despite the appeals of MCHP staff and board members to their contacts in Lansing.

The October 1998 minutes indicate that the Work Group chair and the MCHP director had met with a high-level official in the state department that ran the Medicaid program and determined the allocation of DSH funds. The discussion centered on the possibility of obtaining matching federal funds for the community's one-third contribution to the costs of Access Health.

Subsequently, a funding proposal was submitted to the state of Michigan. According to the Nov. 12, 1998, minutes of the Uninsured Pilot Work Group, "in review of the proposal with the State of Michigan, the feds have stated it is possible to consider the member and employer contributions as matchable community funds." The record then states that "[I]t appears the employer part can be matched; however, it's not certain whether the member part can qualify." Apparently, clarity was gained on the issue of matching funds, or how to pay for the "third share" of Access Health. The work group had learned that the members' contribution to Access Health could not count toward the matchable community contribution, but the employer's contribution would be counted.

Based on work group decisions and the Access Health product designed at the time, it was projected that single white females, 35–40 years old, with two to three children, and an annual income of about $25,000 would be most attracted to Access Health. The cost per member was estimated to be $140 per month, including $30 from the member, $30 from the employer, $10 (in kind) from the provider, and $70 in matching federal funds passed through the state in the form of DSH payments to the hospitals and then to Access Health. The providers' in-kind contribution would not count toward the match. To better understand the factors that led to this arrangement, the following section outlines some facts relating to the allocation of Medicaid DSH funds in Michigan.

Funding the Community Share

One of the biggest challenges was (and continues to be) funding the community share. A number of options were considered before an agreement was reached with the state that provides access to Michigan's Medicaid DSH funds (which include a state share and a federal match). For reasons described below, this source of funding may not be available to other communities, or even sustainable over the long-term for Muskegon. However, it has been a critical element in the program's success to date.

Nationally, the Medicaid DSH program provides the single largest public subsidy to help pay for hospitals' uncompensated care costs. However, since the early 1990s there has been considerable controversy over how states fund their programs and how DSH funds are allocated within states.[13]

Michigan's Medicaid plan creates several DSH funding pools: to provide mental health services, to support safety net hospitals, for the Detroit Medical Center, and for "special DSH hospital payments." The latter pool is reserved for counties that pay the state's DSH share. By prior agreement with the state, Muskegon County includes employers' contributions to Access Health in its "intergovernmental transfer" (IGT) to the state. The state, in turn, certifies the IGT as a DSH payment to Muskegon's two hospitals in order to generate a federal match.[14]

By virtue of an indigent care agreement (ICA) between each of Muskegon's two hospitals and Access Health, the state's allocation of Medicaid DSH money (the original IGT plus the federal match) flows to Muskegon's hospitals and then to Access Health. In this way, the federal match is used to pay the community's contribution to Access Health.

The statutory authority for ICAs rests in state law 260—the Municipalities Health Facilities Act (MHFA)— which enables counties that run hospitals to establish arrangements with local nonprofits that provide care for the uninsured and thus help relieve the uncompensated care burden experienced by hospitals. The MHFA is a double bonanza for Access Health because it also provides that the oversight authority for nonprofit entities that operate under its authority rests with the state treasurer rather than the insurance commissioner. As a result, the state does not treat Access Health as health insurance, and thus it is not subject to state benefit mandates or solvency requirements.[15]

Access Health Today

Access Health began in 1999. By the end of 2004, it was serving more than 420 employers and 1,150 employees and dependents. Discussed below are employer and employee eligibility, the benefits package, enrollment history, the cost of the program, the characteristics of enrollees and employers, and the impact that the program has had on employers and employees.

Employer Eligibility

Employers must meet four criteria to be eligible to offer Access Health:

First, the employer must be headquartered in Muskegon County. (Employees of companies with locations outside Muskegon County are eligible for Access Health, but must receive services from Muskegon County providers, as discussed below.) Although the program is intended for (and typically serves only) small and medium-size employers, there is no upper limit on the size of eligible firms.

Second, employers must not have offered health insurance for a specific period of time. Existing employers are eligible to offer Access Health only if they have not offered health benefits to their defined employee group for at least 12 months.[16] Any employer that is found to have dropped commercial insurance for Access Health would be dropped for life. New employers that have never offered health benefits can start offering Access Health after being in operation for 13 weeks, as long as they have never before provided health benefits to employees.

Third, an employer who is self-employed without any employees is not eligible for Access Health.

Finally, employers are eligible to offer Access Health only if the median wage of workers in the business does not exceed $11.50 per hour.

There are a number of other requirements that employers must abide by when offering Access Health. First, employers must offer Access Health to all uninsured workers employed at least 15.5 hours per week. Second, if the employer offers dependent coverage to one eligible employee, all workers eligible for Access Health must also be eligible for dependent coverage. Third, the employer must agree to its share of the premium, currently set at 30 percent. Some employers could choose to pay the employee's share also, but they are not required to. Finally, employers cannot offer Access Health to retirees, seasonal or temporary employers, or temporarily laid-off employees.

Employee Eligibility

Employees and dependents must also meet a number of criteria in order to be eligible for Access Health when an employer offers it. Employees must work at least 15.5 hours per week over a 13-week period before they are eligible for Access Health. Even though the employer qualifies to offer Access Health only if the *median wage* of workers in the business does not exceed $11.50 per hour, *individual employee income* is not used to determine employee eligibility for Access Health. Employees at all wage levels are eligible for Access Health if they meet the other eligibility criteria.

Employees and dependents must be uninsured and not eligible for public programs such as Medicaid, S-CHIP, or Medicare. The staff at Access Health actually assists employees and dependents enroll in public programs when it is determined that a person is eligible for such a program. This explains why children account for only 10 percent of the Access Health population: Children are often steered to Medicaid or S-CHIP if the Access Health application process determines their eligibility for coverage under those programs.

Employees and dependents are able to remain on Access Health if they experience a COBRA-qualifying event.[17] Only employers with 20 or more employees are required to provide COBRA coverage. Workers and their dependents can maintain COBRA coverage for 18 months if the worker was terminated (other than for gross misconduct) or if the worker experienced a reduction in hours of work, resulting in a change in eligibility for health benefits. Dependents of active workers are able to continue coverage under COBRA for 36 months in the case of the employee's death, divorce, or legal separation; the employee's entitlement to Medicare benefits; or if a dependent child ceased to be a dependent under applicable plan provisions. Employees and their dependents are required to pay 102 percent of the full premium—which includes the employee share, the employer share, and the community subsidy.

There are a number of other requirements of enrollees in Access Health. Members must select a primary care physician (PCP). Members who already have a PCP are required to have an office visit within one year. Those who do not have a PCP or are selecting a new PCP must have an office visit within six months. Finally, according to the Access Health benefit guidebook, members who do not follow recommended treatments or make lifestyle changes to improve health may denied coverage for certain health care services—a radical departure from traditional health benefits.[18] This is designed to ensure that the program actually improves members' health (rather than merely their coverage) and that they are active participants in their own health care.

