ACCESS HEALTH PLAN:

The "We Can" Story

WE CAN

The **"REAL"** Affordable Health Plan

"One community's response to the uninsured worker"

Story told by: Cheryl Schneider

In 1999 the country struggled with the ongoing increases in health care costs. Muskegon County met that challenge. The "We Can Story" of the Access Health Plan. We can keep it affordable. We can get small employers to invest in worker health. We can empower people to invest in their health.

The Access Health Plan

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2:
THE JOURNEY BEGINS

This is the story of the Health Care Journey one community made to address an area that at the national level, politicians, government agencies and think tanks have been struggling to solve. This is the story of one community's answer to offering affordable health care to the working uninsured. I was privileged to be one of those who had fifteen years of this journey. This is my story.

I will attempt to take you through the story from the beginning, when a group of invested community leaders gathered together to solve a problem to when Access Health Plan ended after fifteen years of challenges and successes.

Let me describe the community. It is a fairly typical mid-western community in western Michigan. The community has natural resources which are inviting for visitors and to attract residents. There are blue and white collar workers, a mix of nationalities and cultures and ages; as I said a typical mid-western community.

The idea of Access Health Plan began with community leaders in 1997. This committee identified what was needed to develop Access Health Plan and make it a reality. The first step once they identified the basics was to contact traditional insurance companies. None of the insurance companies were interested in the terms; so the committee moved forward with the community developing its own unique health plan to meet the needs of its working uninsured residents.

This is an excerpt from an article written by a research group out of Washington, D.C. signifying those beginnings.

"• *The pilot project aimed to provide coverage and easy access to primary preventive services with a minimal co-payment.*

• *It was imperative that each patient have a designated primary care physician.*

• *The target premium rate would be well below existing private insurance rates."*

"To achieve these goals, the chair initiated organizational changes, primarily by creating smaller work groups comprised of individuals with similar interests and expertise, and by assigning each a very specific task. With strategic insight, a physician's advisory subcommittee was convened to review health protocols, select evaluation benchmarks and a screening tool, help design the benefit package, and most significantly, tackle the critical questions surrounding provider payment and provider participation. The leader of this subcommittee performed a highly significant role, aided in no small part by the fact that she had accumulated a great deal of local experience working with the local physician networks and hospital systems.

By late February, the work group divided into three subgroups each assigned a central issue area: employers, members, and providers. These smaller, more homogeneous groups proved to be quite productive. They functioned as expert

crucibles in which important details were identified and debated, and from which recommendations were developed and presented to the larger work group."

Planning ahead, the work group considered program evaluation issues. As noted previously, it was generally assumed that Access Health Plan would last for approximately three years. The stated goal was to positively affect the health status of enrollees. Members designed a project that would measure provider and patient satisfaction, track health screenings, track Web site use, monitor costs, and collect measures of access and quality. The work group believed that an important long-term result of the pilot "is to develop a model that can be replicated in other communities." (End of excerpt).

A name was given to Access Health Plan and an Executive Director hired in July 1999. The Executive Director remained with Access Health Plan the entire 15 years. Access Health Plan went well beyond the 3 years expected. The Executive Director has experience in administration and management and a Master's Degree in Psychology which proved invaluable as relationships was a key component of Access Health Plan.

I first became aware of Access Health Plan when the newly hired Executive Director contacted me and invited me to lunch. I had previously been a part of his management team in another organization. He asked me "how was I and did I like my current job". I was honest and responded I did not feel challenged enough, not like when I had when we had worked together in the previous organization. His response was …" let me tell you about what I am now doing and…"

