EMET
Expansion Model Evaluation Template*

***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?iteml

Brief Summary of Expansion Model	**This area serves to identify and describe the coverage expansion model being evaluated. It will include a brief summary of the basic model and any selected components, as well as a concise list of their advantages and disadvantages. Over time, the "Brief Summary of Expansion Model" in combination with the "Dated Summary Opinion" described below, will grow into an "Executive Summary". The "Executive Summary" will be used for management updates.**

A detailed analysis of the expansion model will emerge as results from research and deliberations are synthesized into the four "attribute sections" below. This analysis, together with the Executive Summary, will provide information necessary for scoring expansion models and will serve as the basis for issue briefs and meeting federal reporting requirements.

I. Coverage

The coverage attribute includes a number of related considerations; such as who is covered and which benefits are offered.

- **People Covered**
  - **How many people will be covered who previously were not?**
  - **Which particular populations will be newly covered and which will not? (For example, most needy vs. less needy)**
  - **Access to care (for example, language or culture differences, geographic distance, physical barriers for people with disabilities.**
- **Portability of Coverage& Continuity of Care**
  - **Portability of coverage (maintaining coverage as life circumstances change)**
  - **Continuity of care (maintaining relationships with health care providers over time.**
- **Benefits**
  - **Which services are covered and to what extent?**
  - **Consumer cost-sharing and other financial limits that could affect accessibility**
- **Quality of Care/Effect on Delivery System**
  - **Effect on quality of care (for example, medical outcomes and patient satisfaction)**
  - **Effect on the way physicians practice (for example, greater adherence to practice guidelines)**
  - **Whether the proposal promotes or discourages greater integration and coordination among parts of the delivery system (for example, between primary care providers and specialists)**

II.Cost & Efficiency

The cost/efficiency attribute includes characteristics such as which resources would be used by the model, what costs it would impose on government, how efficient the proposed system is, and what administrative burdens it carries.

Note the distinction between resource cost and budgetary cost. Some approaches (such as large-scale tax-credit approaches) would transfer a large portion of the financial obligation from the private sector to

government, increasing the budgetary cost significantly, but increasing the real resource cost by much less. Other approaches (such as employer mandates) may entail a relatively small increase in costs to the state but a large real resource cost because a significant number of people are newly insured.

- **Resource Cost**
  - **Resource cost considers the value of the new additional labor (for example, additional physician visits and nursing care) and medical technology resources that are consumed as a result of the coverage expansion. Note that coverage expansion may also produce some resource savings, for example fewer visits to the emergency room.**
- **Budgetary Cost**
  - **Budgetary cost considers the governmental costs associated with the expansion.**
  - **Balance between immediate and longer-run budget costs.**
  - **Whether the approach creates entitlements, making it difficult to estimate or control the future budget cost.**
  - **Balance between public and private sector costs.**
- **Cost Containment**
  - **Effect on keeping expenditures under control and ensuring sustainability**
  - **Ensuring that resources are used efficiently.**
  - **Whether the proposal's cost control methods would produce market distortions or inefficiencies**
- **Implementation & Administration**
  - **Ease of initial implementation, including degree of change from the status quo**
  - **Effect on ongoing administrative costs and complexities**
  - **Whether legal or regulatory changes would be required.**
  - **Effect on labor markets and employment levels and composition in affected business entities and government**
  - **Who has accountability for ensuring good performance for quality and efficiency (such as insurers and health plans, employers and government)?**

III.Fairness & Equity

The equity/fairness attribute encompasses who is eligible for coverage, how the financial burden is distributed, and how risks are shared. Horizontal equity refers to equal treatment of people whose circumstances (typically ability to pay) are similar. Vertical equity refers to fair treatment of people whose circumstances differ (typically in terms of income).

- **Access to Coverage & Subsidies**
  - **Effect on who are the "winners and losers": who is covered by government programs or eligible for subsidies, and who is not.**
  - **The horizontal equity principle requires equal subsidies for equally needy people, including those who already have coverage (though that may be more costly). The vertical equity principle requires that more needy people get larger subsidies.**
- **Financing of Costs**
  - **Who pays the bill for the subsidies and how the tax burden is distributed relative to income?**
  - **The principle of vertical equity requires that the burden of a payment be distributed according to ability to pay, while horizontal equity requires that people with equal incomes contribute essentially the same amount.**
- **Sharing of Risks**
  - **The extent to which premium costs are based on risk of needing health resources, which may range from people paying for coverage based on their own health status to all insured people paying the same rate (community rating" approach).**

IV. Choice & Autonomy

Issues under the choice/autonomy attribute include how choices are affected for patients and providers, and to what degree patients and providers are subject to rules and regulations regarding the use of various medical services, such as specialized physician visits and diagnostic tests.

- **Consumer Choice of Providers & Health Plans**
  - **Consumers' choices among providers and provider networks**
  - **Consumers' and employers' choices among health plans**
- **Provider Autonomy**
  - **Effect on the prices providers charge or the reimbursement they receive (economic autonomy)**
  - **Degree to which providers are able to practice medicine without outside constraints or control (clinical autonomy)**
- **Government Compulsion/Regulation**
  - **Degree of government interventions and control over consumers, employers, providers, or health plans**
  - **Whether individuals are mandated to obtain coverage; employers to pay for coverage; or health plans to participate in some purchasing arrangement**

V. Variations & Their Effects

In addition to the four key attributes described above, each discussion of the alternative models includes an exploration of potential variations and their effects. Changes to features of a coverage expansion proposal may have significant implications for coverage, cost and efficiency, fairness and equity, and choice and autonomy. Each "Variations and Their Effects" section provides examples of how central features of the model might be altered and briefly describes how those changes might affect attributes and tradeoffs.

VI. Key Tradeoffs Among Attributes

Designing a coverage expansion policy is essentially the process of making choices about trade-offs. If trade-offs were not necessary, getting agreement on an approach would be relatively easy because most people agree on what is desirable and undesirable, other things being equal.

Almost everyone would approve of a reform that covered all needy people, cost little, had comprehensive benefits, ensured high quality, treated everyone equitably, maximized choice and autonomy, and involved minimal government regulation or compulsion. But, of course, there is no such policy because many of these objectives conflict.

Listed below are some of the typical trade-offs that may affect the design of coverage expansion.

COVERAGE vs. COST	o **Covering more people increases real resource costs and budgetary costs.**
BENEFIT vs. COST	o **More comprehensive benefits normally add to total costs.**
COST vs. CHOICE/AUTONOMY	o **Controlling costs may reduce consumer choice and provider autonomy.**
EQUITY vs. COST	o **Equal subsidies for equally needy people (including those who already have coverage), is more costly than subsidizing only those not already covered.**

EQUITY vs. REQULTAION **QUALITY vs. REGULATION**	o **Universal coverage may require increased regulations for individuals, employers, and insurers.** o **Greater quality of health care services may require increased regulation for providers.**
Dated Summary Opinion	**This area contains a summary of the Workgroup's current opinion of this expansion model. It describes how well the model appears to meet the needs of Michigan's uninsured, it's expected level of acceptance and how well it would fit as a "building block" with other expansion models designed to reach additional uninsureds.**