COMMUNITY MULTI-SHARE COVERAGE vs. SUBSIDIZED THREE-SHARE INSURANCE

There are several key differences between community Multi-Share programs and subsidized three-share insurance products that directly impact the finance and health outcomes.

1. Setting the eligibility criteria
    - Insurance models set eligibility criteria based on risk related actuarial data. Managing financial risk exposure is paramount to insurance business processes.
        i. Eligibility criteria often mitigates against unhealthy members
        ii. A stringent adverse eligibility criteria makes it difficult to enroll sufficient membership from the uninsured small group market to financially sustain a plan.

    - Community programs have more flexibility in balancing risk with community benefit
        i. They have less risk exposure due to collaborative agreements that share risk and integrate safety net resources to spread risks.
        ii. With less risk, these plans can be more open to unhealthy members and thereby enroll greater numbers to sustain the program financially.

2. Design of the Plan's Benefits
    - Insurance plan benefits are designed in large part by:
        i. Government mandates and,
        ii. Market forces (what the customer can afford at rates providers will accept.)

    - Community programs are not generally subject to mandates and the providers typically understand that these programs take the place of uninsured patients who are otherwise "slow pays or no pays."

    - Benefits of multi-shares are limited, but have the flexibility to dovetail with safety net programs to extend coverage in ways that insurance cannot.

3. The integration of safety net services
    - Insurance must operated separate from public safety net programs
    - Multi-shares are like community co-ops and therefore they can merge with safety net programs to provide adequate health coverage to uninsured working people.
        i. Examples: Screenings, immunizations, smoking cessation etc.
    - Medicaid can serve as a "Stop Loss" program to multi-shares
        i. Example: Michigan Medicaid agreements for pregnancy coverage
    - Insurance has to limit risk exposure since they do not qualify for access to public services.

4. Engaging Providers in the Medical Direction of the Program
    - Insurance does not typically engage a community's providers directly in the management of their product. Providers are more like vendors to insurance.
    - Community multi-share programs depend on a high degree of participation by the provider community
        i. Designing the plan's benefit

ii. Board representation
iii. Policy oversight through the Medical Committee

5. Engaging Business Owners
   - Insurance never engages small business owners in the management of their product
   - Community multi-share programs recruit small businesses
     i. Board representation
     ii. Finance Committee leadership
     iii. Marketing via word of mouth

6. The Community as a Stakeholder
   - Insurance companies are national businesses whose stakeholders are their shareholders – not any particular community.
   - Community multi-share health programs only have local shareholders
     i. They are not stockholder commodities
     ii. They are collaborations of families in the community workplaces
     iii. They engage local elected officials
     iv. They engage local media
     v. They strengthen the local health care safety net

LESSON LEARNED IN MUSKEGON:

The easier path to administer a lower cost program is through a subsidized insurance product. That path is subject to the same problems driving up cost in non-subsidized programs and can expect to see annual rate increases for premiums.

Given the limits to public and community dollars to support subsidy payments, annual rate increases might not be a sustainable option. Certainly, significant cost increases for the small business community is not a marketable option.

Community multi-share models are more difficult to implement and require more commitment to administer, but they can get the job done better.