One step followed another and after interviews I was hired as the Health Care Administrator/Case Manager for this newly formed (without members) health plan. I began my journey on September 7, 1999. Why do I remember this date so well? I will tell you. Labor Day was September 6 on a Monday. I decided I would color my hair to start my new job the next day. I purchased a new "red" hair color product and proceeded to put it on my hair. My hair turned a brighter than pumpkin orange, a very Halloween like color. Yikes, I can't start my new position looking like a "clown" so I proceeded to return to the store and purchased a color that I thought would tone down the "orange". This made it worse. It is now one o'clock in the morning. I thought about putting on a hat, maybe a scarf to cover it. "That's what I will do, it will be ok." At 3 am after agonizing I got up went to the all night store and purchased a third hair color, a dark brown. This proceeded to tone the color to more of a reddish color which was workable. Needless to say 3 hair colors in less than 24 hours is not good for the hair and fried the ends. It took several weeks and many hair trims to get it back to health. The experience stayed with me and from that moment on I have left the hair coloring to the professionals. I started my new position on schedule and no one was the wiser.

This is a point to tell you of my background and perhaps why I was hired for the position. I graduated nursing school in 1969. I have worked in all departments of a

hospital. I had a position whereby I set up ICU/CCU (Intensive Care and Coronary Care Units) in rural hospitals in Nebraska. I had worked as a third shift hospital nursing supervisor. I was a crisis team leader at an adolescent psychiatric long term hospital. I was Director of Nursing in a 150 bed nursing home and Director of Nursing for a home care agency. I held positions in public health, prison psychiatric and federal prison infirmary. I was a Clinical Coordinator for an inpatient adult psychiatric unit. I was Neonatal Intensive Care Nurse and a member of a team that established one of the first programs whereby infants on life support could be provided care in the home in Minnesota. I was also a Certified Psychiatric Mental Health Nurse with a degree in psychology. In short, a well-rounded experienced nurse. I also had other experiences (I had for most of my years worked a part-time job in non-medical positions). I had been a truck dispatcher, PBX operator (think of Lily Tomlin at the switchboard), bookkeeper and a bartender to name a few.

I remember thinking about the risk I was taking when informed there were no guarantees this would last. There were those in the community and the health payer world that was sure it would fail. I took the risk in part because of the trust I had in the Executive Director and because challenges have always been a drawing card for me. As you will note the risk paid off and without a doubt I was continually challenged throughout the fifteen years and continue to be with the new plan under the ACA (Affordable Care Act). I would say one of the best, if not the best decision I have made throughout my 40 plus years as a nurse was to accept the position with Access Health Plan.

I became involved in Access Health Plan when Jeff Fortenbacher, the Executive Director, called and invited me to lunch.

I did in discussion mention that at my current position I did not feel challenged. The next call was to offer me the position as Case Manager/Health Care Administrator providing I was approved by the chair of the task force. One of the areas I remember from that interview was that this was a 3 year pilot and after that there were no guarantees of continued employment.

I was excited at the opportunity of developing and shaping the case management arm of the new 'three-share' community health plan called Access Health Plan and at the same time anxious about taking a risk.

In the beginning there was 2 full time staff, Jeff Fortenbacher as Executive Director and myself as Case Manager/Health Care Administrator.

I want to take a few minutes of your reading to introduce you to Jeff and myself.

Jeff and I have a professional history. He was the Clinical Director for an outpatient mental health agency. At that time I was the Clinical Coordinator at a hospital inpatient psychiatric unit. I worked 12 hour shifts so had several days off in 2 weeks. I was approached to work relief as the nurse doing medication reviews with the clients at the outpatient center, as well as conducting didactic groups.

The second association was as his Director of Nursing for a Medicare certified home health care agency.

We specialized in psychiatric patients who were medically compromised. Jeff was the Administrator.

Our motto to the physicians was "Give me your most difficult patients". We were very good at providing home care services with those with both mental health and physical conditions.

The agency was later sold, I moved on to Public Health, Jeff went to work at his family business until we once again became a professional team with Access Health Plan.

Jeff had an MA in Psych and I had my RN, BS in Psych and a certified Psychiatric Mental Health Nurse.

With our backgrounds it became a no brainer that member investment in their health and preventative care had to be a component of Access Health Plan. We could not be a traditional insurance plan or HMO and merely pay for "sick care".

