Launching the Healthy Michigan Plan — The First 100 Days

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The expansion of Medicaid to a greater number of low-income adults remains a controversial component of the Affordable Care Act (ACA). Since the Supreme Court ruling in June 2012 that deemed Medicaid expansion discretionary for individual states, 27 states and the District of Columbia have opted to offer coverage to adults with incomes up to 138% of the federal poverty level.[1] Michigan is one of five Republican-controlled states (along with Arizona, North Dakota, Ohio, and Pennsylvania) to expand Medicaid, and one of four states (along with Arkansas, Iowa, and Pennsylvania) that received a federal waiver to implement state-mandated modifications. Michigan's early experience with Medicaid expansion may provide useful insights as this new coverage option continues to be debated and implemented in other states.

Known as the Healthy Michigan Plan, Michigan's Medicaid expansion was approved by the state legislature and signed by Governor Rick Snyder in September 2013.[2] In late December, the federal Centers for Medicare and Medicaid Services approved the state's waiver application to incorporate cost sharing and Michigan Health Accounts (which resemble health savings accounts) for new Medicaid enrollees. The state also required new enrollees to schedule initial appointments with primary care providers and strongly encouraged them to complete a standardized health risk assessment. Whereas most other states that expanded Medicaid began accepting new enrollees on January 1, 2014, enrollment in the Healthy Michigan Plan began on April 1, which allowed for an extra 3 months to implement these state-mandated provisions.

It was projected that approximately 322,000 low-income adults 19 to 64 years of age would enroll in the Healthy Michigan Plan during 2014. On July 10, Governor Snyder announced that this figure had been reached during the first 100 days.[3] Several factors contributed to the relatively rapid early enrollment.

First, widespread media attention devoted to the problems with the new federal health insurance exchange, HealthCare.gov, and some state insurance exchanges provided persistent public reminders about the ACA's mandate that individuals obtain health insurance coverage. These problems underscored the need for state agencies throughout the country to develop and rigorously test their computer systems' ability to determine applicants' income eligibility and enroll them in Medicaid. In Michigan, certified application counselors and navigators could counsel income-eligible residents seeking assistance through HealthCare.gov to wait until April 1 to enroll in the Healthy Michigan Plan.

Officials in Michigan coordinated their efforts across three state departments (Community Health; Human Services; and Technology, Management, and Budget).[3] These state agencies developed a detailed checklist of major pieces to be put in place before enrollment could begin, including new computer systems to assess eligibility, methods of outreach to potential enrollees, amended contracts with Medicaid managed-care plans, and new communication tools for external groups involved in enrollment. In addition to laying out clear goals and deadlines, the checklist facilitated the transparent flow of information between internal and external stakeholders.

Second, state officials publicized the Healthy Michigan Plan to eligible residents through a decentralized approach, rather than the centralized hub-and-spoke framework used in other states.[4] A toolkit of brochures, advertisements, and social media posts about the program was distributed broadly through existing networks of organizations already working in local communities to drive outreach and enrollment, including the state's primary care and hospital associations, local public health departments, and a broad array of community groups.[5] Given the widely polarized public opinions about the ACA in Michigan and many other states, items in this toolkit described the Healthy Michigan Plan to potential enrollees as a state initiative for working-age adults rather than as a component of the ACA.

Third, as in other states,[4] the Department of Community Health in Michigan collaborated with an established contractor to provide a call-in center for potential applicants. The contractor also placed dedicated phones in sev-

Demographic Characteristics of Nonelderly Michigan Adults Enrolled in the Healthy Michigan Plan and Traditional Medicaid as of July 15, 2014.

Variable	Healthy Michigan Plan (N = 327,912)	Traditional Medicaid (N = 605,376)
	percent	
Age (yr)		
19–24	17.5	17.5
25–34	24.3	27.4
35–44	19.8	21.2
45–54	23.3	17.9
55–64	15.1	16.0
Sex		
Female	51.7	64.6
Male	48.3	35.4
Race or ethnic group		
White	57.5	57.3
Black	25.9	31.8
Hispanic	3.9	3.1
Other	2.7	2.0
Unknown	10.1	5.8
Income as % of federal poverty level		
0	41.7	26.5
1–24	2.7	1.9
25–49	4.0	3.9
50–74	11.4	1.2
75–99	12.9	0.3
100–133	16.1	0.3
>133	0	0.3
Not available	11.3	65.6
Region*		
Southeast	48.3	47.9
Southwest	20.1	21.5
East Central	13.6	13.5
Central	5.7	5.5
Northern Lower Peninsula	9.3	8.9
Upper Peninsula	3.0	2.7

* Regional groupings of Michigan counties are as listed at www.mcir.org/contact_regions.html.

eral Department of Human Services offices to connect applicants directly to a customer-service representative to facilitate enrollment. With very large numbers of calls, during many of which entire health risk assessments had to be completed, callers initially faced waiting times of up to 15 minutes. Efforts to reduce waiting times, including increasing staffing, were implemented rapidly, and the average waiting time was reduced to less than 3 minutes.

As of July 15, 2014, nearly 328,000 residents (3.3% of Michigan's population in 2013) from all 83 counties in the state had enrolled in the Healthy Michigan Plan. Enrollment figures ranged from 73 in rural Keweenaw County on Lake Superior (3.3% of the population) to 90,690 in Wayne County, which includes Detroit and nearby suburbs (5.1% of the population). More than 20% of new enrollees were transferred from existing categories of Medicaid coverage that provided limited benefits to programs for specific subgroups of adults, such as the Adult Benefit Waiver Program for those with incomes up to 35% of the federal poverty level.

The demographics of early enrollees in the Healthy Michigan Plan and those enrolled in the state's traditional Medicaid program are shown in the table. Despite very different eligibility criteria, these two groups are remarkably similar in their distributions across age groups, racial or ethnic groups, and geographic regions within the state. The Healthy Michigan Plan has enrolled larger proportions of men and of adults 45 to 54 years of age than traditional Medicaid has, but as in traditional Medicaid, more than 60% of enrollees are younger than 45. Only 16% of early enrollees have incomes above the federal poverty level; these enrollees will be subject to premium requirements that begin 6 months after enrollment, but they can reduce their contributions by completing health risk

assessments and agreeing to pursue healthy behaviors.[2] Early assessments suggest that the requirement to schedule a primary care appointment has begun to translate insurance coverage into improved access to care: 36% of people who enrolled in April or May had had an outpatient visit by the end of July.

Michigan must still address numerous policy questions, some of which may be relevant to other states that have expanded Medicaid or are considering doing so. What are the medical needs of early enrollees, and is the state's health care capacity sufficient to meet these needs? What is the value of health risk assessments for new enrollees and their primary care providers? What effects will cost sharing and Michigan Health Accounts have on the use of services by new enrollees? Although the federal government covers the full cost of Medicaid expansion through 2016, will state budget savings be achieved to offset the state's 5% share of expansion costs beginning in 2017 (or its 10% share after 2020)? Such savings were required by the Michigan legislature when it approved the Healthy Michigan Plan last year[2] and will probably be monitored by other states as well. Most important, what effects will Medicaid coverage have on the health and financial well-being of new enrollees who otherwise would delay or forgo needed medical care or face the full costs of care they receive?

An audio interview with Dr. Ayanian is available at NEJM.org

To answer such questions, states might consider forming multistate networks in collaboration with universities and other research organizations to assess the effects of expanding or not expanding Medicaid coverage for low-income adults. The findings of such evaluations will be crucial for guiding health care reform as policymakers, health care providers, and the public continue to weigh the benefits and costs of the ACA in the years ahead.

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