Plan members must also use community health programs when referred to them by Access Health. These programs include the following:

- The Breast and Cervical Cancer Screening Program for women ages 40 and older. This public program provides clinical breast exams, mammograms, pelvic exams, pap smears, and diagnostic tests.
- Planned Parenthood for women ages 39 and under with an abnormal pap smear.
- Community Mental Health or Child and Family Services.

The limits on eligibility and the requirement that plan members use certain community health programs were part of a larger strategy to avoid duplication of services. This also helped keep the cost of Access Health lower than it would have otherwise been. However, the limits on employer and employee eligibility may be one reason why the initial expected enrollment estimate of 3,000 has yet to be achieved.

Benefits Package

Access Health is a unique health plan that covers a comprehensive array of health care services, but that also has an array of benefit exclusions. Inpatient and outpatient services are covered, as are primary and preventive care services, emergency room care, and prescription drugs. Figure 1 contains a more detailed list of covered services along with beneficiary out-of-pocket payments for those services. Generally, the benefits package provides incentives for Access Health members to use the least-costly health care services.

While the array of services covered is comprehensive, health care services are provided only within Muskegon County and there are a number of major services and types of injuries that are simply not covered. Routine dental, vision, and hearing exams are not covered. Neonatal care outside of Muskegon County is not covered. Injuries as a result of an automobile accident are not covered.[19] Work-place injuries are not covered. Treatment for organ transplants and certain treatments for burns are also not covered. These exclusions help keep down the cost of the program.

In reality, it is very difficult to compare the Access Health benefits package with more traditional benefits without taking into account the structure of the provider network. Access Health is not like a typical managed care plan, in that nearly all (97 percent) physicians in Muskegon County accept Access Health members. However, plan members are not covered for services provided outside of Muskegon County, so there is a degree of provider network selection similar to a managed care plan. In addition, Access Health *is not* like a managed care plan in that it excludes treatment for certain illnesses and injuries as mentioned above. However, Access Health *is* like a managed care plan in that it provides strong case management.

The cost-sharing aspect of the benefits package is in some respects similar to what many workers receive in traditional employment-based health benefit programs, but in other respects is much different. Most health plans have out-of-pocket maximums when taking into account all health care spending by the plan member. Access Health does not have an overall out-of-pocket maximum, but instead relates out-of-pocket maximums to specific treatments, illnesses, or episodes of care. For example, there is a $110 out-of-pocket maximum for pre-natal care, a $300 out-of-pocket maximum per stay for inpatient care, and a $300 out-of-pocket maximum per service for outpatient care.

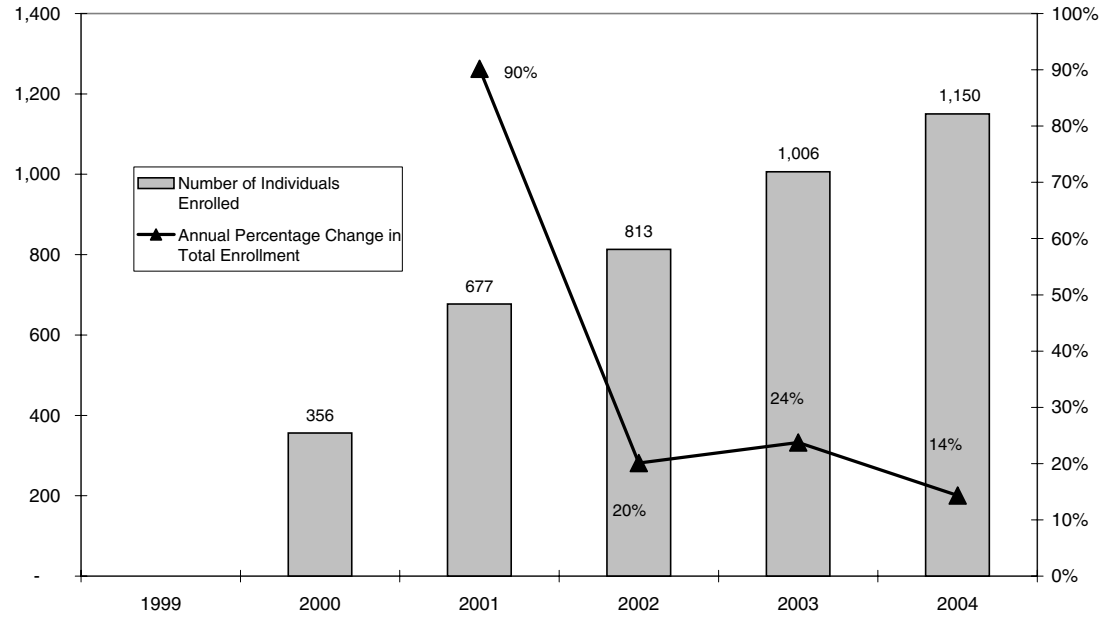
Access Health requires a $10 copayment for primary care physician office visits. Nationally, 19 percent of covered workers are required to make a $10 co-payment for physician office visits (Claxton et al., 2004). Nearly 40 percent of covered workers face a $15 co-payment, while 27 percent have a $20 co-payment and 1 percent face a $5 co-payment. Access Health also requires a $25 co-payment for office visits to physician specialists.

Figure 1
Beneficiary Cost Sharing in Access Health, 2005

Primary Care and Preventive Services		
Primary care office visit	$10 co-payment	
Home-care services	$10 co-payment	Needs prior authorization
Pre-natal and post-natal care	$110 maximum co-payment	
Specialty Services		
Surgical services (office visit)	$25 co-payment	
Specialist provider service (office visit)	$25 co-payment	
Blood component (hospital outpatient)	$20 per unit	
Physical, occupational, or speech therapy	$25 co-payment	20 visit maximum per year
DME, prescribed protheses, or orthoses	20% co-insurance	Needs prior authorization. Shoe inserts are not covered.
Radiation therapy		
Hospital outpatient	$50 co-payment	
Primary care office visit	No co-payment	
Chemotherapy	$20 co-payment per visit	$200 maximum out-of-pocket
Vision and hearing exams		
Primary care office visit	$10 co-payment	Must be related to eye or ear injuries.
Specialist provider service (office visit)	$25 co-payment	Cannot be related to glasses or contacts.
Inpatient Hospital Services	25% co-insurance	$300 maximum out-of-pocket per stay. Needs prior authorization.
Outpatient Hospital Services	25% co-insurance	$300 maximum out-of-pocket per service. Some services require prior authorization.
Emergency and Ambulance Services		
Emergency room services	$75 co-payment per visit	Co-payment is waived if admitted as inpatient.
Urgent care centers	$30 co-payment per visit	Subject to retrospective review.
Ground ambulance services	25% co-insurance	
Prescription Drugs and Supplies		$6,000 maximum calendar year benefit
Generic drugs	$7 co-payment	Up to a 30-day supply
Brand name drugs	50% co-insurance	Up to a 30-day supply
Supplies needed to administer medication	20% co-insurance	

Source: Access Health.

