Access to Health Care Coverage

Among the Employed Uninsured in Genesee County:

Evaluation of the One-Third Share Plan

Demonstration Project

by

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ABSTRACT

In January, 1988, The Robert Wood Johnson Foundation provided a grant to Genesee County for the purpose of providing administrative support for the Health Care Access Project, a demonstration project designed to improve access to health care among the uninsured in that county. Nearly 65% of the total uninsured population in the United States are employed full-time or part-time. Over half of the employed uninsured have incomes less than 150% of the poverty level. In Genesee County, that amounts to approximately 37,000 people, 20% of the total number employed, nearly half of whom have household incomes below 100% of the poverty level. The One-Third Share Plan component of the Health Care Access Project was designed to target low income working adults and their dependents in Genesee County. Analysis of project data revealed that, while access to health care was increased, enrollment in this plan through 1989 did not meet initial projections, nor did the project reach the population matching the profile of the low income employed uninsured; female single head-of-the-households. With the status of future operational funding tentative at best, this project most likely will result in many of the current enrollees once again becoming uninsured or turning to public assistance at the project's end.

INTRODUCTION

In recent years, a large and growing percentage of the population of the United States has had inadequate health insurance or none at all. From 1980 to 1987, the number of uninsured grew by 25% to reach 37 million, and many millions more are underinsured.[1] One part of the problem has been a weakening of the strong historical link between work and health insurance.

Americans traditionally have obtained individual and family health insurance coverage in one of three ways: Some have been covered by public programs (Medicaid for the very poor, Medicare for the elderly), and some have paid directly for policies. But by far the largest number of people have obtained health coverage in the form of group insurance provided through their employers. Consider that:

- Over 130 million of 200 million nonelderly Americans receive health care coverage, directly or indirectly, through the workplace.
- In 1985, 66% of the total nonelderly population, and 76% of the working population, had employer-sponsored health insurance.
- Over 90% of all employees are in firms that offer health insurance to at least some of their workers.[2]

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1. Irene Fraser, Ph.D., "Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage," Action Planning Guide, American Hospital Association, 1988: p.1.

2. Ibid.

Businesses are encouraged to offer health insurance coverage by a federal tax structure that subsidizes group health insurance and other fringe benefits, permitting them to be purchased with pre-tax dollars. The provision of employee health insurance coverage is a high priority for most businesses. However, while getting a job may be the most common way to obtain insurance coverage, it is not a guarantee. There exists a strong link between non-coverage and employment status: the vast majority of the uninsured also are employed workers, or dependents of these workers. For them the system, as it exists, is not effective.

The main reason the system is ineffective for this group of employed uninsured is the cost to businesses in providing health insurance coverage. Double-digit rate increases are being reported nationwide each year. Premiums increased an average of 15% in 1987 and 20% in 1988, and were predicted to increase by another 22% in 1989.[3]

With respect to health insurance coverage, there is an inverse relationship between group size and premium level, because large groups provide the opportunity to reduce administrative expenses and distribute risk more widely.[4] Smaller groups require proportionately higher administrative costs and their risks are harder to protect[5], therefore, smaller groups experience increases which are double or triple those mentioned above (30% to 60% in 1988 alone)[6]. As a

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3. Gregory Wright, CFP, "Health Care Insurance Cost Increases to Continue," Indiana Medicine, March 1989: p. 202.

4. Steve A. Freedman, Ph.D. et al., "Coverage of the Uninsured and Underinsured: A Proposal for School Enrollment-Based Family Health Insurance", The New England Journal of Medicine, Vol. 318 (13), March 31, 1988: p. 843.

5. Roger Rickles, "Health Insurance Becomes a Big Pain for Small Firms," The Wall Street Journal, Dec. 6, 1988, B-1, Col. 3.

6. Wright, loc. cit.

consequence, small businesses have found it difficult to obtain more favorable group rates enjoyed by larger firms.

Yearly renewal periods are not necessarily the norm for small groups. Some small businesses in the Midwest are being given only 60-day or six-month renewal periods for their commercial carriers -- if not outright cancellations if a major illness strikes an employee.[7]

Small businesses are trying to adapt by reducing health care benefits, requiring new employees to wait longer before qualifying for health insurance, implementing co-pay arrangements with employees covering a percentage of the premium cost, or dropping health coverage altogether.[8] The irony of the situation is that small businesses represent the largest area of future job growth, but characteristically are least likely to offer health insurance coverage. A major challenge, then, is to develop strategies to improve access to health care insurance among this population of employed uninsured.

A decline in the overall level of private work-based health insurance and an increase in the number of employed uninsured could be compromising the health status of millions of Americans. Policy options available to address the problem of access to health care among the employed uninsured range from nonintervention to broad-based national health insurance initiatives that would include all uninsured persons. However, responsibility for this problem cannot be placed on either the public or private sector alone.

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7. M.R. Traska, "What 1989 Holds for Health Benefits," Business and Health, January, 1989: p.22

8. Ricklees, loc. cit.

It is unrealistic to look to the federal government as the sole source of funds for such an effort. Debate surrounding the Kennedy-sponsored national health insurance bill reveals that options requiring new spending (read: raising taxes) are not likely to be viewed with favor among legislators.

Likewise, the recent repeal of Section 89 of the Internal Revenue Code, which would have resulted in business and industry assuming financial responsibility for increasing access to health insurance among their employees, serves to indicate that the private sector will fight efforts to legislate and/or mandate health care coverage through the workplace. At the state level, the mandated health care coverage bill passed in Massachusetts has proven to be less than successful and certainly not the model program it was intended to be.

The economic impact of any mandated employer-based health care coverage would be felt especially hard by small business, resulting in higher employee costs, higher production costs, higher product costs, a loss of competitive advantages, a loss of employees, lower profits, and, ultimately, the closing of businesses that may have been only marginally profitable before the implementation of mandatory policies.

A more realistic approach to the problem involves forming cooperative arrangements between public and private agencies for the purposes of subsidizing the total health insurance premium costs paid by the employers and employees. If, through such innovative arrangements, it can be demonstrated that access to health care among the employed uninsured is improved, these experiences may serve as effective guidelines for introducing public policy initiatives at the state or national level.

One cooperative strategy developed in Genesee County was the Health Care Access Project. This paper will first identify who the employed uninsured are, what approaches are recommended to aid in increasing health coverage to this population, and what the situation is in Michigan and, specifically, Genesee County. A brief overview of the background of the Health Care Access Project will be followed by an evaluation of the extent to which the project's One-Third-Share Plan goals and objectives have been accomplished. Data to be gathered includes the number and type of businesses enrolled in the One-Third Share Plan as well as the size and characteristics of the population enrolled. Sources of this data include group and individual enrollment applications (see Attachments 1 & 2), marketing referral analyses, and interviews with program administrators or the Genesee County Health Department and Michigan Department of Social Services, as well as the marketing director at Blue Care Network and the membership services coordinator at the Flint Area Chamber of Commerce.

PART I

BACKGROUND

"Uninsured" is defined as those persons not covered at any time during the year by employer related or private health plans, or through the public programs of Medicare, Medicaid, or military service related health care.[9] There are several sources for information regarding the total number of persons uninsured. Data from the 1977 National Medical Care Expenditure Survey (NMCES) found that at any given point in time, more than 25 million persons were uninsured.[10] The trend since 1977 has been that the uninsured population is growing. NMCES data showed a 13% uninsurance rate in 1977. The 1980 Current Population Survey (CPS) found that rate had increased to 14.6%. Census Bureau estimates 15% of the population (35 million people) were uninsured in 1983, and CPS data indicates that 17.6% were uninsured in 1986.[11] Across the nation, it is estimated that up to 37 million Americans are currently uninsured[12], representing a 32.4% increase in the uninsured population in the last twelve years. At this same rate of percentage increase, by the year 2000 nearly 50 million Americans could be without health insurance.

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9. Michigan Department of Management and Budget, October 12, 1988. (Interim report to the Governor's Task Force on Access to Health Care from the Problem Identification Committee.), Goal A: 1.

10. Suzanne Mulstein, "The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options," Inquiry, 21, (Fall 1984): p. 215.

11. Michigan Governor's Task Force, loc. cit.

12. Ibid.

Who are the employed uninsured?

In 1986, 24 million working adults did not have employer, union or other group based health insurance, representing nearly a quarter of the U.S. work force and 65% of the total uninsured population. Seven million of these purchased their own policies. The remaining 17 million without any health insurance represent over half of the uninsured adults in the United States.[13]

Although full-time workers are far more likely than part-time workers to have employer related health insurance coverage, 70% of the working uninsured are full-time workers and 30% work part-time.[14] The workers who are most likely to lack health insurance tend to be young (19-24 years of age), in better overall health, but in relatively poor economic circumstances, and less educated. Almost half of the employed uninsured are workers over 30 years of age, half are married, and 60% are full-time wage earners.[15] Many no longer qualify as dependents under the health insurance of their parents and may have to pay for their own insurance out of relatively low earnings. They may also not be eligible for coverage through their employer due to their limited work experience or transitory employment status.[15]

The job market is forecast to show an increase in the proportion of part-time workers to full-time workers between 1985 and 1995, therefore it is likely the proportion of uninsured-to-insured workers will also increase.[17]

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13. Katherine Swartz, "Workers Needing Insurance: Who Are They?", Business and Health, (Sept. 1987): p. 20.

14. Ibid.

15. Monheit et al., op. cit., p. 349.

16. Ibid, p. 351.

The single characteristic most often shared by the employed uninsured is low earnings. Nationally, one-third of the uninsured have incomes below the poverty level.[18] In 1985, 21.6% (5.18 million) of the employed uninsured had family incomes below the poverty level, and 34.1% (8.52 million) had family incomes of less than 150% of the poverty level.[19] (Poverty level in 1985 defined as an income of $8,850 for a family of three.) Businesses without health plans are more likely to employ low wage earners:

- In businesses with health plans, 12% of the employees earn less than $10,000 per year.
- In businesses without health plans, 54% of the employees earn less than $10,000 per year.[20]

Workers in industries characterized by seasonal employment, self-employment, or a less technically skilled work force are twice as likely to be uninsured as are workers in manufacturing, transportation, communications, and utilities industries, which offer year-round employment to a specialized and more unionized labor force.[21] Almost one-third (7.7 million) of the uninsured workers are employed in the service sector of the American economy. Another 5.7 million are in the retail trade, 2.4 million are construction workers, and 1.6 million work in the agriculture, forestry and fishing industries.[22]

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17. Jeanne T. Black, "Comment on 'The Employed Uninsured and the Rule of Public Policy'," Inquiry, 23, (Summer 1986): p. 210.

