EMET
Expanding Publicly Subsidized Coverage for Low-Income Adults Expansion Model Evaluation Template* (Working Draft)

***This template is based on work by Dr. Elliot Wicks and the Economic and Social Research Group for the California HealthCare Foundation. You can reach the California HealthCare Foundation at: http://www.chcf.org/topics/healthinsurance/coverageexpansion/index.cfm?itemI**

Brief Summary of Expansion Model	This model has three distinct strategies for expanding publicly subsidized coverage for low-income adults. • Phased in expansion of Medicaid-eligible adults by incrementally increasing income limits to 200% of FPL. • Increase income disregards for Medicaid spend-down population as income limit for full coverage is increased to 200% of FPL. • Allow individuals with incomes over the income limit to "buy-in" to Medicaid with a monthly deductible based on income
I. Coverage **People Covered** **Portability of Coverage& Continuity of Care** **Benefits** **Quality of Care/Effect on Delivery System**	**People Covered -** This model increases access to federally-coverage for low-income families, persons with disabilities, and young adults 19-21 between 100-200% of FPL**.** **Portability of Coverage & Continuity of Care** – Individuals would have portability and remain covered as long as they remained within the income limits. Continuity of care is subject to availability of health plans in rural areas and availability of providers willing to take Medicaid. **Benefits** – The benefit package would be the same as the existing Medicaid benefit which includes the following. • Physician visits • Specialists • Lab and diagnostic testing • Prescription drugs and supplies • Inpatient and outpatient hospital services • Home help services • Nursing home* • Mental health • Durable medical equipment • Vision • Hearing • Physical and occupational therapy • Dental • Podiatry • Chiropractic

	*Most current nursing home residents with incomes below 200% are already receiving Medicaid. **Quality of Care/Effect on Delivery System** – • Quality of care under current Medicaid system varies and needs improvement • There is currently a shortage of fee-for-service providers and participating health plan providers due to low reimbursement rates which needs to be addressed in order for this model to be successful • Increasing enrollment and creating a larger pool may increase the number of health plans willing to participate in smaller, more rural counties.
II.Cost & Efficiency **Resource Cost** **Budgetary Cost** **Cost Containment** **Implementation & Administration**	**Resource & Budgetary Costs** • Since this model expands coverage, there would be increased spending on a broad range of medical goods and services. • There would also be an increase of State administrative costs to process applications and claims • There is also a need to increase the provider payment rates to attract and retain more providers. **Resource & Budgetary Savings** • Lower cost, early intervention prevents or reduces spending on higher cost care when health conditions deteriorate • Reduced mortality and disability • Increased productivity and reduced absenteeism for employed enrollees **Cost Containment** • Factors that promote cost containment – used of managed care, disease management, bargaining power of being a large purchaser of health care goods and services • Factors that inhibit cost containment – Medicaid is an entitlement, causing enrollment to increasing during difficult economic times and Federal law prohibits limits on certain services **Implementation & Administration** • This model uses the existing infrastructure and delivery systems
III. Fairness & Equity **Access to Coverage & Subsidies**	**Access to Coverage & Subsidies** • This model provides equities within low-income families by providing coverage to parents and children at the same income level • This model provides equity across adult Medicaid populations by expanding coverage to parents and young adults at the income

Financing of Costs **Sharing of Risks**	levels as the elderly and people with disabilities who are currently covered. • Does not provide equity for childless adults with no total or permanent disability as they are not a group that can be covered by Medicaid. **Financing of Costs** • This model requires increased public responsibility for subsidizing care to those with low-incomes. • Equity and fairness would depend on the specific taxes or funding mechanisms chosen. • Provides potential to achieve greater equity and fairness by reducing the burden of those with private insurance paying for the uninsured or exploring the option of taxing employers who do not cover their low-wage workers
IV. Choice & Autonomy **Consumer Choice of Providers & Health Plans** **Provider Autonomy** **Government Compulsion/Regulation**	**Consumer Choice of Providers & Health Plans** • Choice of health plans is limited in the UP and in some LP counties • Choice of providers within plans and within fee-for-services is limited • Higher reimbursement is necessary to attract more providers and increase choice **Provider Autonomy** • Same limits to financial autonomy as in private insurance. Providers must the reimbursement allowed • Same clinical autonomy as in other managed care arrangements **Government Compulsion/Regulation** • As a publicly financed program, there is a higher degree of government regulation than private insurance
V. Variations & Their Effects	Each option can be treated as variations if all strategies are not adopted.

VI. Key Tradeoffs Among Attributes **COVERAGE vs. COST** **BENEFIT vs. COST** **COST vs. CHOICE/AUTONOMY** **EQUITY vs. COST** **EQUITY vs. REQULTAION** **QUALITY vs. REGULATION**	**Coverage v. Cost** - Expansion of Medicaid inherently increases cost to the program because more people would be eligible. However, there may be some long term savings from having a healthier low income population and reducing cost shifting to private insurance and making safety net resources available to other low-income individuals. **Benefit v. Cost** – This model provides a broad benefit package based on the MDWG's goal of providing a comprehensive benefit package. In addition, the Medicaid program places controls on which services can be limited and/or reduced. **Cost v. Choice/Autonomy** – Low provider reimbursements limits choice of providers. Limitations of choice vary based on geographic location and types of services (e.g. specialists, dental, etc.) **Equity v. Cost** - Adopting all three strategies and phases will encourage the greatest equity, but the cost will be the most. **Equity v. Regulation** – Federal regulation ensures equitable treatment of enrollees **Quality v. Regulation** – As a publicly financed system, there are checks within the system to monitor for quality. Health plans monitor quality of care. State reviews claims for provider fraud. Recipients have right to administrative appeals/hearings should services be reduced or denied.
Dated Summary Opinion	