Figure 2
Enrollment in Access Health, 1999–2004



Source: Access Health.

Access Health provides a strong incentive for plan members to use generic drugs when in need of a prescription drug. A one-month supply for a generic drug requires a $7 co-payment. This compares with $10 for the average national copayment for generic drugs in 2004 (Claxton et al., 2004). However, Access Health requires 50 percent coinsurance for a one-month supply for a brand name drug. Nationally, only 11 percent of workers with prescription drug benefits were in a plan that used coinsurance for brand name drugs in 2004 (Claxton et al., 2004). Coinsurance rates averaged 26 percent for brand name drugs that were included in the formulary (preferred drugs) and 31 percent for brand name drugs that were not included in the formulary (nonpreferred drugs) in 2004.

Enrollment History and Experience

More than 420 employers had employees enrolled in Access Health at the end of 2004,[20] and more than 1,150 individuals were enrolled in the plan (Figure 2). Enrollment of both employers and employees into Access Health has grown substantially since the program first started in 1999. Access Health enrolled its first employer in late 1999, and a total of 356 employees and dependents were enrolled in the program by the end of 2000. By the end of 2001, nearly 700 employees were enrolled, a 90 percent increase in enrollment from 2000. While annual growth in enrollment has continued, it has slowed to 14 percent.

Initially, the MCHP estimated that Muskegon County had about 17,000 uninsured residents, and the director and key community stakeholders set a goal of enrolling 500 businesses and 3,000 individuals into Access Health. The program has not been able to meet these goals: As mentioned above, more than 420 businesses offer Access Health and only a thousand individuals are enrolled. However, initial enrollment goals should not be used to judge the success or failure of the program (Fronstin and Lee, 2005).[21] In 1999, the economy was strong, unemployment was low, and employers were interested in offering health insurance to recruit and retain workers in a competitive labor market. In 1999, the unemployment rate was 4.7 percent in Muskegon County (Figure 3), but by 2003 the unemployment rate had more than doubled, to 10.6 percent. The weak national economy that developed after the introduction of Access Health likely had a large impact on employers' ability and need to offer health benefits.

Premiums

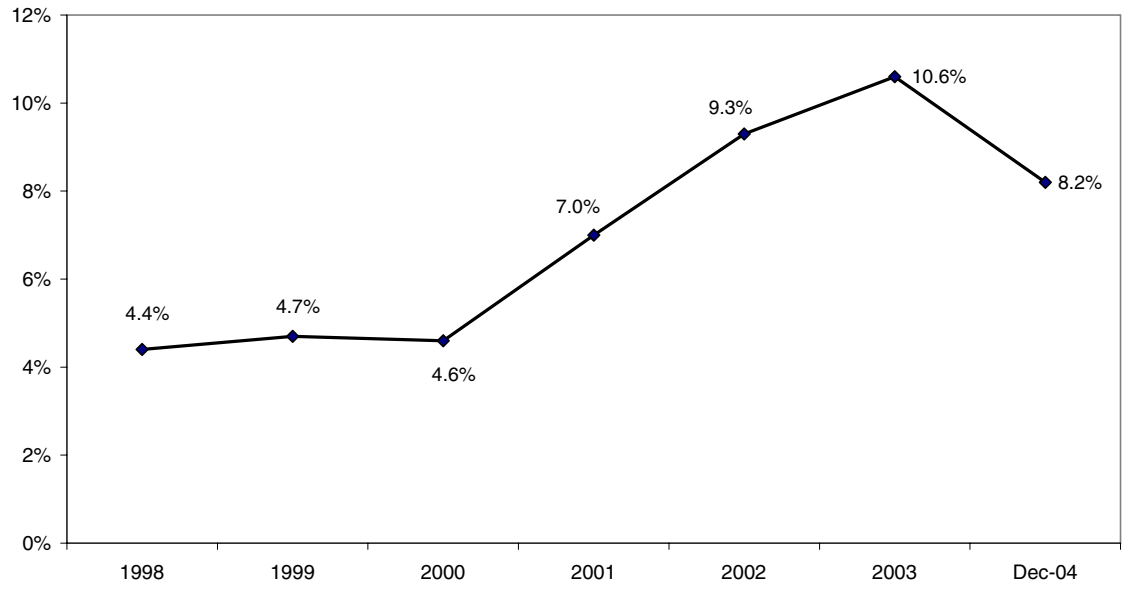
In 1999, 200 uninsured businesses in Muskegon County were interviewed to determine their willingness to pay health insurance premiums. Ninety-five percent of those businesses reported that they could afford a premium of $35–$50 per person per month. A similar survey of uninsured workers was conducted, and it was determined that 65 percent were able to pay $35–$50 per month. As a result, the benefits package was designed in such a way as to keep the employee share of the premium within this range. In 1999, the employee share of Access Health coverage was $38 per month (Figure 4). By 2003, the employee share was $46 per month, an average annual increase of 5 percent since 1999. Employers are required to pay the same amount as employees, though they are also allowed to pay the employee share. A number of employers that paid the employee share were interviewed for this report, as were some employees who benefited from this practice. The community share was $46 per member per month in 1999, and reached $62 per member in 2003. Employee and employer premiums have not increased since 2003.

Premiums for children are lower than they are for adults covered by Access Health. The premium for children was $29 per month in 2003, up from $25 per month in 1999 (Figure 5). The community share of the premium for children was $37.50 per month in 2003, and the total monthly premium for children was $95.50.