Before we could enroll employee members, we needed the buy in of small employers. Initially we had no criteria of a business needing W2 employees and enrolled "sole props". A sole prop is an individual that works for themselves. They have a business but no W2 employees. Some of these were husband and wife family businesses.

The other area that made Access Health Plan unique was that part time employees (a minimum of 15.5 hours per week) were also eligible. We had some employers that the management and/or full time staff had traditional insurance and part time staff was offered Access Health Plan.

We also needed to not be in competition with local insurance agents so an employer could not drop their existing traditional insurance to offer Access Health Plan. The employer needed to not have offered health insurance to their employees for 12 months previous to be eligible to be an Access Health Plan employer member.

In the beginning we had group information meetings in the community. We had presentations at the library, at a theatre building and other venues. We also did some door to door outreach. Jeff went to store front business south and I went north. We merely introduced ourselves and asked the question "does your employer offer you health insurance". If the answer was no and the manager or owner was not available we left a packet of information.

THE MEAT OF THE HEALTH PLAN

Access Health Plan needed to be affordable but at the same time provide comprehensive health coverage.

Access Health Plan was known as a "3-share plan"; a third paid by the employer, a third by the employee and a third was community contribution. These contributions were from providers and community agencies that provided some type of health services or products. These agencies needed to be "not-for-profit"

Access Health Plan provided PCP services with a $10 co pay. Specialty Services for a $20 co pay. Outpatient and inpatient services had a 25 % with a maximum of $300 co pay.

Other services of therapies, durable medical equipment, home health care and hospice were covered benefits as well.

It was important to minimize as many barriers to care as we could; therefore, we had no deductible. We also had no co pays for laboratory tests. The intent was to afford the opportunity for members to have preventative labs, diagnostic labs and monitoring medication labs without out of pocket costs.

This was a community health plan and not traditional insurance so all services needed to be provided in Muskegon County. It was estimated that 98% of health services were available in the county.

We had 3 hospitals and one or the other provided, open heart surgery, cancer care services and most other medical and surgical services. There were very few services not available. Those not available in the county were burn units, organ transplants and neonatal intensive care. The majority of our members however met eligibility for other safety net financial assistance when those needs arose.

Access Health Plan did not have a formulary (list of covered medications). We allowed the members to set their own formulary. There was a $5.00 co pay for generic medications and a 45% co pay for brand name medications. The member would determine if they wanted to pay the higher costs for their medications. We did develop a formulary 9 years later.

In the initial Access Health Plan there was one option offered. In later years we would offer two options.

In the beginning we had no prior authorizations requirements. Our expectation was the health services community would be the gatekeeper and we would trust that there would be no duplication of services and the appropriate services at the appropriate time at the appropriate place would be followed. We would later identify this was not cost effective. We also had no reviews of emergency service and paid all emergency service claims no matter how trivial.

There were many changes that we made in later years but two remained constant. One was all members completed a health risk assessment. The second there will be a face to face new member meeting (group or individual) for all members. These meetings continued for the entire fifteen year life of Access Health Plan. Initially the meetings were out at the employer site and group meetings at the MCHP building.
Later when we had our own building, the meetings were there as well as at the employer site.

Case Management Is….

One of the responsibilities, besides outreach and member meetings was meeting with those members who were higher risk and higher needs. The first tool was the general HRA (Health Risk Assessment) that all members completed. Those that were flagged based on comorbidities were then contacted and a more extensive 5 (five) page HRA was completed. Added support and limited education was given to those with diabetes, heart disease and asthma/COPD. Some coordination occurred with those being discharged from the hospital. There was still a significant number that

were admitted to the hospital, discharged without notification. The hospitalization identification came later when claims were received.

Another role was screening claims payment. My office (cubicle) had stacks of EOB's (evidence of benefit) that needed screening review before payment. The piles were sorted by "not a provider"; "covered… ok to pay"; not a covered benefit"; "service out of the county" and "motor vehicle accident or work related injury".

