# Limited Multiple Payer-Universal Coverage Group

## 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** | MODEL<br><br>a. Limited Multiple payer –mandatory community benefit<br>b. Tiered model would have everyone covered with a basic package (which would be comprehensive for medically necessary services) and the ability to purchase further coverage if wanted. This purchase could be done either by the individual, a group, or an employer.<br>c. Integrate workman's compensation, uninsured motorists, auto accident insurance, including catastrophic, etc. into plan to maximize administrative efficiency.<br>d. Tax auto owners, providers, and employers at a rate lower than what they are currently paying for health care, workman's compensation, etc.. Make the tax expense-neutral for businesses. The tax assessment would be tiered—lower rate for smaller businesses. |
| **I. Coverage**<br><br>**People Covered**<br><br>**Portability of Coverage& Continuity of Care**<br><br>**Benefits**<br><br>**Quality of Care/Effect on Delivery System** | Coverage<br>a) Everyone Covered<br>b) Phasing in uninsured first<br>c) There would be no need factor<br>d) The insurance would be portable and have seamless continuity<br>e) Coverage would correspond to current Medicaid coverage<br>f) Those with Medicare would need less benefits<br><br>Quality of Care/Effect on Delivery system<br>i. Model would promote Evidenced Based Medicine<br>ii. Model would promote preventative services<br>iii. Pay for performance with improved information technology<br>iv. Disease Based protocols (Treatment pathways)<br>v. Patient incentives for healthy behaviors<br>vi. Incentivize providers to adopt electronic medical records in accordance with IOM recommendations<br>vii. Incentivize plans and providers to ensure geographic access<br>g. Establish a mechanism to measure cost savings because of quality control. |
| **II.Cost & Efficiency** | |

| | |
|---|---|
| **Resource Cost**<br><br>**Budgetary Cost**<br><br>**Cost Containment**<br><br>**Implementation & Administration** | a) Resource cost<br>i) Do anticipate an initial cost increase<br>(1) Stretching of provider pool with increased number of people seeking care<br>(2) Initial quantity of services and costs will increase temporarily due to the uninsured neglecting care<br>b) Cost containment<br>(1) Re-insurance not needed because of size of pool<br>(2) Disease based protocols<br>(3) Evidence based medicine<br>(4) Negotiating of drug costs<br>(5) Decreased administration secondary to not vying over what type of claim it is<br>(6) Reduced administrative costs by standardization of benefit package<br>(7) Standardize insurance forms<br>(8) Standardize billing<br>c) Implementation and administration<br>**(1)** Begin collecting medical premiums from Workman's Comp, PIP, etc..<br>**(2)** Decrease overall number of health plans in Michigan through having health plans contract with the State through a bidding process as in Medicaid.<br>**(3)** Administration streamlined by standardizing forms and billing across plans. In addition, plans are incentivized to streamline administration by virtue of their capitation. While the plans would be capitated (receive a given number of dollars per lives covered), the plan could choose how they reimburse providers (capitation vs. fee-for-service). |
| **III. Fairness & Equity**<br><br>**Access to Coverage & Subsidies**<br><br>**Financing of Costs**<br><br>**Sharing of Risks** | 1. Employer contribution (?tax) enabled by decreasing their other expenses (i.e. workman's comp). All employers would contribute.<br>2. Workman's comp, Auto insurance, etc. premiums utilized to provide care<br>3. Decreasing administration (i.e. forms, standardized benefits)<br>4. Decreasing cost through care management<br>5. Decreasing cost by increasing primary care access<br>6. ?Pool of state funding currently used for insurer of last resort<br>7. ?Funding from VA |
| **IV. Choice & Autonomy**<br><br>**Consumer Choice of Providers & Health Plans**<br><br>**Provider Autonomy**<br><br>**Government Compulsion/Regulation** | *Consumer would have limited choice as to health care plans, but would have large autonomy in choosing a primary care provider*<br><br>*There would be provider autonomy. Providers would be incentivized to utilize evidence-based medicine and diagnosis based protocols* |

| | |
|---|---|
| | |
| **V. Variations & Their Effects** | |
| **VI. Key Tradeoffs Among Attributes**<br><br>**COVERAGE vs. COST**<br><br>**BENEFIT vs. COST**<br><br>**COST vs. CHOICE/AUTONOMY**<br><br>**EQUITY vs. COST**<br><br>**EQUITY vs. REQULTAION**<br><br>**QUALITY vs. REGULATION** | *Coverage vs. Cost*<br>*Full coverage, cost minimal to individual, funding through sources as above*<br><br>*Benefit vs. Cost*<br>*Benefit would be for everyone, cost set off as above*<br><br>*Cost vs. Choice/Autonomy*<br>*This plan does give up some autonomy in choosing health plan for decreased cost. There will still be a lot of autonomy in choosing a primary care provider*<br>*Providers would have autonomy but would be incentivized to utilize evidence-based medicine and disease-based protocols.*<br><br>*Equity vs. Cost*<br>*This plan will give good equity. All are covered and coverage is not dependent on employment. Coverage would be the same for everyone.*<br>*Cost is spread out evenly by utilizing payroll and auto ownership as basis for revenue generation*<br><br>*Equity vs. Regulation*<br>*There would be some increased regulation. Equity would be improved.*<br>*Greater regulation of provider charges*<br>*Greater regulation of pharmaceutical pricing*<br><br>*Quality vs. Regulation*<br>*Providers would be incentivized to provide increased quality of care* |
| **Dated Summary Opinion** | |