Enrollees

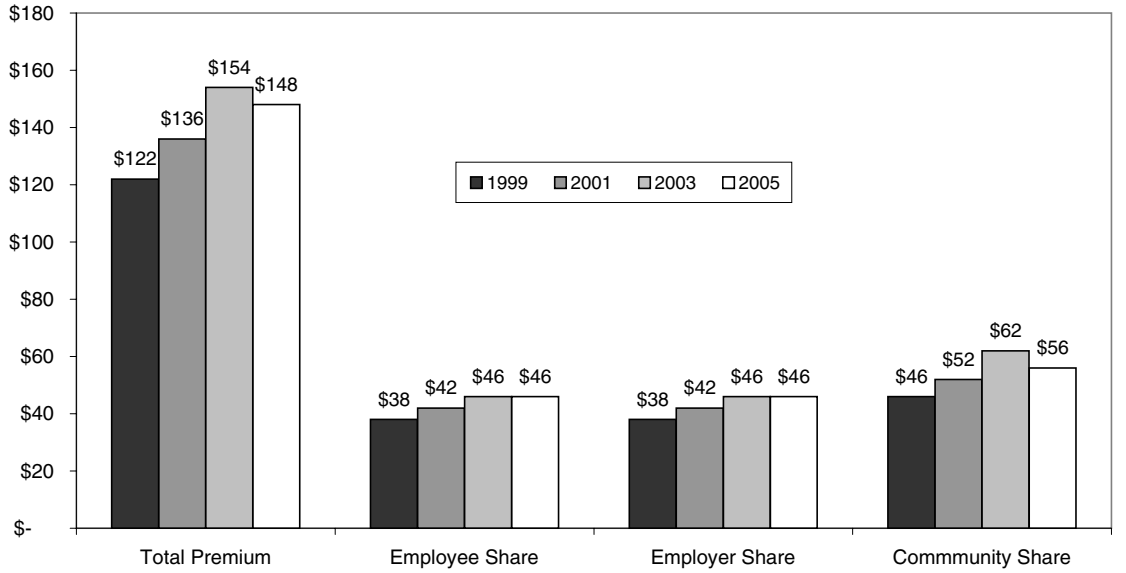
Initially, employers with more than 20 employees were not eligible for Access Health. This ceiling was lifted in order to meet initial enrollment targets. Still, Access Health caters mainly to small businesses. According to findings from the 2002 Muskegon Access Health Small Business Survey, 28 percent of employers offering Access Health had only one employee, and 15 percent had only two employees. Fifty-two percent of participating employees had three or fewer employees. This translates into very few

Figure 3
Muskegon County Unemployment Rate, 1998–2004



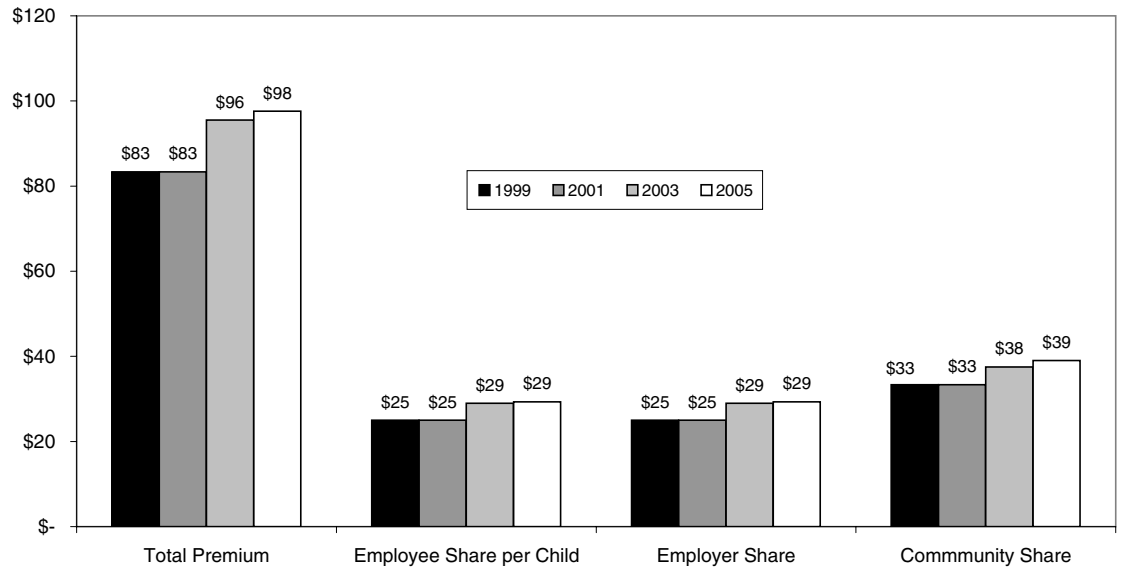
Source: U.S. Department of Labor.

Figure 4
Monthly Premiums for Adults, 1999–2005



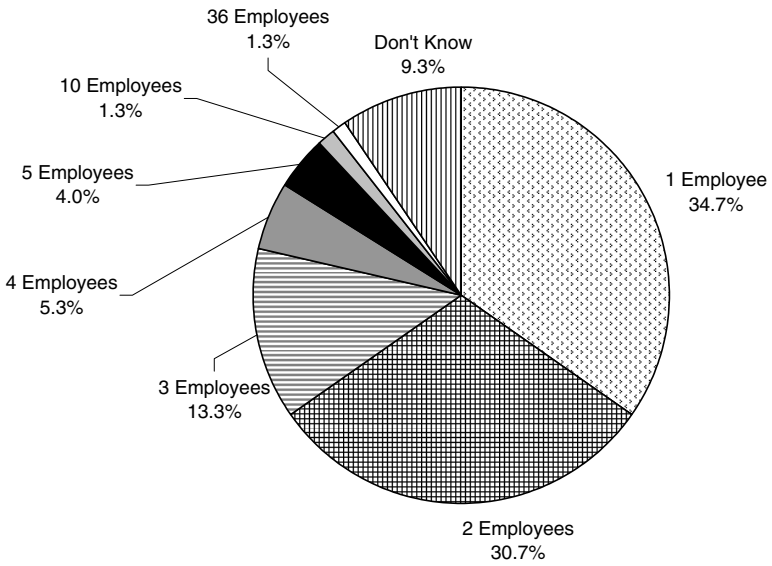
Source: Access Health.

Figure 5
Monthly Premiums for Children, 1999–2005



Source: Access Health.

Figure 6
Number of Employees Enrolled, 2002



Source: 2002 Muskegon Access Health Small Business Survey.

employees per employer enrolled in Access Health. Specifically, 34.7 percent of employers participating in Access Health enrolled only one employee, while 30.7 percent enrolled two employees (Figure 6). Overall, 78.7 percent of employers participating in Access Health enrolled three or fewer employees.

While there were very few enrollees per employer, the majority of employers were enrolling all of their employees. Fifty-two percent of participating employers enrolled 100 percent of their employees, although 12 percent of participating employers enrolled less than 25 percent of their employees and 25 percent enrolled between 30 and 50 percent (Figure 7).

Industry

Most employers that offered Access Health are in the service sector. According to findings from the 2002 Muskegon Access Health Small Business Survey, 23 percent of participating employers were in the commercial service sector, 11 percent were in the food service industry, and 4 percent were social service (Figure 8). Nearly 30 percent were in the retail trade sector and only 1 percent were in manufacturing.

