"Developing Realistic Strategies and Viable Options to Provide Comprehensive and Affordable health Insurance Coverage for All Michigan Citizens"

Meeting Minutes

Meeting Name: Models Development Workgroup

Date & Time: Wednesday, November 9, 1-4pm

Location: AARP Michigan, 309 N. Washington Square, Ste 110, Lansing

Present: Ken Miller, Department of Community Health; Amy Upston, Calhoun County Department of Public Health; Ellen Rabinowitz, Washtenaw Health Plan; Dave Cluley, Michigan Association of Health Underwriters; Collen Sproul, Health Plus of Michigan; Christine Romcala; Lary Wells, Michigan League of Human Services; Nancy Lindman, Michigan 2-1-1; Rick Nowakowski, Wayne County Four Star; Eileen Ellis, Health Management Associates; Lonnie Barnett, Department of Community Health; John Freeman, SEIU; Andy Kruse, Genesys Health System; Jackie Doig, Center for Civil Justice; Margaret Meyers, Mercy Primary Care Center; Gary Petroni, SEMHA/CPH; Ellen Speckman-Randall, Department of Community Health; Greg Cline, Trinity Health; Jeff Fortenbacker, Access Health; Lynda Zeller, Kent Health Plan; Kim Hodge, Paraprofessional Healthcare Institute; Del Malloch, Jackson Health Plan Corp-3-share; Paul Duguay, Michigan Association of Health Plans; Michelle Munson-McCorry, Complete Compassionate Care; Susan Steinke, MQCCC; Jennifer Wood-Tayler; Hollis Turnham, Paraprofessional Healthcare Institute; Don VeCasey, Michigan Consumer Healthcare Coalition; Tameshia Bridges, Paraprofessional Healthcare Institute; Don McMahon, Department of Community Health, Tyffany Shadd-Coleman, BCBSM; Sheryl Lowe, BCBSM

On Conference Call: **N/A**

Action Item

Item	Responsible	Deadline
Please contact Angela Awrey for any administrative changes	All	Ongoing
The next Models Development meeting will be held on Tuesday, November 22nd.	All	
A presentation reviewing the EMETs will be given on December 5th to the Advisory Council. The PowerPoint presentations should be 10 minutes long and should not have more than 3 bullets per pages. Whenever possible, presentations should use existing data on uninsured.	All	December 5th

Minutes

Topic	Discussion	Conclusions
EMET Presentation	Basic Benefit/Specific Subpopulation Group	*Summary*: County Health Plans (CHP) have been around for quite some time. The Ingham Health Plan (IHP) represented a breakthrough in financing. The concept made it possible to use qualified local dollars to draw down Medicaid match from the government. The IHP then identified a hospital eligible for a special DSH (S-DSH) payment. This was the vehicle that returned money to the community.
Detailed Group Presentation of EMET	Basic Benefit/Specific Subpopulation Group	All CHP's are organized as non-profit corporations and have community boards. This model is being used by 26 County Plans in 74 counties. CHPs operate 3 types of coverage: Basic Coverage, Small Employer (3 share) and Volunteer Networks. *People Covered*: Low-income people who generally have income under 200% of FPL. *Portability and Continuity of Care*: CHPs operate in a county or multi-county region. The elements of the CHP include outreach, enrollment, eligibility determination, health assessment, assignment to PCP, untilization review and case management. *Benefits*: Primary care, speciality care, outpatient lab, x-ray, and prescription drugs. Outpatient and inpatient care are not covered unless they operate a small employer subsidy program. Volunteer models render episodic, primary and specialty care and use paid staff to provide other services. Case management and health education is provided under all models. *Quality of care/Effect on Delivery System*: Will promote managed care principles; use of health appraisals will reduce health burdens on individual and society; enrollment and issuance of ID card will promote sense of belonging. *Resource Costs*: Benefits society by providing access to depression, diabetes and hypertension medication. Other cost savings include fewer ER

Detailed Group Presentation of EMET	Basic Benefit/Specific Subpopulation Group	visits and preventable hospital stays. *Budgetary Cost*: S-DSH allocated to CHPs totals $49 million. Typical subsidy for Basic and Small Employer model is $60 per month. Total cost for Small Employer Model is $160-$200 per person per month. Upper limit of enrollment given current allocation is approximately 70,000 people. *Cost Containment*: Basic and Small Employer model generally reimburses providers at Medicaid rate. Some small employers use other payment schedules. Group expressed concern that this may restrict provider networks. *Implementation and Administration*: Most CHPs contract with a TPA for "back room" functions which include: Maintenance of enrollment rosters, formulary mgmt, pharmacy benefit mgmt, case mgmt and control of high cost users. MDCH provides a measure of accountability for good performance. *Access to Coverage and Subsidies*: Enrollment is limited to people with income at or below 200% of poverty. *Financing*: CHPs are financed through a special DSH (S-DSH) mechanism. Net financing is $49 million and requires transfer of qualified local funds to draw down a Medicaid match. *Consumer Choice*: Medicaid rates make it difficult to organized provider networks. Choices of providers vary among programs. *Key Tradeoffs*: Most people covered under CHP model rely on hospital charity of cover inpatient and non-covered hospital services. An argument can be made that CHPs add to the cost of uncompensated care by increasing procedures covered by charity policies. As an alternative to S-DSH payment some hospitals would prefer that the state increase the provider tax to draw down matching funds.

Detailed Group Presentation of EMET	**Universal Coverage**	*Coverage*: Everyone will receive coverage although the uninsured will be phased in first. There will be no means test and insurance ill not be related to employment. *Benefits*: Preimary and preventative care, defined pharmacy beneft, SA/MH Rx, dental, hospitalization, specific plans for targeted illness (ex. Diabetes) and care management. *Quality of Care/ Effect on Delivery*: Promote evidence-based medicine with incentives, use pay for performance and disease-based protocols. *Cost*: Anticpate greater cost initially, will lessen thereafter. Cost containment by negotiating Rx prices, evidence-based medicine, disease based protocols and less overhead (because fewer insurers). *Implementation*: Standardize all forms. Legislation to transfer other programs is needed. Possibly to expand Medicaid or 3-share before full implementation of Universal Coverage. *Fairness*: Fairness is increased because everyone will have access to insurance. Administrative cost is decreased for all. *Funding*: Reserves for present carries, not as necessary. Reserves would be used to expand coverage. Group expressed concerns that reserves would not be available to expand coverage. *Equity*: Everyone would have set benefits with ability to buy more. No loss of health insurance with job loss. *Consumer Choice*: Consumers given list of companies to choose from. May select any provider. *Tradeoffs*: End some programs to increase funds for health insurance, greater regulation of provider pricing. Employers lose "control" of health insurance. Health insurance no longer part of

Detailed Group Presentation of EMET	**Universal Coverage**	collective bargaining.