18. Michigan Governor's Task Force, op. cit., p.2

19. Swartz, op. cit., p. 21

20. Fraser, op. cit., p. 2.

21. Monheit, op. cit., p. 351.

22. Swartz, op. cit., p. 21.

Characteristics of Businesses Employing the Uninsured

In 1986, there were 3.8 million business enterprises nationwide, of which 301,471 were "small" and 3.3 million were "very small".[23] "Very small" businesses employ 1 to 19 persons, and "small" businesses employ 20 to 99 persons.[24]

Nationally, almost all of the working uninsured are employed by work places having fewer than 100 employees; half have fewer than 20 employees. Two-thirds of work places having fewer than 100 employees, and 40% of sites with fewer than 20 employees provide health insurance. In fact, 99% of the firms which do not offer any health insurance have fewer than 25 employees, and 92% of non-insuring firms have fewer than 10 employees.[25] All together, about 55% of firms with fewer than 100 employees offer coverage.[26]

In the period between 1977 and 1984, manufacturing, transportation, communications, public utilities, and government accounted for a decreasing proportion of total employment, while services and trade increased their share. More than half the overall job growth between 1980 and 1986 was in service industries, followed in growth by retail trade. The Bureau of Labor Statistics has forecast that these same trends will continue through 1995.[27] In other words,

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23. U.S. President, "The State of Small Business: A Report of the President, Transmitted to The Congress", Government Printing Office, Washington, DC, 1988: p. 20, 90.

24. Ibid, p. 19.

25. Fraser, op. cit., p. 20.

26. Michigan Governor's Task Force, op. cit., p.4.

27. Black, op. cit., p. 209.

those sectors that historically have offered the most extensive health insurance coverage will experience relative shrinkage, while those providing the least coverage are now the economy's growth industries. (Table 1)

A Small Business Administration survey found that firms not covering their employees overwhelmingly cited insufficient profits and high insurance costs as reasons for the decision.[28] (Table 2) Other reasons why small businesses are less likely to offer health insurance are the following:

1. Small businesses are likely to be unincorporated and therefore receive fewer tax advantages than large businesses.
2. Small business is dominated by services, retail trade, and construction, often characterized by low and uncertain profits and high employee turnover.
3. Many small businesses have a high number of minimum wage workers and providing health insurance would increase an employer's total compensation costs.
4. Small businesses employ a large share of young and old workers, low-wage and part-time workers who are either more difficult or more costly to cover.[29]

For a worker to obtain health coverage through a workplace, three conditions must be met:

1. The employee must work for a firm that offers health coverage.
2. The employee must qualify under the employer's plan.
3. The employee must be willing to enroll in the plan, agreeing to pay the employee share of the premium, if any.[30]

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28. Fraser, op. cit., p. 17.

29. Michigan Governor's Task Force, op. cit., p. 9.

30. Ibid.

Employee eligibility is affected by several factors:

1. As of January 1, 1989, firms are allowed to exclude from eligibility persons who have not completed one year of service, work less than six months during the year, are under age 21, have certain non-resident alien status, or are in collective bargaining agreements.[31]
2. Part-time status. (68% of all firms exclude part-time employees from their insurance plan).[32]
3. Pre-existing health conditions.[33]

Even if they meet the conditions and are eligible, many employees will still reject the coverage offered for a variety of reasons:

1. The employee may already have coverage through a spouse.
2. The employee cannot afford the coverage, especially for dependents.
3. Non-coverage may be a rational choice taking cost, health status and wages into consideration.[34] (Table 3)

Consequences of Poor Health Care Access

The steady growth in businesses that characteristically are least likely to offer health insurance coverage is causing a decline in the overall level of private work-based health insurance, and increasing the financial barriers to obtaining health care. It is the poor and near-poor who most often feel the brunt of this trend.

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31. Fraser, op. cit. p. 54.
32. Ibid, p. 30.
33. Michigan Governor's Task Force, op. cit., p. 4.
34. Ibid.

The poor and uninsured utilize services of the health care system less than those who have insurance and/or higher incomes. A 1983 Robert Wood Johnson Foundation survey found that 20.4% of the uninsured reported themselves to be in fair or poor health as opposed to 13.4% of the insured. Not surprisingly, then, the poor and uninsured also more often consider themselves to be in poorer health than the population as a whole.[35]

The economic and social consequences of poor access to health insurance coverage are not limited to the individual who is employed and uninsured. The dependents of the employed uninsured are also affected.

As a group, the employed uninsured account for more than 50% of the uninsured and, with their dependents, account for at least 75% (27.8 million).[36] The 1983 Robert Wood Johnson Foundation survey reported that 15% of the uninsured needing health care for their families the prior year did not obtain it, compared to 4.8% of the insured.[37]

Children as a group are disproportionately uninsured. Nearly one American child in five has no coverage and one-third (12 million) of the total uninsured are children. The chance of being uninsured is 37% higher for a child than for an adult, and more than a third of all uninsured children (4.1 million) live with a parent or guardian who is insured.[38]

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35. Ibid, p. 15.

36. Gail R. Wilensky, Ph.D., "Should Private Insurance Be Made Mandatory?", Hospitals, (Feb. 5, 1988): p. 24.

37. Michigan Governor's Task Force, op. cit., p. 16.

38. Freedman, et al., op. cit., p. 844.

There is a clear relationship between insurance status and family composition. Over half of the uninsured (but only one-third of the population as a whole) live in single head-of-household families. A closer look at the insurance status of full-time workers emphasizes this relationship: Non-coverage rates in full-time worker families without children were (1985):

- o 11.4% for families with both spouses present.
- o 22.4% for families with one spouse absent.

Non-coverage rates in full-time worker families with children were (1985):

- o 11.9% for families with both spouses present.
- o 32.8% for families with one spouse absent.[39] (Table 4)

A closer look at this information reveals that single parent families without coverage tend to be headed by women who are likely employed in retail, service, or other low-coverage businesses.[40]

Forty-five percent of unmarried working mothers earning under $3.50 an hour (about $6,700 a year) are uninsured. Only 31% are covered by Medicaid. Between 1976 and 1984, the percentage of the poor covered by Medicaid declined from 65% to 38%, while the overall number of people living in poverty increased.[41] Medicaid is an all-or-nothing entitlement that complicates the welfare-to-work transition. AFDC (Aid to Families with Dependent Children) recipients who are able to find a job and move off welfare soon lose Medicaid eligibility for

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39. Michigan Governor's Task Force, loc. cit.

40. Fraser, op. cit., p. 56.

41. Ibid, p. 60.

themselves and their families, but the jobs that most of these former welfare recipients take do not offer health insurance.

No single factor explains why some employees are uninsured at the work place while the rest are insured. For the most part, the uninsured are victims of an accumulation of disadvantages resulting not only from the insurance system but from legal factors, demographic trends, and changes in federal programs as well. The irony is that, through taxes on their wages, the employed uninsured are helping subsidize health insurance for those, who, unlike themselves, qualify for some type of government sponsored assistance.[42]

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42. Ibid, p. 80.

PART II

APPROACHES TO INCREASE COVERAGE OF THE EMPLOYED UNINSURED

An action planning guide for promoting health insurance in the workplace published by The American Hospital Association (AHA) in 1988 provides an analysis of approaches for lowering costs and increasing product awareness. These approaches include:

- o Forming new large groups.
- o Including more people in existing groups.
- o Subsidizing the product.
- o Changing the product or its delivery.
- o Increasing awareness of health insurance options.[43]

Using the information provided in the AHA planning guide, an overview of these approaches follows.

Forming New Large Groups

As was previously discussed, large groups have a distinct advantage over small groups when it comes to obtaining health insurance. By combining several small groups into a larger group, employers and employees of these small groups can realize the economies of scale advantages enjoyed by larger groups. New large groups can be created by developing a multiple-employer plan, creating statewide pools, employee leasing, and by requiring employers to provide health insurance.

Multiple-employer plans combine two or more employers together through a central organizer or trustee who then obtains the master insurance policy.

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43. Ibid, p. 68.

Organizations such as labor unions, trade associations, business associations, financial institutions and insurers commonly sponsor these arrangements.[44]

Under an employee leasing arrangement, the client company officially fires its employees, who are then rehired by the leasing or contract staffing firm. These same employees are then leased back to the original client. Leasing employees relieves the small firm of the responsibility and associated costs of common personnel functions as well as the administration of all employee benefits.[45]

Pooling arrangements provided by the state are commonly established as a means of providing insurance to high-risk, "medically uninsurable" individuals; those who have been denied conventional coverage from private insurers due to chronic health conditions.[46]

A state may also establish general eligibility pools in order to cover a broader cross-section of the population. Such pools mix high-risk enrollees with healthier population groups. Premium rates would be lower than in a high-risk pool because healthier enrollees essentially subsidize the less healthy ones.[47]

Mandated employer health insurance is a legislative-driven alternative to increasing the number of groups offering insurance coverage. Such action on the part of lawmakers is intended to ensure that almost the entire working population

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44. Ibid, p. 70.

45. Ibid, p. 72.

46. Ibid.

47. Ibid, p. 73-74.

is provided a minimal level of coverage, leaving the government with the responsibility of providing care to the unemployed.[48]

Currently, Hawaii and Massachusetts are the two states which have enacted some type of legislation mandating coverage. Nationally, Section 89 of the Internal Revenue Code was introduced in 1988 with the intent of avoiding discrimination in benefit plans and mandating coverage be extended to all individuals working at least 17.5 hours per week. This proposed legislation has not survived attacks and the House of Representatives has voted 360-36 to repeal the measure, based on its cost, compliance burden, and its effect on executive recruitment.[49] There are issues additional to those mentioned above related to the formation of new large groups that must be taken into consideration.

When a new large group is created, increases in its premium rate are determined by the usage patterns that the group establishes. Essentially, the more claims made, the higher the premiums are adjusted the next rating period. While virtually all insurance companies require medical screening of each worker employed by firms with 10 or fewer employees[50], there will still be a number of enrollees in these new large groups who will have a higher utilization rate than the rest of the group. Large claims made by a few people can raise the premium rate at the expense of the entire group. Therefore, adverse selection can occur whereby the low utilizers of health care become attractive to an insurer and are

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48. Ibid, p. 78-80.

49. "Section 89 Appears Doomed", Flint Area Business to Business, Dec., 1989, p. 5.

