EMET
The County Health Plan Model: Expanding Basic Coverage for Low Income Adults
(Working Draft)

Brief Summary of Expansion Model	This model proposes to expand the number and percentage of low income adults who can get basic coverage through a network of county health plans that are financed using a mechanism that is cost neutral to the state. • The target population are uninsured adults age 19-64 with income under 200 percent of the federal poverty level • Financing is already in place to cover 20 percent of the target population • The expansion would bring basic coverage to a greater percentage of the target population. • The expansion is cost neutral to the state since the money used to pay for basic services consists of federal match generated by local funds
I. Coverage **People Covered** **Portability of Coverage& Continuity of Care** **Benefits**	**People Covered –** This model provides basic coverage to low-income adults age 19-64 who have income at or below 200 percent of poverty. The people covered include people in transition, young adults, people who do not qualify for other government programs and those who lose government sponsored coverage **Portability of Coverage and Continuity of Care -** Services are delivered via a network of county/community health plans that exist in 72 of Michigan's 83 counties One element of the expansion would be extend participation to all 83 counties. Another element would be to increase the number of people covered in the state. Reciprocity across county lines and programs is possible with expansion. **Benefits –** • ID card and member booklet describing covered service and exclusions • Assignment to primary care provider • Physician visits • Specialist visits • Laboratory, x-ray and other diagnostic testing • Prescription drugs and supplies • Coordination with Hospital Charity Care and Community Benefit Programs for hospital related services • Referral and linkages with other community resources including mental health and substance abuse • Assistance navigating health care system • Health appraisal and risk reduction services • Referral to other government/community sponsored services (e.g. family planning, BCCCP, smoking cessation, diabetes education, weight loss programs etc) • Some programs operate Small Employer models that cover hospital care

Quality of Care/Effect on Delivery System	• Case management and utilization review • Use of managed care principles promotes the idea of the right care at the right place at the right time • Health appraisal focusing on smoking cessation, weight loss and exercise increases the chance of reducing health burdens on the individual and society • The process of enrollment and issuance of an ID card and member materials promotes sense of belonging, membership and health security • Access to medicine results in treatment of diabetes, hypertension, depression and other conditions for which effective pharmacological remedies • Utilization review and case management identifies people who may be eligible for Medicaid or whose use of service falls outside of established parameters • The models foster appropriate use of services and normalize the health care experience of people who have low income and limited options
II. Cost & Efficiency	
Resource Cost	**Resource and Budgetary Cost –** Program is cost-neutral to state since funding comes from federal match generated by local funds. Disproportionate Share Hospital (DSH) mechanism is used to generate federal funds and return both local and federal funds to communities. Current financing • $38 million in local funds • $50 million in federal funds • Average Cost = $60 per member per month • Cost of Small Employer Subsidy models = $160-$200 pmpm Expansion funding • Additional DSH capacity • Additional local funds • Non DSH-source needed to cover the entire target population
Budgetary Cost	**Resource and Budgetary Savings –** • There are benefits to society resulting from the covered population having access to basic services and medicine • Some cost savings/shifting occurs when people have access to basic care (e.g. fewer ER visits and fewer preventable hospital stays)
Cost Containment	**Cost Containment –** • The approach is locally based and does not create an entitlement • Providers are generally reimbursed for covered services at levels slightly above the Medicaid rate.

	• Prescription drug use is controlled through use of a basic formulary
Implementation & Administration	• Programs use a small number of TPA's for "back room" functions. These include maintenance of enrollment rosters, formulary and pharmacy benefit management, case management, identification and control high cost users, etc.
III. Fairness & Equity	
Access to Coverage & Subsidies	**Access to Coverage and Subsidies** • Enrollment is generally limited to people who have income at or below 200 percent of the FPL • People eligible for the ABW program are often enrolled in CHP Basic programs because the ABW program is closed to new enrollees • The enrolled population in all CHP programs reflects national data showing that about half of the uninsured are without coverage for 24 months • Coverage could be more uniform under expansion
Financing of Costs	• This model is cost-neutral to the state since funding comes from federal match generated with local dollars • Programs are paid separately for managing the care of people covered under the ABW program • Funds are supplemented by local dollars, hospital community benefit contributions, member co-pays, premiums paid by employers, co-payments paid by enrollees, and through the efforts of community volunteers
Sharing of Risks	
IV. Choice & Autonomy	
Consumer Choice of Providers & Health Plans	• Choice of providers varies among programs. Some programs have large networks, while others place enrollees with providers one-by-one
Provider Autonomy	• Provider contracts resemble those of any managed care organization
Government Compulsion/Regulation	• There is no compulsion involved; regulation is limited to essential elements

V. Variations & Their Effects	• Since the cost of a Basic and Small Employer program are the same (approximately $60 pmpm) a desirable variation would be for projects to cover more people in Small Employer Subsidy programs • For this to happen, barriers to Small Employer Subsidy program growth need to be better understood • It is important to keep in mind national data showing that subsidizing the cost of employer coverage by one third will only induce 15 percent of firms that do not offer coverage into the market, and only reduce the number of uninsured people by 5 percent
VI. Key Tradeoffs among Attributes **Coverage vs Cost**	**Coverage vs Cost** • Most of the people covered under this model get very basic coverage. Use of managed care principles in the financing and delivery of care help contain cost and facilitate coordination with existing community resources • Few states can they cover 20 percent of the target group. An expansion could raise the percentage covered without use of additional state funds •
Benefit vs Cost	**Benefit vs Cost** • The programs use the funds to create coverage models for uninsured people that for the most part have the "look and feel" of insurance (and in some instances are insurance)
Cost vs Choice/Autonomy	• Low provider reimbursement limits choice of providers. Low benefit level requires that hospital charity care programs be used to cover inpatient and other non-covered services (except in Small Employer Subsidy Programs)
Equity vs Regulation	• The Department of Community Health Medicaid Program relationship with programs for services to ABW recipients provides state oversight and accountability for good performance, quality and efficiency