Impact on Employers

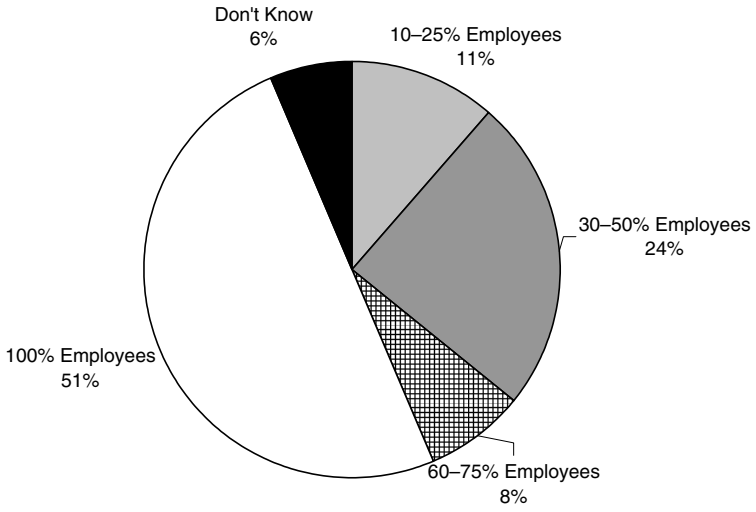
While the Kellogg Foundation made it clear early on that the CCHM project was an attempt to bring together purchasers, consumers, and providers to engage in a community decision-making process about health care resources, the Foundation did steer the MCHP Board toward focusing on access to health care. There was a perception that small businesses in Muskegon County needed a more affordable approach to providing health benefits in order to compete for workers with larger firms (especially large chain stores based out-of-state) also providing higher wages. However, the MCHP received mixed signals from the local business community on whether focusing on access to health care would be good for local business. According to a 1999 survey, 74 percent of small businesses not offering health benefits reported that the business was able to attract and keep all of the employees needed without offering health benefits.[22] However, the same survey found that 66 percent of those same employers reported that it would be easier to attract and retain good employees if they were able to provide health benefits to employees. When the Access Health program was described to these employers, 89 percent thought the program was a good idea, and 94 percent reported that lower health costs were important to attract and keep businesses in the county—however, only 20 percent reported that they were certain or somewhat certain to participate in Access Health.

Muskegon County employers were generally interested in lowering the cost of health benefits. The Muskegon Chamber of Commerce was considering the formation of a purchasing group to lower the cost of health benefits. Yet, there was also a concern among businesses that the availability of a product like Access Health would create unfair competition. Businesses then offering health benefits saw other companies being rewarded with a bare-bones plan and government subsidy if they had not provided coverage in the past. This was especially true in the late 1990s, when the labor market was tight, unemployment was low, and employers were competing for workers.

Today, members of the MCHP Board as well as the Access Health Board believe that employers should benefit from less turnover and higher productivity. However, they understand that high unemployment makes it difficult to sell employers on the business case for providing health coverage. They also understand that some employers are generally hesitant to offer Access Health because they are concerned that if the program fails, they will then be obligated to offer a commercial product at a much higher price. In this case, some employers see the BlueCross BlueShield product offered by the Muskegon Chamber as representing the only other option available to small business in the county in the absence of Access Health. The BCBS/Chamber plan had a $400 per month premium for employee-only coverage and a family premium of nearly $1,000 per month in 2003.

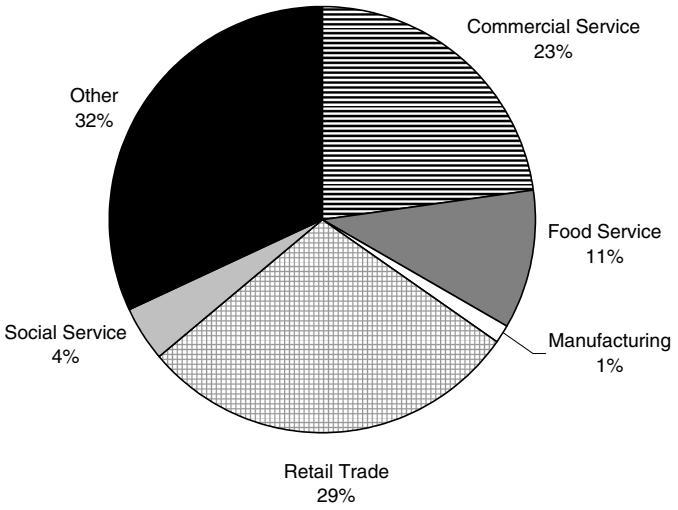
Many employers offering Access Health generally believe that it has had a positive impact on employee recruitment and retention, but an equally large group disagrees. A 2002 survey of Access Health businesses revealed that 36 percent of responding employers reported an improvement in recruitment and retention, while 36 percent reported no improvement and 28 percent did not know if Access Health affected recruitment and retention (Figure 9).

Figure 7
Percentage of Employees Enrolled, 2002



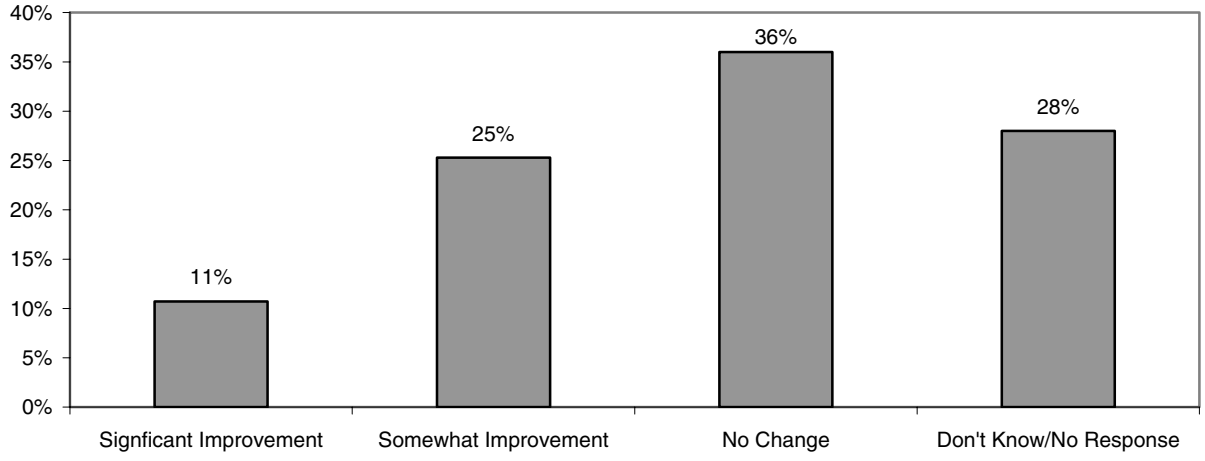
Source: 2002 Muskegon Access Health Small Business Survey.

Figure 8
Distribution of Employers in Access Health, by Industry, 2002



Source: 2002 Muskegon Access Health Small Business Survey.

Figure 9
Impact on Recruitment and Retention, 2002



Source: 2002 Muskegon Access Health Small Business Survey.

Nevertheless, businesses interviewed for this report said they were motivated to offer Access Health to reduce employee turnover and felt very strongly that offering health benefits assisted the overall success of their business because it allowed them to better compete for workers. Interviews for this report covered a child-care center, a landscaping company, three restaurants, a woodworking company, a manufacturing company, and a company that provides services to the developmentally disabled. A summary of selected findings from these interviews is below.