50. W. David Helms and Randolph DeSona, "New Initiatives to Expand Health Insurance", Business and Health, (December, 1988): p. 13.

creamed "off the top" and put into another, lower risk, lower cost group.[51]

In cases of state pools, most often, premiums are set by law to allow those matching the profile of the uninsured and employed uninsured better economic access to health care. However, because this population tends to have high health needs, premiums charged prove insufficient to cover costs. Subsidizing these pools can be done by assessing insurers, seeking an increase in state appropriations, or taxing hospitals.[52] Finally, no matter at what level premiums are set, there will still be a portion of the employed uninsured who will not be able to afford coverage.

Increasing Existing Group Size

An alternative to forming new groups is to find ways for new people to be brought in under ongoing public and private programs, which might include expanding Medicaid eligibility.[53] Other options under this approach would include expanding employee eligibility to include part-time workers, requiring dependent coverage, and expanding coverage period to allow those receiving government and/or state assistance to become employed and remain covered while waiting to become eligible under their employer's plan.[54]

Subsidizing Coverage

As with state pools, subsidizing provides financial assistance to help prevent gaps

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51. Fraser, op. cit., p. 71.

52. Ibid, p. 73 & 74.

53. Ibid, p. 82.

54. Ibid, p. 85.

in coverage. Subsidies can be in the form of hospital fee discounts, private donations, insurer deductible and co-pay discounts, and public subsidies.[55]

Changing The Product Or Its Delivery

This approach involves the design of a special, less expensive, product or system of delivery. Products under this approach may be specialized, such as a catastrophic care plan, or a primary and preventive care-only plan.

Insurance products delivered through a managed care program or a Health Maintenance Organization (HMO) are considered to be less costly due to the "gatekeeper" design of these delivery systems.[56]

Increasing Product Awareness

In many small businesses, the owner assumes the role of chief executive officer, personnel director, finance officer, marketing and sales manager, and more. Finding the right health insurance product can be very time consuming, and the opportunity costs associated with researching different products can be a barrier to finding the best coverage for that firm.

Product awareness can be enhanced by developing a marketing strategy to correct any misinformation about qualification requirements, publicize the availability of pooling options, and facilitate comparison shopping among available products.[57]

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55. Ibid, p. 86 & 87.

56. Ibid, p. 91.

57. Ibid, p. 96.

Product awareness is critical: no approach to expanding groups, expanding coverage or lowering costs will work unless potential beneficiaries know about it.

The background information thus far has provided a profile of the uninsured and the employed uninsured nationwide and some strategies for improving access to health care insurance. This leads us to a discussion of the situation in Michigan, specifically Genesee county, where a decline in manufacturing jobs and an increase in small businesses has compromised access to care for a large number of uninsured and working uninsured.

A specific strategy has been implemented in Genesee County to improve access to care among the employed insured. This paper will examine the issues surrounding this project, its level of success to date, and a summary of conclusions based on these findings.

PART III

THE SITUATION IN MICHIGAN

The Michigan League for Human Services (MLHS) estimates that 1,025,767 or 10.9% of Michigan residents were uninsured in 1985.[58] The Center on Budget and Policy Priorities estimates that 14.5% of Michigan's population, or 1,318,000 persons, lived in poverty in 1985.[59] Of the 805,000 persons on AFDC or General Assistance in Michigan, 425,000 are children, and half of all households below the poverty level in Michigan are headed by women.[60] Michigan's maximum benefit levels for a family of three under the AFDC program amounts to 56.5% of the poverty level. From 1970 to 1987, AFDC benefits fell 31.4% in Michigan when adjusted for inflation.[61]

In 1986, there were 135,858 business enterprises in Michigan. Ninety-nine point six percent (135,366) employed less than 500 people.[62] Applying the percentage increases found nationally in the number of businesses less than 100 to those with fewer than 500 (the size 100 to 499), it is estimated that 132,821 small Michigan enterprises employ less than 100 people.[63] In 1986, the Greater Detroit Area

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58. Michigan Governor's Task Force, op. cit. p. 1.

59. Ibid, p. 2.

60. Ibid.

61. Ibid.

62. U.S. President, op. cit., p. 92.

63. Nationwide, 3,719,737 business enterprises employ less than 100 persons, and 3,791,344 employ less than 500 persons. 71,607 employ between 100 and 499, representing a 1.88% increase between less than 100 and less than 500. At a state level, 135,366 business enterprises in Michigan employ less than 500. Multiply 135,366 x 1.88 = 2,545 persons in the 100-499 range. 135,366 - 2,545 = 132,821 Michigan businesses employing less than 100 persons.

Health Council found that, even though the dominant form of health care coverage in Michigan is the employer group plan, the employed constitute 41.6% of the uninsured in this state (426,719 persons).[64] Perhaps it is of no surprise to find that an estimated half of the people who leave public assistance to take a job in Michigan are not offered insurance benefits at the work place.[65]

The description of the employed uninsured in Michigan, then, is nearly identical to the national description. However, the situation in Michigan, with its decline in large manufacturing jobs over the past few years, presents a major problem in comparison with other state.

Genesee County

Between 1978 and 1986, 205,000 manufacturing jobs were lost and 161,000 service jobs gained in Michigan. By the third quarter of 1989, Michigan was expected to lose 71,000 General Motors related manufacturing jobs as a result of announced plant closings.[66] Results of a recent Mott Foundation-sponsored study reported in the November, 1988, issue of the Flint Area Chamber of Commerce's Business To Business publication states that, with GM's plan to downsize, Genesee County employment could decline by as much as 10 percent in 1992 from its 1986 level of 180,000, with GM employment slumping to 46,755. That study also reports the identification of a need for more service jobs in Genesee County.[67] While this

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64. Michigan Governor's Task Force, op. cit., p. 21.

65. Fraser, op. cit., p. 61.

66. Michigan Governor's Task Force, loc. cit.

67. Scott Willett, "Mott Study Shows Need for More Service Jobs", Flint Area Business To Business, November, 1988, p. 1.

may be a good sign in one respect - the creation of new jobs - it must be kept in mind that the jobs being created are likely to be low wage jobs that do not offer health insurance to those workers.

With General Motors being the largest employer in Genesee County, and given the old axiom "What's good for General Motors is good for the country", one could draw the conclusion that the majority of Genesee County businesses are unionized and pay higher wages than comparable businesses across the county. In actuality, the opposite is true. The Flint Area Chamber of Commerce estimates there are over 7,000 businesses in Genesee County, with 70% employing fewer than 25 people and 90% employing less than 10 people.[68] With regards to unions, 16.1% of employers in Genesee County report having a unionized workforce compared to 21.6% across the rest of Michigan.[69] Wage levels in the non-General Motors sector of Flint and Genesee County's economy are lower than the national averages and lower than wages in the Detroit area.[70]

In 1987, the Michigan Department of Management and Budget estimated the population in Genesee County to be 443,637.[71] Unemployment in Genesee County declined between 1984 and 1987 from 12.1% to 9.5%.[72] However, this rate increased in 1988 to 12.1% and the Michigan Employment Security Commission

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68. Interview with James Minca, Membership Services Coordinator, Flint Area Chamber of Commerce, November, 1988.

69. Willett, loc. cit.

70. Ibid.

71. Robert Pestronk, M.P.H., Proposal for Health Care Access Project submitted to Vernon K. Smith, Ph.D., Project Director, March 20, 1987, p. 4.

72. Ibid, p. 5.

reports a current 1989 rate of 12.5% (compared to 7.7% statewide).[73]

The level of unemployment served as a proxy to assist a 1987 PURA survey in estimating 22,000 Genesee County residents were without any type of health insurance.[74] However, using the 1986 Genesee County employment level of 180,000 and the national statistic previously found stating that the employed represent 41.6% of the uninsured, it can be estimated that the employed uninsured in Genesee County number nearly 75,000.

In 1986, 25% of Genesee County residents lived in households with incomes at or below poverty level, with one household in six having income less than $10,000.[75] Again assuming previous 1985 statistics finding 21.6% of employed uninsured with family incomes below the poverty level, an estimated 16,000 of the employed uninsured in Genesee County have household incomes below the poverty level. This represents nearly 10% of the total Genesee County population living in households with incomes below the poverty level in 1986. (See Attachment 3.)

The need for a program to improve access to health care among the employed uninsured in Genesee County is evident. In 1987, a proposal was submitted to The Robert Wood Johnson Foundation to help fund a demonstration project in Genesee County, the Health Care Access Project (HCAP). The One-Third Share Plan component of HCAP was specifically designed to target small businesses by subsidizing the cost of health insurance for 20 or fewer employees at qualifying firms.

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73. "Soft Sales Prompt Cutbacks at Flint Assembly Plants", The Flint Journal, December 6, 1989, Sec. A, p. 1 & 11.

74. Pestronk, op. cit., p. 3.

75. Ibid, p. 5.

PART IV

THE HEALTH CARE ACCESS PROJECT

In 1986, The Robert Wood Johnson Foundation began the Health Care for the Uninsured Program. The program was designed to provide grant support to state and local groups that were trying to improve health care access. Fifteen demonstration projects were selected and almost all included strategies to improve the rate of health insurance coverage for small firms and their employees.[76,77]

Approaches being used in these projects include:

- o Developing or modifying insurance products.
- o Forming or expanding insurance groups such as multiple-employer plans.
- o Subsidizing insurance for individual enrollees.
- o Operating in tandem with state high risk pools.
- o Using deep provider discounts or sliding fee scales.
- o Using managed care.
- o Tying in program with Medicaid.[78]

The One-Third Share Plan of HCAP was designed to incorporate a subsidized insurance premium, provider discounts and sliding fees, and a tie-in with Medicaid. This program has seen the largest percentage enroll under HMO coverage, although standard Blue Cross/Blue Shield and other commercial packages are also available.

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76. Helms, op. cit., p. 12

77. Fraser, op. cit., p. 68.

78. Ibid.

Origin of the Health Care Access Project

In late 1985 and early 1986, a series of meetings were held as a result of a request by the Michigan Department of Public Health Advisory Committee to review the issue of access to health care by the uninsured, and to identify the size and severity of the problem.

A consortium of public and private agencies and organizations was formed to determine the best ways to go about developing policies to address the problem. The individual committees within this consortium had been meeting regularly when the Robert Wood Johnson Foundation announced competition for a demonstration grant to help administer a project designed to improve access to health care among the uninsured. It was decided that the efforts of the consortium be directed toward pursuing this funding.[79]

The Michigan League for Human Services (MLHS), a non-profit statewide citizen's organization engaged in research, planning, and action to improve human services in Michigan, was engaged to apply for funding on behalf of the consortium. MLHS proposed to be the fiscal agent, and provide staff support for the project.[80]

The first proposal submitted to The Robert Wood Johnson Foundation (RWJ) was to conduct a study of the dimensions of the problem in order to form a solid base for policy development. Since RWJ is interested in funding projects and not research, this proposal was denied in mid 1986. The proposal was reworked to

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79. Interview with Vernon K. Smith, Ph.D., HCAP Project Director, in November, 1988.

80. Project narrative of the grant application submitted to The Robert Wood Johnson Foundation dated December 23, 1986, p. 1.

include the One-Third Share Plan and a managed care plan for General Assistance clients and other persons not eligible for Medicaid.[81]

The proposal was resubmitted, proceeded from first round of review by a technical advisory committee (see Attachment 4), and resulted in a site visit to Michigan by RWJ in September, 1986. In January, 1987, RWJ notified the Michigan Department of Social Services that the grant had been approved.[82] The funding from the grant was to be for project administration over a 2-year period.

The grant was then restructured in early 1987 and in the spring of that year, MLHS asked Michigan counties to submit proposals for the funding of one rural and one urban demonstration pilot project. Proposals from counties were asked to focus on:

1) The size and scope of the potentially-eligible population in each area;
2) The availability of medical providers willing/able to deliver services to the population;
3) The degree of local support for the project (e.g., level of cooperation from local government officials, DSS offices, business, employers, medical providers, recipient groups, and community organizations.[83]

By late spring, 1987, six proposals had been received: two urban (Oakland and Genesee counties) and four rural (Linoway, Delta, Marquette, and Ottowa counties). Critical to the decision of which urban county would receive the

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81. Smith interview.

82. Ibid.

83. Project narrative, op. cit., p. 6.

administrative dollars was showing that dollars would be available to fund the operationalization of their proposed projects.[84]

Being the wealthiest county in Michigan was both an advantage and disadvantage for Oakland County: the dollars were available for their proposed project, but their demographics and economic conditions did not present as much of a need as those of Genesee County. While Genesee County's economic problems, plant closings, and high unemployment level made it a more fundable county, the financial package needed to support project operations was incomplete.

At the state level, $2.9 million had already been budgeted for General Assistance medical in Genesee County. At the county level, $1.3 million was budgeted for the Resident County Hospitalization Program in Genesee County. (This program provides inpatient care for non-Medicaid eligible patients.) With these two sources combined, the project was still about $4 million short.[85]

Local hospitals in Genesee County were approached and all agreed to accept 20% less for inpatient Medicaid payments over the course of this project. This was estimated to add $800,000. The C.S. Mott Foundation then offered support in the amount of another $800,000. Still, the project was over $2 million shy of the amount needed. At this point, Genesee County State Representatives Robert Emerson and Joseph Conroy went back to the state and were able to get $2.5 million in new appropriations for the Genesee County project. With the necessary $8 million in hand, Genesee County was chosen in the summer of 1987.[86]

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84. Smith interview.

85. Ibid.

86. Ibid.

In order to make the Genesee County project work, four major policy changes had to be made by January 1, 1988. Those were:

1. Combine the Resident County Hospitalization and General Assistance medical into one comprehensive benefit covering both inpatient and outpatient care.
2. Issue individual medical identification cards to all 9,000 General Assistance recipients. These cards would expedite care needed by these individuals. Previously, the system required those seeking care to go through their case worker to get approval. This system acted as a barrier to care and thus contributed to the underutilization of the health care system by those in need.
3. Reduce the gap between Medicaid eligibility and General Assistance requirements for those who meet Medicaid financial eligibility requirements but do not qualify because they are not aged, blind, disabled, or in families with dependent children.
4. Extend medical benefits four months to welfare clients whose cases close because of employment. Previously, medical benefits ended immediately upon the employment of a welfare recipient.

All these policy changes were made in the last four months of 1987, and all took effect on January 1, 1988. On that same date, the Health Care Access Project in Genesee County was initiated, targeting some 12,000 people in that county over the course of the two year project. On May 1, 1988, the One-Third Share Plan component of HCAP began.[87] Approximately 5% of the total budget was allocated to the One-third Share Plan.

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87. Ibid.

The Genesee County Health Department handles all administrative functions for HCAP's One-Third Share Plan, including marketing (one full-time staff person hired with RWJ funds), verification of business and individual eligibility, establishing and monitoring of procedures by which a provider will submit claims for services rendered, maintenance of records for all components of HCAP.[88] (See Attachment 4.)

Health Care Access Project Goals and Objectives

The Health Care Access Project has three rather broad goals:

1. Increase access to health care.
2. Decrease dependency on welfare.
3. Increase the number of insured.[89]

The Health Care Access Project has the following objectives:

1. Improve access for current General Assistance clients.
2. Offer a health care plan to former General Assistance clients who have moved off welfare and become employed.
3. Offer a health care plan to former clients of Aid to Families with Dependent Children who have become employed and lost their Medicaid.
4. Offer a health care plan to persons who are poor but not eligible for Medicaid because they are not aged, blind, disabled, or in families with dependent children.

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88. Interview with Linda Lane, Genesee County Health Department, and local HCAP Project Coordinator, November, 1988.

89. Vivian D. Roeder and Vernon K. Smith, Health Care Access Project goals, press release, 1987.

5. Develop the One-Third Share Plan which will finance the cost of health care for the employed individuals mentioned above, their co-workers and their dependents.
6. Contract with selected providers to deliver managed care to the target population on a pre-paid basis.[90]

The One-Third Share Plan

The One-Third Share Plan is designed to be a subsidized health plan available to persons who work their way off welfare, and to the employers who hire them. This plan is directed at small businesses in relatively low wage industries that, in the past, have not provided health benefits.[91]

To participate in the program, an employer may not have offered group coverage in the past two years and must have hired at least one former welfare client whose case closed on or after September 1, 1987, or whose Medicaid or GA medical benefits extension ended after January 1, 1988.[92]

Originally, HCAP's plan was to compete with other insurers by creating a new insurance product through a modified Medicaid plan. Instead, it was decided that

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90. Ibid.

91. "Subsidized Health Plan Helps Small Businesses", Flint Area Business to Business, March, 1988, p. 10.

92. "Health Care for the Uninsured: Program Update", Alpha Center, Washington, DC, (July, 1988).

NOTE: The Health Care Access Project negotiated a 4 month extension of G.A. benefits to allow a former welfare recipient to still have health care coverage for an additional 120 days after becoming employed. Under normal circumstances, the Department of Social Services would close that person's file immediately upon employment. This added time was designed to allow this person to fulfill the 90 to 120 day eligibility period required if new employees by most businesses, while still maintaining some level of health coverage.

a better approach would be to subsidize existing insurance products that met certain minimum standards, thereby making it easier to continue the program after the grant ends December 31, 1989. The maximum subsidy was based on the least expensive, acceptable policy that is readily available in the community. That policy in Genesee County is the Blue Care Network HMO.[93] This HMO policy meets the following benefit requirements:

Minimum benefit requirements-

- Annual deductible: no more than $100 per single/$300 per family;
- Co-payments: no more than 20% of major medical benefits; annual maximum limit of $2,500 per individual or family.

Required benefits-

- Full coverage for hospitalization and associated medical and ancillary care;
- Emergency room services;
- Outpatient services;
- Medical/surgical physicians benefits;
- Major medical benefits such as doctor's office visits, allergy testing;
- Prescription drugs;
- Maternity and prenatal care;
- Psychiatric care - inpatient and outpatient (with up to 50% co-pays).[94]

Because the participating hospitals accepted a 20% reduction in DRG Medicaid reimbursement, this HMO policy was available to participating firms at a premium rate of approximately 20% less than the going rate.[95]

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93. Flint Area Business To Business, (March, 1988), loc. cit.
94. Interview with Linda Lane, November, 1988.

95. Interview with Michael Curdy, Vice President, Marketing, Blue Care Network, November, 1989.

Blue Care Network Premium Rates
(See Attachment 5)
(guaranteed through December 31, 1988)

	Non-Discount	HCAP Discount
Single	$ 95.90	$ 79.92
2 person	220.58	183.82
Family	239.76	199.80

Usually, there are very strict insurance underwriting guidelines for small groups: the employer must pay at least 1/2 of the single rate and the group must be a "true group", not a group comprised of independents (i.e., service organizations, clubs, etc.). Additionally, by law, HMO's can require medical screening for groups that have less than 25 employees. In order to make the One-Third Share Plan more appealing, the mandatory health screening was waived and the premium payment structure was altered.[96]

By hiring a former welfare recipient, a qualified business becomes eligible to offer health coverage to this former welfare recipient and up to 19 other employees in that company at a discounted rate. Under the One-Third Share Plan, insurance premium rates were divided into thirds.

A sliding scale based on the individual's level of poverty determined the employee's share. If the employee's income was less than 100% of poverty, HCAP paid two-thirds of the premium cost. For employees earning between 100% and 200% of poverty, both HCAP and the employee paid one-third. Employees earning

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96. Ibid.

over 200% of poverty paid the entire two-thirds of the premium cost.[97] The employer's cost is always one-third of the premium.

It was estimated that 2,000 former welfare recipients, their co-workers, and their dependents would participate in the one-third share plan in 1988. From May through September, 1988, expectations of high levels of enrollment in the One-Third Share Plan were not realized (11 businesses enrolled and a total of 67 persons insured), and the eligibility requirements were altered to attract more businesses. Between September 15 and December 15, 1988, an open enrollment period allowed any business that had not offered group health insurance in the past two years to enroll in the One-Third Share Plan. These businesses need not have hired a former welfare recipient to qualify during this period. However, enrollment under these conditions was limited to the first 300 people. Additionally, HCAP changed to allow a one-third subsidy of any insurance plan, regardless of price, as long as it meets the benefit requirements.[98]

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97. Roeder and Smith, op. cit.

98. Smith interview, November, 1988.

PART V

FINDINGS

Marketing of HCAP

In the original program design, the Department of Social Services (DSS) served as the main referral agent for HCAP. DSS would notify the HCAP administrator at the Genesee County Health Department when a former welfare recipient's case had been closed. (See Attachment 6.) The HCAP marketing representative would then contact that business to explain the One-Third Share Plan. Businesses were either eligible, not eligible, or declined the coverage.

Under the special open enrollment period, advertisements were placed in business publications and local newspapers. Brochures were mailed to businesses and telemarketing was done, all in the effort to promote awareness as to the availability of this program.

Eligibility

Reasons for not being eligible included:

- Already offering insurance.
- Hires part-time seasonal, or contractual workers; spouse had plan.
- Out of the Genesee County area.
- Out of business.
- Unable to locate.
- No welfare recipient (when not in open enrollment period).