The child-care company had been experiencing high turnover presumably because health benefits were not offered. Annual turnover had been estimated at about 40 percent. The operator of the establishment wanted to improve employee retention because of the sensitive nature of the relationship between care givers and children. The operator was also interested in offering health benefits to prevent illness among both the employees and the children in their care. There was a high incidence of illness because children tend to contract illness from other children, and children would often convey those illnesses to the center employees. Similarly, the employees at the child-care center would often have the same illnesses as the children. After offering Access Health, turnover was virtually nonexistent and the incidence of illness has dropped. In addition, an individual previously employed by the center returned to work there because of the availability of Access Health.

The landscaping company was motivated to offer Access Health because the owner wanted insurance protection for his family and his employees. He was also motivated to offer Access Health to improve employee retention because there was a high degree of competition for workers in the landscaping industry. Even though unemployment in the county was relatively high, there was a perception that Access Health has had a big impact on recruitment and retention. One employee was also able to avoid filing for bankruptcy because of the availability of Access Health. Generally, the owner of the landscaping company thinks that Access Health had positively affected the overall success of his business and said he would continue offering the plan even if the premium doubled.

One of the ***restaurants*** surveyed for this report adopted Access Health when there was a highly competitive labor market. The owner reported that offering Access Health had helped him improve recruitment and retention, and had also helped the staying power of the business, since the high costs of turnover were reduced because of the availability of Access Health. The owner of the restaurant also reported that he would not drop the program even if the premium doubled. He perceived Access Health to be an advocate for both employers and employees.

The owner of the ***woodworking company*** generally believed that employees should be covered by health insurance, and he offered it because he believed that it was the right thing to do. This woodworking company also employed individuals with very specific skill sets and competed with large national chains for

workers. As a result, the employer felt it was necessary to offer a health plan to recruit and retain skilled workers, and generally thought that offering Access Health had a positive impact on recruitment, retention, turnover costs, and the overall success of the business.

An owner of a restaurant reported that offering Access Health was simply the right thing to do. Recruitment and retention was not a big issue for the employer as there was no shortage of job applicants. The owner of the restaurant did report that turnover was much higher at the location outside of Muskegon County, where Access Health was not offered. The owner did not have a strong feeling that offering Access Health had affected the overall success of the business. However, he did think that offering the health plan had not only reduced turnover, but also that reduced turnover had an indirect effect on the business. Reduced turnover appears to have helped regular customers establish a relationship with employees. Regular customers place value on the fact that they are familiar to the employees and are known by name, which may have had an impact on the overall success of the business.

Another restaurant owner reported that he offered Access Health but offering it was part of a larger philosophy that there is an enormous return on investing in workers. A total of 35 individuals were employed at the establishment, and all had been in their jobs since 2002. There was no turnover. However, Access Health had not contributed to retention, as only two people at the establishment were enrolled in the plan; instead, the high level of retention was due to the fact that the owner of the restaurant created a highly desirable work environment, and the availability of Access Health was just one part of that environment. The owner of this restaurant reported that he could afford to provide Access Health to all 35 employees, and that he would offer the more expensive BlueCross BlueShield plan if Access Health were not available.

A nonprofit organization that provided services to the developmentally disabled reported that—similar to the child-care service—they also needed highly trained employees and served a population that depended on a close relationship with caregivers. This organization competed with nursing homes, retail establishments, and some schools for workers. The company offered Access Health to part-time employees (full-time employees were already eligible for a commercially insured product). More than 25 percent of the 80 eligible part-time employees were enrolled in Access Health. The company thought that Access Health had a big impact on reducing turnover, but also recognized that the weak labor market in western Michigan may have also contributed to the historically low turnover. Consistent with other employers interviewed, this employer reported that it offered Access Health because it was the right thing to do, and that premium increases would need to be very large to have a significant budgetary impact.

A different perspective came from ***a manufacturing employer*** with nearly 50 employees that did not offer health benefits. This employer was in a highly competitive industry that was cyclical with the auto industry, and had been hurt financially by the downturn in the economy. While some employees expressed an interest in health benefits, the employer thought that most employees already had coverage through a spouse. In addition, the employer was not concerned about recruitment and retention, and had lost employees because of lack of benefits. This employer generally did not think that the lack of health benefits had a negative impact on his business, in part because of the economic downturn.

Impact on Employees

Workers who were interviewed generally liked Access Health, but not all workers see value in the program. As a result, some workers who were eligible for Access Health continue to choose to be uninsured.

One man, who was in his mid-50s and worked in the construction industry, was enrolled in Access Health. This individual has had health insurance on and off over the course of his working life, and had never considered the availability of health insurance while searching for employment. Even when he and his wife were raising children, there were periods where his family was uninsured. He paid for health care services out of pocket when services were needed for himself or his family because the costs of treatments were generally not expensive. He often put money aside for emergencies. He reported to us that Access Health was the best health benefit plan that he was ever associated with. He added that Access Health even helped to straighten out a billing problem with one of the local hospitals.

Another Access Health participant was a woman in her mid-50s who worked in the retail garment industry. She was divorced and did not have access to other employment-based health insurance. She also never

considered health insurance when looking for a job. She was attracted to Access Health not only because of the low monthly premium, but also because it was operated locally. She also had a problem with a hospital bill that Access Health resolved.

Finally, a woman in her early 20s who lived with her parents and was eligible for Access Health reported that she had decided to remain uninsured. This woman offered a mixed message: She reported to us that health insurance was important to have, but she did not ask about it when looking for a job. She reported that she could not afford to go to a doctor without insurance, but admitted that a recent visit to the emergency room cost her more than the premiums she would have had to pay had she been enrolled in Access Health. She said that as a young woman she felt "invincible," but at the same time understood that anything could happen to her health.

Financial Solvency

The Access Health board monitors the finances and other components of the plan in order to ensure that it remains fiscally viable. Because Access Health operates under the authority of the state treasurer instead of under the Michigan Office of Financial and Insurance Services, it does not need to meet state insurance solvency requirements.

Early in the evolution of Access Health, the board was very concerned that one or two large claims could bankrupt the program. In addition to start-up funding of $125,000 from Michigan's Tobacco Settlement Funds and a $132,000 loan that was repaid by the MCHP, Access Health has received $900,000 in total through two direct federal appropriations to fund a reserve pool to address the issue of solvency. Furthermore, because Access Health grew out of the larger MCHP planning process, funded by Kellogg's CCHM initiative, some of this funding could also be counted as start-up funding. However, it is not possible to determine the exact amount contributed by the planning grant because MCHP was simultaneously pursuing other initiatives.

Access Health believes that enrollment is now high enough that the operating margins can provide enough revenue to address solvency issues related to unexpected high claims costs. However, were the program to become insolvent, plan members would be responsible for any unpaid claims, and providers would be at risk for uncompensated care.