From September 1, 1987, to December 31, 1988, a summary of marketing efforts shows that of 680 businesses contacted, 429 were not eligible for one or more of the above listed reasons. Of those businesses eligible, 17 enrolled under the regular enrollment guidelines, and 53 enrolled under the special open enrollment

from September 1 through December 31, 1988. Another 146 declined the coverage. The remaining 35 were considered "potentials" for enrollment. (See Attachment 7.)

A second special open enrollment period began October 1, 1989. From January 1, 1989 to November 30, 1989, another 303 businesses were contacted. Of that number, 188 were not eligible, 7 enrolled under the regular enrollment guidelines, 6 enrolled under the 1989 open enrollment, and another 102 declined coverage. The number of potentials remained at 35, and 3 businesses dropped out of the coverage plan. (See Attachment 8.)

As of December 1, 1989, reasons for declining the health coverage plan included (businesses may have given more than one reason):

35 No response to sales efforts.

81 Not interested in providing coverage (i.e. don't want to spend money on health ins.)

27 Too expensive.

58 Company not profitable enough.

14 Company too new.

1 Can hire without offering health insurance.

1 Administrative - too much paper work.

8 Project subsidy only thru 12/89.

13 Employee turnover too high.

1 Do not want to pay premiums for families.

10 Chose a plan that's ineligible for subsidy.

8 Income too high for subsidy.

9 Employee cannot afford to pay one-third share.

31 Other

A closer look at these responses reveals that most reasons given for declining were economic/cost related, which matches the national trend for small businesses who decline health insurance. This issue of cost is confirmed by data found on the businesses enrolled in the One-Third Share Plan. When asked why they have not offered health insurance in the past, 60 answered that the cost was too high (64 said their reason for participating in the HCAP plan was the lower cost).

Enrollment in One-Third Share Plan

	Year 1 (9/1/87-12/31/88)	Year 2 (to date) (9/1/87-11/30/89)
Total eligible businesses	251	366
Total enrolled businesses	70	80
- number with welfare recipient	17	24
- # unionized	0	0
Percent of eligible businesses	27.9%	21.8%
Number enrolled per provider group		
- Blue Care Network (includes 2 with multiple carriers)	49	50
- Blue Cross Traditional	9	15
- Commercial Carriers	6	7
- Other HMO's	3	6
- Preferred Provider Organizations	3	4
Total # of employees all businesses	335	373
# employees insured through 1/3 plan	198	222
# dependents insured through 1/3 plan	187	230
Total # insured through 1/3 plan	385	452
Average insured business size	4.79	4.84
Average # insured persons per business	2.83	2.88
Average # insured dependents per business	2.67	2.99
Of the totals enrolled, the numbers receiving subsidies:		
Number of employees with subsidies	146	166
- Number of one-third subsidies	132	152
- Number of two-third subsidies	14	14
Number of dependents with subsidies	147	178
Total number benefiting from subsidies	293	344

The information on the previous page reveals that, while the total number of businesses enrolled has increased by 10 in year 2, the total enrolled compared to total eligible has decreased by over 6%. These numbers likely would have been better had there been less uncertainty about the status of the project past December 31, 1989. Little, if any, marketing took place between June and October, 1989. It was difficult to market insurance coverage when the HCAP administrators were unable to guarantee a subsidy, or the program itself, will still be available in the future. Additionally, DSS began repeating some of their referrals, meaning that some of the same businesses previously contacted as a result of hiring a former welfare recipient were being referred again for contact.

On October 1, 1989, it was announced that HCAP had received operational funding for calendar year 1990. However, no further dollars will be available for administration of the project after March 31, 1990. It was therefore decided to offer a second special open enrollment from October 1, 1989 through March 31, 1990. Marketing for the One-Third Share Plan has begun again in earnest.

This information also shows that 40.9% of the total number of employees said "no" to the plan in 1987, and 40.5% have said "no" so far in 1989. Why are these employees declining this coverage plan?

An analysis was done on data taken from individual enrollment forms for 72 participating groups, representing 349 employees (95.4% of the total enrolled business employees). Of this number, 230 (65.9%) chose insurance through the HCAP plan, 115 (33%) did not, and 4 (1.1%) gave no answer.

Reasons for choosing coverage (more than one answer may be given):

- o 157 Security/peace of mind.
- o 4 Family member needs insurance.

- o 87 The cost is low.
- o 26 Other.

Reasons for not choosing coverage (more than one answer may be given):

- o 93 Already have health insurance.
- o 5* Monthly premium too high.
- o 1* Don't get sick.
- o 2 Doctor not part of plan.
- o 20 Other (not eligible or part time).

* These 6 employees have chosen to go without any health insurance coverage.

There is no question that having health coverage is important to almost all of these employees. However, in comparing the issue of cost between businesses and individuals, while cost is the overwhelming factor for businesses declining the HCAP plan, it is not the biggest reason for individuals either choosing or not choosing the share plan coverage.

The need for security is basic in the hierarchy of needs. It is difficult to put a price on such a need; therefore, considering the alternatives, cost becomes a relative issue. It can be concluded that nearly 93% of the total employees who have either chosen the HCAP plan or already have insurance feel strongly about the issue of security in this area of their lives.

That value of security is underscored when consideration is given to the number of dependents insured through the One-Third Share Plan. The total number of dependents insured in Year 2 is greater than the number of employees insured. This indicates the important role the family plays in making this kind of decision.

Program Goal Accomplishments

Has the One-third Share Plan helped increase access to care? Has it helped decrease dependency on welfare or increased the number of insured? The answer to all three of these questions is yes.

Increased access to care.

In the analysis of data from 72 participating businesses, nearly 40% of the employees enrolling in this coverage reported having delayed getting medical care in the past because they did not have insurance. Another 5.3% reported having been refused care because they did not have insurance, while 3.1% reported that they or their dependent had been unable to get insurance due to a health problem. Therefore, access to care has been increased for 48.4% of participating employees.

Additionally, a list of 74 of the enrolled groups by type of business reveals that 79.7% can be considered either service, retail, or a combination of service and retail. (See Attachment 9.) We have seen that these are the sectors of the economy experiencing growth now and in the future and are most likely to employ the uninsured. The HCAP plan has provided access to care that otherwise would not have been available.

Decrease dependency on welfare.

Of the 26 individuals enrolled as former welfare recipients, 20 are now insured through the One-Third Share Plan. Three left their jobs and one is covered through a spouse (14 of these 26 receive 2/3 subsidy). While this represents only 11.7% of the total number insured through this plan, these individuals are being encouraged through this plan to become active, productive members of society. No value can be placed on the sense of pride felt by these individuals working to decrease their dependency on welfare.

Increase the number insured.

We have already seen that the total number insured through the One-third Share Plan has increased from 385 in Year 1 to 452 (thus far) in Year 2. While it has been shown that the One-Third Share Plan has helped accomplish these broad goals, has this project reached the population characterized earlier as being low wage earners and female single heads of households?

Low wage earners, yes. A greater percentage of employees in the 72 businesses from which data was collected reported low individual hourly incomes or low family incomes. Of the 196 providing hourly income information, 16.8% reported income of less than $4 per hour, while 46.1% reported income of $4 to $6 per hour. Another 13.2% reported earning between $6.01 and $8 per hour, and 9.7% earned $8.01 to $10 per hour. Only 3% reported making more than $10 per hour. the remaining 11.2% listed themselves as "salary" employees (which does not necessarily denote high earnings).

Of the 177 providing information on yearly family income, 45.8% reported a family income below $10,000 per year. Another 23.7% had family incomes between $10,000 and $15,000 per year, while 11.3% reported incomes between $15,001 and $20,000. Another 6.2% said their household income was in the range of $20,001 to $25,000 per year. Somewhat surprising is the 13% reporting incomes over $25,000 per year, although this may represent the small business owner/operator's income.

With regard to hours worked, of 220 providing information on hours worked per week, 23.2% reported working less than 40 but not less than 30 hours per week. Another 48.2% said they worked an average of 40 hours, and 28.6% reported working more than 40 hours per week.

As far as providing coverage to female single heads of households, this project fell short of reaching that target group. Only 8% of the enrolled are in this category. The largest enrollment, 31%, is among single males, followed by male heads of household at 29.9%. Single females comprise 20.5% of the enrolled, while 7.1% of the enrollment might be called female heads of household. Another 3.4% are single male heads of households.

Of the number of individuals not enrolling, 32.6% were female family heads, 28.6% were single females, 17.3% were single males, 15.3% were male household heads, 4.1% were single female household heads, and 2.1% were single male household heads. ("Female household heads" could indicate coverage is provided by a spouse plan.)

Here we conclude that the profile of the One-Third Share Plan is nearly the same as the average employed uninsured individual: most work in service or retail related businesses, have low wages and low yearly family household earnings.

The statistic related to the low percentage of single female household heads receiving coverage may be interpreted as meaning this population is at a greater disadvantage when it comes to seeking employment. Since this group tends to be the lowest wage earning group, the conclusion would be that they simply cannot afford to seek employment, pay insurance rates, and/or forego medical assistance they may be receiving by not being employed. More Medicaid-related information is needed regarding the size of this population, the percent now receiving some form of assistance, and the number eligible for employment. The problem in finding this information is that unless an individual is actively seeking employment, she/he is not recorded as "eligible." This may be the segment of the population most in need and underserviced.

One assumption made in the literature was that individuals who have been without health insurance would delay seeking medical treatment and, as a result would rate their overall health status lower than average, and would have a higher incidence of chronic health problems leading to a higher-than-average utilization rate once insurance coverage becomes available to them.

Self-reported data gathered on enrolled individuals found only 9% stating that they or a member of their family had any chronic health problems. The remaining 91% reported no such problems.

When asked for their perception of their own current state of health, 52.3% answered "excellent," 42.9% answered "good," while only 4.8% answered "fair." No one answered "poor." A longitudinal study of those who have accessed the health care system through the One-Third Share Plan needs to be done in order to determine the project's impact on their health status.

Information on utilization rates was not accessible at this writing. However, if there is a direct correlation between utilization and low percentages reporting chronic health problems and high percentages reporting good to excellent health status, the assumption would be that utilization rates for enrollees in the HCAP plan have been lower than predicted.

Budget

Data available from Year 1 shows 22.7% of the total premium dollars were spent on employee subsidies, and, in Year 2 (to date), that amount has increased to 28.3%. Overall, to date, 28.1% of total premium dollars expended under the One-Third Share Plan have been spent on employee subsidies. The 2-year total of $350,431.76 represents 4.2% of the total HCAP budget, which is below the 5% allocated the One-Third Share Plan. (See Attachment 10)

A cost-benefit analysis using budget data and costs associated with health care utilization rates needs to be done in order to gain a more complete understanding of whether the dollars allocated for this project were, in fact, well spent.

PART VI

CONCLUSION

The Health Care Access Project's One-Third Share Plan has been successful in helping accomplish the overall HCAP goals. While the operational funding has been extended through December, 1990, the provider premium rates are not fixed: increases of 12% occurred in 1989-90 and increases of 12-16% are expected for 1990-91. This additional expense may result in a number of current enrollees dropping coverage because they can no longer afford it, even if they only have to pay one-third of the already discounted rate. (See Attachment 11.)

The loss of administrative dollars will result in the One-Third Share Plan entering into a maintenance-only stage April 1, 1990. No new marketing will be done. In fact, given the experience of 1989 when extended funding was in question, even with administrative dollars, the program more than likely would have still entered a maintenance stage around the same time.

This again raises the question "What will happen to these businesses and employees after the program ends December 31, 1990?". What options are available?

Loss of the subsidy will undoubtedly have an adverse impact on some of the businesses now enrolled in the One-Third Share Plan. This, in combination with increasing premiums will result in some businesses dropping coverage altogether.

Although the option exists for businesses to enroll in the Flint Area Chamber of Commerce's group plan, these premium rates are still higher. And, most importantly, without the available employee subsidy, businesses still may not be able to afford coverage (employee contributions under the Chamber plan are negotiated between the employer and employee).

The average size of businesses enrolled in the HCAP plan is 4.84. Because commercial carriers and local HMOs will not provide coverage to those businesses employing fewer than 5 people, the option of seeking another carrier will not exist for some businesses.

Requirements for medical screening may disqualify a larger business because, if even one employee made a claim while covered under the One-Third Share Plan, that business may be labeled high risk with premiums reflecting this rating.

While this data has indicated that utilization of the health care system under this plan may not be as high as predicted, what happens to those who desire to plan families, or who have chronic problems which may require extensive and costly care in the future? It is ironic that the population first targeted by this program - the employed former welfare recipient - may, in fact, have only one option: leave employment and turn again to the state for health care assistance.

The issues raised in this paper are not unique to Genesee County. While projects like this are important to demonstrate that access to health care can be achieved through cooperative efforts, they raise an ethical question. Is it right to actively seek out and enroll participants, knowing that the project has an identified end point when coverage might be taken away?

This project has proven successful in increasing access to health care. However, without a mechanism in place for long-term tracking of those who have accessed the health care system, a definitive statement that improved access yields improved health status cannot be made.

We have seen that the main reason businesses do not offer health insurance is cost. This project has encouraged small businesses to offer an insurance plan by subsidizing the monthly premium, and requiring larger than usual co-payments

from those employees not eligible for subsidy. The impact on the retention of some of these employees when the project is completed has been discussed: chances are some of these businesses will drop their health care coverage, resulting in a loss of some employees. The dollars invested by the business in selecting and training these employees would be lost. In the case of having to replace that person, these dollars could be even doubled or more.

Not enough data is available to draw accurate conclusions on the impact of providing and then taking away access to health care. It is certain that future projects across the country will need to approach the problem of the employed uninsured from the standpoint of long term versus short term improved access to health care.

Further Issues

This study has shown that, while only 8.1% of the total businesses contacted actually enrolled in the One-Third Share Plan, nearly 93% of the total employees represented by these businesses feel having health insurance, whether purchased through this plan or some other, is an important priority for themselves and their dependents. Simply put, if it is accessible and reasonably affordable, employees will enroll in company-sponsored health insurance plans.

However, it is not so much whether employees will enroll in an employer's plan as it is whether or not the employer will even choose to offer a health insurance plan in the first place. Eighty percent of the businesses enrolled in the One-Third Share Plan cited cost as the number one factor for previously not offering health insurance to their employees. Unless action is taken, the growth of small businesses in the low paying service sector of the economy in combination with the spiraling costs of health care could result in a veritable health care caste system in this country.

Health insurance must be made more affordable and more accessible. If an employer does not offer an insurance package, an employee has two choices: buy their own insurance or go without.

Buying a policy is very cost prohibitive: the health insurance industry does not design its policy rating structure to be accessible to individual buyers, therefore, monthly premiums are much higher than those for groups. Even if an individual could afford to purchase a policy, it would take only one claim for monthly premiums to double, triple or more.

Workers choosing to go without health insurance run the risk of incurring huge, bankruptcy - inducing medical bills in the case of an emergency. Those choosing not to work can become eligible for government sponsored health care in the form of Medicaid. There exists no structure to permit partial government sponsored health care to workers. Therefore, there is that much less incentive for individuals with Medicaid coverage to seek employment.

The increased burden being placed on Medicaid is creating its own problems. Medicaid will not reimburse 100% of medical charges, and, as a result, many hospitals are not able to even cover the costs of some Medicaid-related procedures. Add to that the revenue limitations under the DRG reimbursement process and you see the bottom line of many hospitals turning from black to brighter and brighter shades of red. And what rewards to hospitals get for working their best within this system to contain their costs? At this writing, Medicaid is proposing to further reduce its reimbursement. Hospitals cannot be expected to provide care at a loss. It is likely that many smaller hospitals will close in the next decade, further reducing access to health care for that population currently in greatest need right now.

The cost of health care coverage must be more equally distributed. The current health insurance system is a penalty-based system that does not insure health, but assures the payment of some or all of health care costs. This system does not reward conservation of resources or containment of costs. It uses "experience rating" and "community rating" to justify its cost increases. Consumers would not sit idly by while other industries raised the cost of their goods and services by 20, 30, 40% or more each year. They would stop their purchases and seek lower-cost alternatives. However, there is no such thing as a "lower-cost alternative" in the health insurance industry, only what may be called "lower high-cost alternatives".

Some states have made legislative moves to reduce the cost of automobile insurance premiums. It may be only a matter of time before the same legislative moves are made on health care insurance premiums. What may be a better long-term solution, however, is the development of a state-wide community rating system, whereby a formula is developed taking the state's total health care usage experience into account. Politically, this solution presents challenges to those who represent rural areas that would no doubt realize a rate increase. It would also represent an opportunity for urban representatives to flex their legislative muscle to reduce rates for their constituents.

At the same time, it would behoove the consumer to begin to demand that the health insurance industry make some of the same changes the life insurance industry has made when it comes to rewarding healthy behaviors and lifestyles. It is common for life insurance companies to offer non-smoking or non-drinking rate discounts. With the mounting evidence supporting the notion that healthy behaviors result in lower health care costs, health insurance companies have an obligation to begin to reward healthy subscribers through discount and/or smaller annual rate increases. As well, from a public relations standpoint, it would make

sense for health insurance companies to offer payment assistance for lifestyle modification programs, thereby committing themselves to helping subscribers actually insure their good health.

Another issue that needs to be researched is giving more authority for health care decisions to other allied health practitioners. Why couldn't a nurse practitioner or a physician's assistant make many of the same diagnostic decisions a physician makes? Certainly the cost for these individuals to make these decisions would be much less than physician-made decisions. Many of the uninsured now use hospital emergency rooms, the highest cost point of entry in any hospital, as they would their family physician's office, if they had one. The insurance industry could be re-designed to reimburse outpatient clinics staffed by health practitioners given the autonomy to make non-urgent health care decisions, thereby creating a lower cost alternative for the treatment of both the uninsured and the insured.

Standing in the way of this alternative is the fact that advances in health care have created new levels of expectations on the part of the consumer. These higher expectations have done their part in also creating an unparalleled litigious climate, which, in turn, has resulted in higher malpractice insurance costs. Higher malpractice insurance costs have contributed to higher fees for service, which costs the health insurance companies more in claims payments, thereby contributing to the increased cost of health insurance coverage. It is a vicious circle, which, even if insurance companies work together to address, would still take a carefully crafted plan to convince the health care consumer that they are not being asked to lower their expectations by being seen in a clinic by health practitioners other than physicians.

There are no simple solutions to improving access to health care. Some have suggested government regulation, while others have promoted increased

competition. Some foresee a rationing of health care, while others see a future of socialized medicine. More than likely, the future will see a combination of legislative actions, cost containment efforts and consumer activism. The key to involving the consumer is getting those who now take for granted their employer provided health insurance to better understand the issues. The weight of this problem cannot be supported by the shoulders of the disenfranchised alone.

TABLE 1

Percentage Distribution of Firms Which Do Not Offer Health Plans, by Industry and Size

Industry	Employment Size of Firm								
	Total	1-9	10-24	25-99	100-499	500+	Less Than 100	100 or More	Less Than 500
Retail	43%	40%	3%	*	*	*	43%	*	43%
Services	17%	16%	*	1%	*	*	17%	*	17%
Construction	15%	14%	1%	*	*	*	15%	*	15%
Transportation	8%	8%	1%	*	*	*	8%	*	8%
Wholesale	6%	5%	1%	*	*	*	6%	*	6%
Manufacturing	6%	5%	1%	*	*	*	6%	*	6%
Finance	5%	4%	*	*	*	*	5%	*	5%
	100%	92%	7%	2%	*	*	100%	*	100%

Source: ICF analysis of SBA, Office of Advocacy, Health Benefits Data Base, 1986, in ICF Incorporated 1987. Promoting Health Insurance in the Workplace, AHA Action Planning Guide p.181

*Less than 0.5 percent.

TABLE 2

Percent of Firms Not Offering Coverage,
By Reason and Firm Size

Reason for Not Offering Coverage[a]	Employment Size of Firm						
	Total	1-9	10-24	25-99	100+[b]	Less Than 100	Less Than 500
Insufficient Profits	67%	68%	62%	54%	36%	67%	67%
Insurance Costs	62%	61%	70%	41%	68%	62%	62%
Turnover	19%	17%	31%	36%	83%	18%	19%
Group Coverage Not Available	16%	17%	3%	22%	0%	16%	16%
Lack of Interest	13%	13%	6%	5%	0%	13%	13%
Administrative Costs	9%	10%	2%	0%	51%	9%	9%
State Minimums	1%	1%	0%	0%	0%	1%	1%
Other	9%	8%	21%	5%	54%	9%	9%

[a]Responses sum to more than 100 percent because of multiple answers.
[b]Because virtually all firms with more than 500 employees offer health insurance, this size group has been combined with 100-499.