Lessons Learned

In the realm of health care policymaking, there are few signs that large-scale change is on the horizon at the national level. For a host of reasons rooted in the history of the 20th century, the majority of insured Americans are covered by employment-based health benefits, yet nearly 45 million individuals (or 17.7 percent of the country's population under age 65) are uninsured (Fronstin, 2004). Given the political climate today, there is little evidence that this situation will be reversed through either federal- or state-initiated health care reform.

In light of the magnitude of the problem of the uninsured, many communities are searching for local strategies to address it themselves. Increasingly, there is interest in "bottom up" efforts to increase access to health care for local uninsured and underinsured populations. Certainly, the Muskegon Community Health Project—and Access Health in particular—are such efforts. For a variety of reasons, Access Health has attracted the interest of community organizers and politicians at all levels of government.

This detailed analysis of the emergence of Access Health and the program's experience since it was formed in 1999 paints neither a rosy nor a bleak picture, and certainly not a simple one. This study has attempted to describe the birth and growth of the program objectively. However, considering the big picture, it is remarkable that Access Health has become what it is today. It is remarkable that it prevailed at all when one considers the barriers and obstacles that any such project would face, and it seems all the more remarkable that it happened in a community with the unique characteristics of Muskegon County, MI. Of course, some of the county's special qualities (including its strong sense of community in the face of economic hard times, as well as access to a wide range of individual and institutional skills) probably kept the project going whereas it would have fizzled out in other places.

The purpose of this report, however, is not purely descriptive. It describes what has been learned, and draws lessons that may help others who are interested in establishing similar community-based three-share health plans. Because some of the most important lessons can be expressed in a fashion that may seem trite to some observers, each includes commentary drawing upon the MCHP and Access Health experience.

Educate Stakeholders; Work Toward a Common Understanding of the Problem

- Key stakeholders will overlap from community to community, but identifying who they are and motivating them to learn about the existence, causes, and consequences of the uninsured in their community is a critical early task in any effort to address the problem.
- The initial goal is to work toward a common vision of change, and to establish collaboration among stakeholders. Changing the status quo is an up-hill battle due to entrenched interests. The MCHP board worked hard, even as the bonds that held it together were greatly strained, but they ultimately achieved a common vision once fears were aired, orientations modified, expectations revised, and trust earned.
- A common vision promotes collaboration, which brings down barriers and leads to integration among service providers. This is crucial in a health care system that is duplicative—and highly competitive—and characterized by multiple independent "silos" of expertise.
- The importance of achieving and maintaining a common vision and purpose among key stakeholders cannot be overemphasized. It is a cauldron for testing ideas and gaining consensus; it is a well to draw from when a project needs to mobilize for community action.

Key Stakeholders Must Share a Common Vision But Anticipate a Rocky Road

- The MCHP Board traveled a bumpy road but ultimately reached its goal. Other communities with similar goals may face lower or higher barriers (or both), but it must be recognized that obstacles are inevitable. Project leaders would be wise to build into the planning process (and the execution phase) room for flexibility and conflict resolution

A Purely Representative Democracy Is Ideal But Hard to Attain in Practice

- Kellogg's Consumer-Provider-Payor (CPP) committee structure made ample sense in theory. However, in Muskegon County, "entrepreneurial" leaders initiated most action. Whether these leaders direct the project, hold key board positions, or operate in a less formal "behind-the-scenes" manner, they invariably bring knowledge and commitment to the issues. Their expertise and skill may be narrow or it may be broad, but it is unmistakable and fills an important need.
- An important skill that the best such leaders possess is the ability to work productively with the most entrenched interests. Such leaders see the big picture, even when mired in the trenches. They are strategic and manage to keep key players at the table—without giving too much or too little.

A Boat in a Storm Needs a Strong Captain to Lead the Crew

- Critical to the emergence of Access Health was the fact that the MCHP director enabled work to continue (in the work groups) even when the governing board was absorbed with internal conflict and disagreements about mission and vision.
- Change agents with close ties to the community, when involved and coordinated through strong leadership, bring tremendous skill and abilities that are invaluable to achieving local change. National experts may not have the necessary local connections to achieve the same ends.

Knowledge Is Power

This truism is reflected in at least three ways that helped make Access Health a reality:

- In the beginning especially, but also throughout the Uninsured Work Group activities, a large amount of information was collected (e.g., surveys assessing the extent of the uninsured throughout the county, the number and type of firms that did not offer coverage, the degree of public and

employer support for the innovation). This information was used to support internal decision-making, shape local media reports, and influence outside entities with a stake in the project.

- MHCP leadership selected highly competent staff—with substantial experience and both local and state connections to important players—to work on increasing access to care through the Uninsured Work Group. Thus, even while the MHCP Board was divided over a common vision for the project, the central issue of vital concern to the Kellogg Foundation was actively addressed.
- Again, the leadership populated the key physician subcommittee with knowledgeable, forward-thinking members to study and make recommendations about the Access Health benefit package, physician fee schedules, and the mechanics for accessing different types of care. Provider participation gave legitimacy to the product during its developmental phase and assured the crucial acceptance by the broader physician community.

Power Gets Results

- The political connections enjoyed by several strategically positioned staff were critical to obtaining funds for the three-share plan, both federal (the line-item appropriation) and state (DSH funds and money from the tobacco settlement).
- Whether it was power, knowledge, or an astute lawyer, the ability to avoid state regulation as an insurance product (which also freed Access Health from compliance with state benefit mandates and capitalization requirements) enabled Access Health to create a benefit package that kept the price low and the product attractive. Knowledge of the regulatory structure (and in this case, how to avoid it) was crucial.

Money Counts

- There is little doubt that without the initial funding by the Kellogg Foundation, there would not have been the critical seed money necessary for planning, coordination, design, and establishing community buy-in.
- In addition, it is obvious that some form of significant financial subsidy is needed to implement a three-share plan, to operate it, and to keep it sustainable. In this case, federal and state funding was critical to getting the project off the ground.
- Like other health plans, Access Health was faced with the dilemma of how to control the costs of its services. Two key factors in doing so were to sharply limit the number of participants eligible to participate in the program and to sharply limit the types of services that would be covered.

Markets Matter

Two facts about Muskegon County kept the circle of critical decision-makers relatively small and allowed them to set key parameters around the type of benefit package Access Health would offer.

- Most care received by Muskegon County residents is provided by health care professionals within the county. The fact that highly technical specialty care (e.g., certain neonatal procedures, organ transplants, treatment of severe burns) is obtained out of county made exclusion of these benefits easier than would have otherwise been the case. Of course, these benefit limitations also helped to keep premium costs lower.
- The providers within Muskegon County have a great deal of influence over the care offered there. The number of state and federal employees within the country is small, and the number of private firms that offer insurance and with headquarters outside the county is also small. Thus, as noted above, health care is largely indigenous to the county, which means there were fewer "cooks stirring the pot" of change than might be case in other communities.

Is Access Health Sustainable?