Source: U.S. Small Business Administration 1987.
Promoting Health Insurance in the Workplace, AHA Action Planning Guide, p. 177

TABLE 3

Percentage of Eligible Employees
Refusing Coverage, By Firm Size[a]

Employment Size of Firm	Percent of Eligible Employees Declining Coverage
1-9	14
10-24	13
25-99	11
100-499	10
500+	7
Less than 100	13
100 Or More	9
Less than 500	13
Average	13

[a] Includes only eligible employees in firms sponsoring health plans.

Source: ICF analysis of SBA, Office of Advocacy, Health Benefits Data Base, 1986, in ICF Incorporated 1987.
Promoting Health Insurance in the Workplace, AHA Planning Guide, p. 184

TABLE 4

Nonelderly Population and Population Without Health Insurance, by Family Type and Family Head's Employment Status, 1985

Family Type and Employment Status	Total (millions)	No Health Insurance (millions)	(percent of uninsured population)	(percent within category)
Total	199.8	34.8	100.0%	17.4%
Spouse present,				
no child present	40.2	5.1	14.7	12.7
full-year worker[a]	35.1	4.0	11.5	11.4
part-year worker[b]	1.6	0.3	0.9	18.8
nonworker	3.5	0.8	2.3	22.9
Spouse present,				
child present	95.6	12.1	34.8	12.7
full-year worker[a]	91.0	10.8	31.0	11.9
part-year worker[b]	2.3	0.7	2.0	30.4
nonworker	2.3	0.6	1.7	26.1
No spouse present,				
no child present	34.3	8.7	25.0	25.4
full-year worker[a]	27.7	6.2	17.8	22.4
part-year worker[b]	2.4	0.9	2.6	37.5
nonworker	4.2	1.6	4.6	38.1
No spouse present,				
child present	29.6	8.8	25.3	29.7
full-year worker[a]	18.0	5.9	17.0	32.8
part-year worker[b]	4.0	1.2	3.4	30.0
nonworker	7.6	1.7	4.9	22.4

[a]Includes steadily employed and sometime-unemployed workers that worked or sought work 35 weeks or more during the year.

[b]Includes all workers that worked or sought work fewer than 35 weeks during the year.

Source: EBRI tabulations of the March 1985 Current Population Survey, in EBRI 1987a. Promoting Health Insurance in the Workplace, AHA Planning Guide, p. 199

ATTACHMENT 1

code _____ (revised 6/14/88)

HCAP - INDIVIDUAL ENROLLMENT QUESTIONNAIRE

HCAP is a special project designed to increase access to health care by helping to pay the health insurance premiums for employees at some small businesses. Your answer to these questions will not affect your health care coverage under HCAP. Your employer and the health insurance company will not see this questionnaire. It is confidential and for research purposes only.

Your Social Security Number _____

1. Are you choosing to get health insurance coverage through HCAP? yes _____ no _____
2. If yes, please state the main reason for getting health insurance:
   - _____ security/peace of mind
   - _____ a family member needs medical attention
   - _____ the cost is low
   - _____ other (please explain) _____
3. If you are choosing <u>not</u> to participate, please state the main reason:
   - _____ The monthly premium is too high.
   - _____ The deductibles and copays are too high.
   - _____ I already have health insurance.
   - _____ I don't get sick.
   - _____ My doctor is not part of the plan.
   - _____ Other (please explain)_____
4. How many hours a week do you usually work at your job? _____ 5. What is your current job title? _____
6. For each member of your family, please indicate the date of birth, sex, and type of health coverage the family member has currently (before HCAP coverage begins)

	Date of Birth	Sex	Name Most Recent Health Coverage	Date Ended	Enrolling in HCAP?
employee					
spouse					
child					
child					
child					
child					

page two - individual questionnaire (revised 6/14/88)

7. If currently uninsured, where was the last place you received medical care? _____
8. Have you ever been refused care because you didn't have health insurance? _____
9. Have you ever delayed getting medical care because you didn't have insurance? _____
10. What is your average hourly income?_____
11. What was your annual household income last year?_____

The following questions about your health status are confidential. They will not affect your health care coverage. Neither your employer or the health insurance company will see this questionnaire. It will be used by the project for research purposes only.

12. Have you or any eligible dependent ever been unable to get health insurance due to a health problem? _____(yes or no)
13. Have you or any eligible dependent been hospitalized for any condition in the past year? _____(yes/no)

If yes, for each occurance, please list name of person hospitalized, the diagnosis, and the dates the person was in the hospital:

Name	Diagnosis	Dates Hospitalized

14. Have you or any eligible dependent ever been diagnosed or treated for:

_____Kidney disease
_____Heart disease
_____Lung condition
_____Mental or Nervous Conditions
_____Alcoholism or Drug Abuse
_____ Diabetes
_____ Cancer
_____ Hypertension
_____ AIDS

15. Do you or any eligible dependent have any disabilities or chronic health conditions? _____Yes _____No
If yes, please describe _____
16. Are you or any eligible dependent currently pregnant? Yes _____ No _____
17. How would you describe your own health?
_____Excellent ____ Good _____ Fair _____ Poor

Thank you for your cooperation. Please return this to:

Health Care Access Project
310 W. Oakley
Flint, Michigan 48503
(313) 257-3581

ATTACHMENT 2

(revised 6/14/88)

HEALTH CARE ACCESS PROJECT
GROUP ENROLLMENT QUESTIONNAIRE

HCAP is designed to provide affordable health insurance to small businesses. Please answer the following questions about your business.

1. Company Name_____Phone _____
2. Address _____City_____Zip_____
3. Contact person_____Chief Exec._____
4. Nature of Business_____SIC Code_____
5. Are your employees unionized? _____
6. How is full-time defined at your company?_____(hrs/wk)
7. How many of your employees have existing health coverage through a spouse or other source?_____
8. Number of employees enrolling in BCN_____
9. Number of employees enrolling in BC/BS_____
10. Number of employees enrolling in other type of health plan and name of health plan(s)_____
_____
11. What is the waiting period for new hires before they're eligible for health insurance? _____
12. What year did the firm start business _____
13. Has the firm offered health insurance in the previous 24 months?_____
14. If yes, to which group of employees do you offer health insurance and what plans are offered? _____
15. If you haven't offered health insurance, why not?
_____The cost is too high
_____Denial of medical coverage by health insurer
_____Lack of information
_____Other (please explain)_____
16. What is your reason for participating with HCAP?
_____Lower cost
_____Availability (absence of medical underwriting)
_____Competitive edge
_____Other (please explain) _____

see reverse side

page two -group enrollment questionnaire (6/14/88)

List the date of birth, sex, and hours worked per week for employees (full and part-time)

	DOB	Sex	Hours
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			

Thank you for your cooperation.

ATTACHMENT 3

Number of employed uninsured in Genesee County with household incomes below the poverty level.

Poverty Level Family of 3	Year	Employment All Sectors	Number of Employed Uninsured*	Employed Uninsured in Households Below Poverty Level*
$ 9,120.00	1986	180,000	75,000	16,000
$ 9,300.00	1987	169,600	70,553	15,239
$ 9,690.00	1988	162,200	67,475	14,574
$10,060.00	1989	168,600*	70,137	15,149
$10,560.00**	1990	169,000**	70,304	15,185

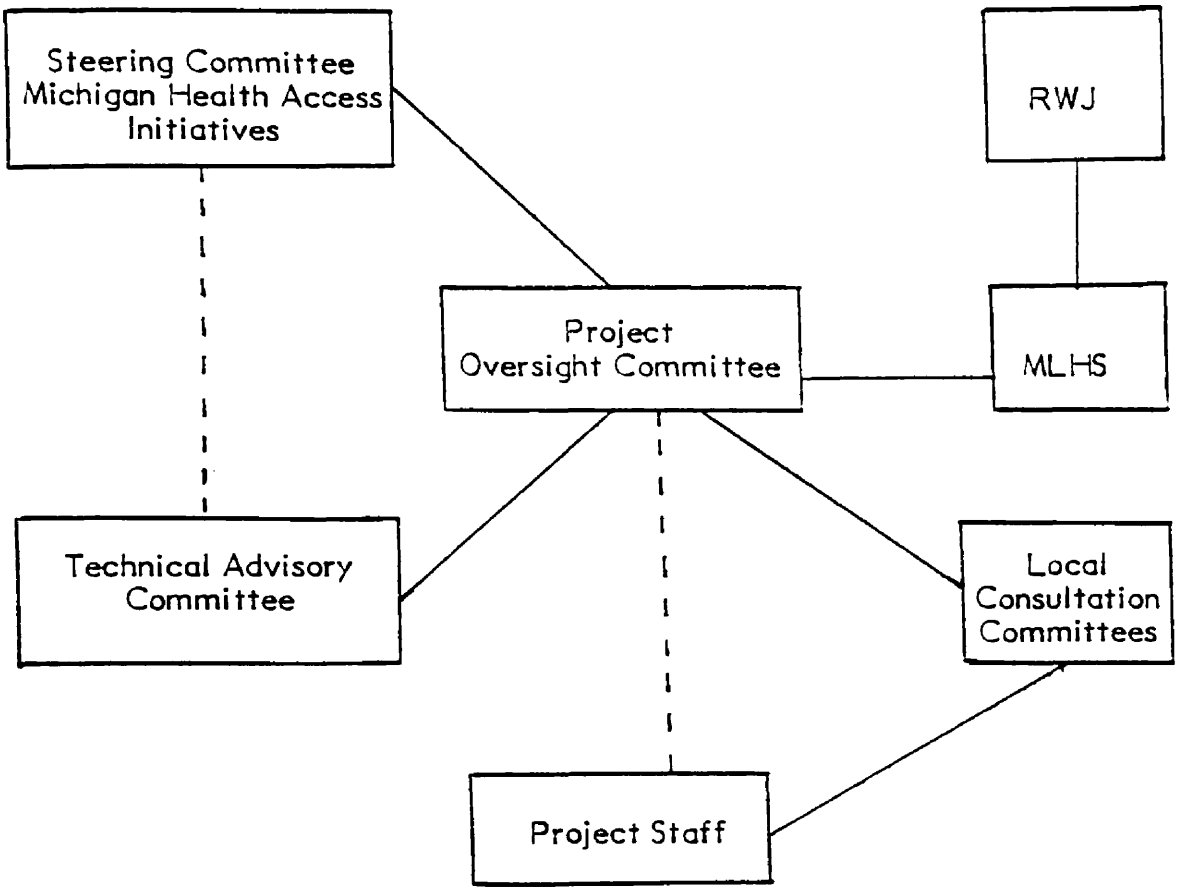
* Estimated
** Projected

Poverty level source: Michigan Department of Social Services

All sector employment source: Local Business Trends, Volume 2, Number 4, published December, 1989, by NBD Genesee Bank.

ATTACHMENT 4

PROJECT STRUCTURE



source: Application to The Robert Wood Johnson Foundation: Project Narrative.

ATTACHMENT 5

BLUE CARE NETWORK BENEFIT COMPARISON

DSS SHARE PLAN

All medical care MUST BE provided, arranged, or authorized by the member's Primary Care Physician. Copayments are the amounts the member must pay.

Health Benefit	BCN5 Low Option
Professional Services	
Office Visits	$5 copayment for office visit.
Maternity Care, including pre and post-natal visits, delivery, and other services	Delivery covered in full. $5 copayment for each pre & post-natal visit.
Pediatric Care, including well child visits	$5 copayment for office visit.
Doctor's Home Visits	$5 copayment for office visit.
Inpatient Professional Services, including services of Anesthesiologists, Radiologists, Pathologists, etc.	Covered in full.
Consultations-Inpatient	Covered in full.
Consultations-Outpatient	$5 copayment for office visit.
Surgery & Surg.Asst.-Inpatient	Covered in full.
Surgery & Surg.Asst.-Outpatient	$5 copayment for office visit.
Diagnostic & Therapeutic Services, including Lab. Pathology & Radiology	Covered in full.
Preventive Health Services	
Periodic Physical Exams and Health Assessments	$5 copayment for office visit.
Pediatric & Adult Immunizations	$5 copayment for office visit.
Nutritional Education, Counseling and Supervision	$5 copayment for office visit.
Vision & Hearing Screening	Covered with $5 copay per visit.
Health Education Counseling and Supervision	Covered *

* Some programs have nominal fees.

Health Benefit	BCN5 Low Option Page 2
Hospital Services	
Semi-private room and board, nursing service, use of operating rooms, etc.	Covered in full. Unlimited days.
Anesthesia	Covered in full.
Physical, Speech & Occupational Therapy	Covered in full.
Other Hospital & Ancillary Services	Covered in full.
Inpatient Mental Health Services	
Hospital Services	Up to 30 days per calender year.
Partial Hospitalization Program	Up to 60 days per Member. Two days for each unused day of phsychiatric hospitalization.
Outpatient Hospital Services	
Hospital & Ancillary Services	Covered in full including anti-cancer drugs and administration of outpatient chemotherapy.
Emergency Care	
In-Area	$10 copay in non-hospital urgent care center. $5 copay in BCN-EM physician's office. $25 copay in hospital emergency room.
Out-of-Area	Same as In-Area.
Ambulance	Covered in full for emergency ambulance services. Non-emergency ambulance must be authorized.
Reproductive Health Care & Family Planning Services	
Family Planning Services	$5 copayment for office visit.
Genetic Testing & Counseling	$5 copayment for office visit.
Adult Sterilizations	50% copayment for all associated charges.
Infertility Services	Covered with a 50% copayment for diagnostic workup, procedures, & treatment, limited to one sequence of workup & treatment per member per life.

Reproductive Health Care & Family Planning Services	
Voluntary First Trimester Terminations	50% copayment on all associated charges once per 24 months of continuous Membership.
Mental Health Services	
Outpatient Evaluation, Crisis Intervention, Short term Therapy	20 visits per Member per calendar year covered with 50% copayment per visit.
Substance Abuse Service	
Outpatient	20 visits per Member per calendar year covered with 50% copayment per visit.
Intermediate Treatment	Limited to 1 program every 24 month period - 50% copayment.
Detoxification (Short-term)	Covered in full.
Physical Therapy & Rehabilitation Services	
Short-Term Physical Therapy and Medical rehabilitation services including speech therapy	$5 copayment per visit, limited to 60 days per condition per year. Long-term therapy for chronic conditions not a benefit.
Skilled Nursing Facility	
Medically necessary care for general medical conditions	45 days. Covered in full. Custodial or domiciliary care not covered.
Prescription Drugs	
Any Participating Pharmacy	$3 copayment.
Prescriptive Contraceptive Devices & Drugs	$3 Copayment. Must be dispensed through BCN-EM dispensary.
Other Services	
Chemotherapy	Covered in full.
Blood	Covered in full.
Hemodialysis	Covered in full.
Durable Medical Equipment	Covered for rental or purchase with a 50% copayment.
Home Care	Covered $5 copayment each day.

Other Services	
Prosthetic & Orthotic Appliances	Covered with 50% copayment.
Pap Smears	$5 copayment for office visit.
Allergy Testing & Serum	Covered with 50% copayment.
Allergy Injections	$5 copayment per injection.
Miscellaneous	
Maternity Benefits	Immediate.
Newborn Dependent Coverage	Date of Birth.
19-25 Year Dependent Coverage	Available .
Sponsored Dependent Coverage	Available, extra charge.
Patient Grievance Procedure	Provided Locally.
Conversion Privilege	Provided.
Enrollment Outside HMO Service Area	Limited - requires completion of Waiver form.
Master Medical Deductible	None
Master Medical Copayment	None
Maximum Amount of Coverage	Unlimited

Please Note:

This summary is provided as a brief description of the Blue Care Network Plan. Detailed information, limitations & exclusions are contained in the Member Certificate and Riders.

ATTACHMENT 6

Referrals From DDS

	1988
July	20*
August	19
September	30
October	24
November	24
December	21

	1989
January	17
February	13
March	17
April	23
May	28
June	23
July	14
August	17
September	13

* While the effective date for former welfare recipient eligibility was September 1, 1987, no staff was available to administer the One-Third Share Plan until June, 1988. As a result, no record exists of the number of DSS referrals made from September 1, 1987 to June 30, 1988. (The One-Third Share Plan marketing representative indicates that number was "minimal".)

ATTACHMENT 7

Referrals Analysis

Following is a summary of marketing results to date. It includes all referrals received from September 1, 1987 to December 31, 1988.

Business Status		Number
Not Eligible		
Already offering insurance		281
No welfare recipient		21
Hires part-time, seasonal, or contractual workers, spouse plan		59
Out of area		53
Out of business		5
Unable to locate and Unknown		10
	Total	429
Regular Enrollment		
Declining health insurance		75
Enrolled		17
Potentials		19
	Total	111
Special Open Enrollment		
Declining health insurance		71
Enrolled		53
Potentials (Pending as of 12/15/88)		16
	Total	140
	Total Contacts	680

ATTACHMENT 8

Referral Analysis

Following is a summary of marketing results to date. It includes all referrals received from September 1, 1987 to November 30, 1989.

Business Status		Number
Not Eligible		
Already offering insurance		410
No welfare recipient		23
Hires part-time, seasonal, or contractual workers, spouse plan		67
Out of area		85
Out of business		6
Unable to locate and Unknown		26
	Total	617
Regular Enrollment		
Declining health insurance		151
Enrolled		24
Potentials		12
	Total	187
Special Open Enrollment		
Declining health insurance		36
Enrolled		50
Potentials		0
Dropped-out		4
	Total	138
1989 Open Enrollment		
Declining health insurance		11
Enrolled		6
Potentials		23
	Total	40
	Total Contacts	983

ATTACHMENT 9

Genesee County HCAP Enrolled Groups as of 12-1-89.

Type of Business	Number of Groups Enrolled
Adult Foster Care	1
Accounting Service	2
Auto Leasing	2
Auto Parts and Repair	6
Appliance Sales & Service	2
Attorney	3
Bakery	2
Bar	2
Beauty Shop	1
Business Consulting	4
Business Office Service	2
Building Contractors	5
Car Wash	1
Church	1
Commercial & Residential Carpet Cleaning	3
Convenient Food Store	3
Distributors	3
Equipment Sales & Service	2
Employment Service	1
Florist	1
Funeral Home	1
Gas & Oil Station	1
Insurance Agency	1
Lawn Cazre	1
Meat Processing	1
Medical	3
Manufacturing	2
NON-Group	1
Pet Service	1
Retail - Gift Store	1
Rehab - Drug Abuse Center	1
Rehab - Housing	1
Restaurant	3
Service to Handicap	3
Sign & Painting	2
Sport Shop	1
Schools, Private	3
	74

ATTACHMENT 10

Month/Year	Subsidies	Total Premium
October 1988	$ 1,106.79	$ 4,900.96
November 1988	1,090.34	4,771.73
December 1988	1,106.79	4,900.96
Subtotal 1988	**$ 3,303.92**	**$14,573.65**
January 1989	$ 7,614.51	$25,786.20
February 1989	7,981.76	27,282.86
March 1989	8,389.99	28,105.30
April 1989	8,467.75	28,470.79
May 1989	8,711.73	30,145.19
June 1989	8,719.37	31,669.06
July 1989	8,825.13	31,734.25
August 1989	8,929.82	32,578.83
September 1989	8,922.94	32,583.87
October 1989	9,234.48	33,662.28
November 1989	9,284.30	33,839.48
Subtotal 1989	**$95,081.74**	**$335,858.11**
GRAND TOTAL 1988/89	**$98,385.66**	**$350,431.76**

In the above data, "subsidies" refers to the number of dollars spent by the program to subsidize the premium rates for qualifying employees, those earning below 200% of poverty and receiving either a 1/3 or 2/3 subsidy.

"Total premium" includes this subsidy plus the 1/3 subsidy given to the business to offset their total premium rate.

ATTACHMENT 11

	1988/1989	1989/1990	Anticipated % Increase 1990-1991
Blue Care Network			
Single	$ 80.24	$ 91.18	+15%
Two-person	$183.96	$209.04	+15%
Family	$200.60	$227.95	+15%
Blue Cross/Blue Shield* (Chamber of Commerce)			
Single	$103.31	$118.06	+15-16%
Two-person	$237.16	$271.03	+15-16%
Family	$248.44	$283.93	+15-16%
Health Plus			
Single	Rates are negotiated and may vary due to type of plan enrichment employer desires. Increases are based on community rating.		
Two-person			
Family			
American Community			
Single	No flat-rate premiums. Rates are negotiated between company and business. Rates will depend or how much plan enrichment employer desires. Rates are competitive with other carriers.		
Two-person			
Family			
Employers Health Insurance			
Single	No flat-rate premiums. Rates are negotiated between each company and employer. Rates will depend on how much plan enrichment the employer desires. Rates are competitive with other carriers.		
Two-person			
Family			

* Same rates as the "traditional" BC/BS option. Difference being that businesses with fewer than 5 employees cannot enroll in "traditional" BC/BS plan, therefore, the Chamber program is attractive to those firms. Also, this group's rates are adjusted annually based on their own group utilization.

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