Although Access Health was created with the stated goal of lasting for only three years, it is now in its sixth year. However, Access Health faces a number of short-run challenges which, if not addressed, could threaten the future of the program. Factors driving the cost of providing health benefits to workers, such as technological innovation and the aging population, affect Access Health as much as they affect employers generally. Access Health has managed to keep premium increases below the average trend, but cost pressures may nevertheless catch up with the program.

Access Health does appear to be affected by adverse selection. Nearly 80 percent of employers enroll three or fewer employees. More importantly, only one-half have enrolled all employees and 35 percent have enrolled 50 percent or less of their employees. Eligibility requirements do not mimic the eligibility requirements of a typical insurer offering coverage in the small group market. There are no minimum participation requirements, which means that employers offering the program do not need to enroll all workers, or, at a minimum, require that workers have coverage at all.

The 13 weeks that employees are required to wait before becoming eligible for Access Health may also be contributing to higher-than-expected costs. While Access Health encourages the use of preventive care, it is also encouraging individuals to postpone seeking preventive care and care for acute conditions through the use of a waiting period. This may mean that individuals first enrolling in Access Health are even less healthy and more expensive to treat.

Access Health may find that it needs to provide new incentives for young persons to enroll in the program. Currently, employers are eligible to offer Access Health only if the median wage is lower than $11.50 per hour. However, employees at wage levels below and above the median wage are eligible if the employer is eligible. Access Health could consider using an income-based premium, where workers below a certain wage level pay a lower premium than workers above that level. This would remove a potential barrier that prevents young workers making at or near the minimum wage from enrolling in the program. Under this scenario, Access Health would continue to collect the employer share of the premium, which would be set at the community rate, and would still draw DSH money to fund the third share of the premium.

Notwithstanding the foregoing sustainability concerns, Access Health's greatest financial vulnerability rests on the uncertain continued availability of the monies it uses to subsidize the program. Increasingly, the federal government is scrutinizing a variety of mechanisms used by some states to obtain federal matching funds. For example, through federal law enacted in 2000, and regulation promulgated in 2001, some states were prohibited (after a phase-out period) from exploiting upper payment limits (UPLs) used to claim an excessive match.[23] More generally, the full range of states' methods of drawing down federal matching funds through IGTs is attracting congressional scrutiny.[24] As a result, the largest of the three shares—the community share that is subsidized by federal DSH funds—could be reduced or redirected in the future. In addition, state fiscal problems could result in fewer federal matching dollars, which has the potential of affecting Access Health sustainability.

Another potential threat to the continued availability of DSH funds to subsidize the third share relates to the fact that Muskegon County is allowed to count the employer's share of the premium toward the community's contribution for uncompensated care. Although this arrangement is unique to Muskegon's three-share plan, no direct threat was observed that would prohibit the continuation of this arrangement. However, if such a threat were to materialize, the county potentially could fund the third share through another revenue-generating mechanism, such as a property tax increase. There was no direct indication that the community would or would not support such a measure, although it did not appear to have been a viable funding option when Access Health was under development.

Is Access Health a solution for other communities? Given the special conditions that existed in Muskegon, clearly it could not be duplicated measure-for-measure elsewhere. Nevertheless, other communities may be able to learn from Access Health and build their own unique type of multi-share program. The demand on MCHP leadership for technical assistance by numerous communities throughout the country suggests that this is the case.

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Endnotes

[1] See 108th Congress, 2nd session, S. 2544, and 109th Congress, 1st session, S. 16.

[2] On the Internet at www.wkkf.org/Knowledgebase/Grants/GrantDetail.aspx?ID=P0025984 (last accessed Dec. 24, 2003).

[3] While an effort was made to involve the physician community from the start, they became more active only later, as described below.

[4] Board minutes reveal that board members were concerned that "the volunteers working in various Leadership Teams [or Work Groups] would encounter frustration in the event that the Board does not reach consensus regarding the Project's purpose and goals." Minutes of the Meeting of the Board of Directors of the Muskegon Community Health Project, July 25, 1997.

[5] The Kellogg Foundation reviewed proposals and asked for revisions from all three CCHMs sites.

[6] Minutes of the Meeting of the Board of Directors of The Muskegon Community Health Project, Friday, July 25, 1997.

[7] See Cline (2001), p. 170.

[8] Minutes of the Meeting of the Board of Directors of The Muskegon Community Health Project, May 5, 1997.

[9] This was consistent with an early decision to coordinate with public programs, which would become an important mechanism to control costs.

[10] Minutes of Uninsured Pilot Work Group, Thursday, March 26, 1998.

[11] It was hoped that the physician give-back would be counted as community funds to help draw down additional DSH money, but this was not to be.

[12] Eventually, pharmaceutical access was broadened to include national pharmacies.

[13] T.A. Coughlin, L. Ku and J. Kim, "Reforming the Medicaid Disproportionate Share Hospital Program," *Health Care Financing Review*, vol. 22, no. 2 (2000): 137–158.

[14] For more detail, see P. Fronstin, and J. Lee, *The Muskegon Access Health Plan: Aligning Employer, Worker, and Community Interests to Create a Three-Share Health Plan*, Report submitted to the W.K. Kellogg Foundation, Grant No. P0104648 (2004); and B. Bruen, T. Coughlin S. Guterman, and A. Lutzky, *The Medicaid DSH Program and providing Health Care Services to the Uninsured: A Look at Five Programs*, Report to HHS/ASPE, Contract No. HHS-100-97-0010, Task Order 12 (2001).

[15] Michigan counties that receive funds from the special DSH hospital payment pool must also agree to accept a fixed dollar amount to run the State Medical Program (SMP) locally (a health care program for the medically indigent, defined as persons who earn less than $250 per month and not eligible for Medicaid).

[16] There are exceptions to this eligibility rule. In particular, employers that offered health benefits to full-time workers can offer Access Health to part-time workers if they have not offered any health benefits to part-time workers for at least 12 months.

[17] COBRA is a federal law, enacted in 1986, which allows many employees and their dependents to continue to be covered by their employment-based health insurance plan (at the employee's own cost) after the employee (or dependent) is no longer eligible for health benefits.

[18] This provision is supposed to be enforced through case management. In only a couple of cases have benefits been denied when members chose not to attend smoking cessation classes or otherwise participate in their treatment.

[19] It is the members' responsibility to notify their auto insurers that they do not have medical coverage for injuries caused by automobile accidents and to carry adequate medical coverage on their auto policies.

[20] There are an additional 60 employers that offer Access Health but do not have any employees participating in the program. These employers plan to continue offering Access Health in case new hires are interested in the program.

[21] See footnote 9 on page 863.

[22] EPIC-MRA survey of 200 small businesses not offering health benefits in 1999.

[23] Although Michigan was granted a five-year transition period, there is no evidence to suggest that Access Health ever benefited from UPL financing schemes.

[24] See Allen (2004) and http://energycommerce.house.gov/108/News/01112005_1421.htm (last accessed April 2005).

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