Mind you, this was before the changes in HIPAA—one entire suitcase on vacation trips was filled with EOB's (evidence of benefit) that I sorted and reviewed while on vacation. Sounds crazy don't you think? Now all my suitcases have clothes, no claims or EOB's.

For the first several months case management was limited, it would morph into additional responsibilities in 2001.

Member Services…

There was not a member services department. Both Jeff and I acted as member services. We did for a short time, less than 3 months hire a contract staff (she had moved from California) for member services. She left primarily because we did not offer the kind of benefits she was seeking. At that time we offered no health coverage (both Jeff and I were covered by our spouse's employers insurance). Benefits were primarily vacation and PTO, little else.

3:
INTRODUCTIONS

Writing this book was not on my "bucket list". Writing a book, however; was on my mind off and on throughout the years and more than one person has said to me "you ought to write a book." I made the decision to take the course "Launch Your Dream Book" through the "Institute of Integrative Nutrition" (IIN). IIN is the same institute that I graduated in November 2014 from the year long program to become a Certified Health Coach. This six month program involved writing a book as part of the coursework.

It was at this point that I decided to write the "Community Health Plan" story. I did not have a title until later but I knew there was a story to tell about this unique community health plan, how we grew and evolved over the past fifteen years. The advice from the instructors ,Joshua Rosenthal and Lindsey Smith, was to write what you know. I know the Community Health Plan, which will, henceforth, be referenced as "Access Health Plan". This has been a significant part of my life for the past fifteen years and continues to be with the new Plan under the ACA (Affordable Care Act). I am passionate and believed strongly in our vision and mission. I had put together a power point of our journey for our tenth anniversary so I already had the outline. This is the story of how a relatively small community (county population of 172,000) came together to develop a bona fide "affordable health coverage plan, "the 'real' affordable" health plan for the working uninsured. You will come to understand the processes developed and redeveloped to meet the changing needs of our members and community. You will be introduced to some of the staff, not by name but by skills and experience. I will also introduce some of the community volunteers that were responsible collectively for the success of Access Health Plan. There were times that programs were developed coming from the committees and task forces within the community. I want to give a special thanks to two people. One to the Executive Director, Jeff for bringing me with him for what has proven to be an incredible opportunity. The second to a fellow colleague who was my "accountability partner". Since this book was written after hours in my home she would prompt me "are you writing in your book? How many pages did you do? "when I came in to work in the mornings. You will learn more of people instrumental to Access Health Plan in the section of acknowledgements. Because I have been cautioned not to, I will not use specific names.

I am proud of the community and proud of the health plan and what we have accomplished and the benefit and service that has been provided to the working uninsured in the community I live.

I was requested by others, not to use the first and last names of any of the staff or community supporters even though I had their written permission. It is my belief that using initials instead of names of people who were instrumental in the success of

this plan diminishes their contribution. What comes to mind is a phrase I learned years ago that seems apropos: "Mine is not to reason why, mine is but to do and die".

So the cryptic nature of this book is the doing but make no mistake not by choice.

When Access Health Plan ended on September 30, 2014 after fifteen years, it was not without mixed emotions. I was saddened that we could not continue Access Health Plan that we had developed, nurtured and grown throughout the years. I was excited that on October 1, 2014 we would launch the new Plan. This new plan met the minimal essential coverage (M.E.C.) criteria under the Affordable Care Act (ACA). This meant our members would not be subject to the individual mandate penalty imposed through IRS.

I was proud that this new plan (C3 Health Plan) was the only (to date) community health plan (not insurance, Medicaid or Medicare) in the United States approved as meeting the standards. I was also proud what our community had developed, supported and allowed Access Health Plan to grow to enable us to meet the challenge. I was both excited and anxious. Excited for the future of the "new plan" and what it would mean to our community; anxious, with the changes of the new plan. Would we be able to sustain Access Health Plan? Would we lose some long term business partner members and employee members due to the changes?

A journal publication from 2003 recounted the early beginnings of our community health plan. The article describes the state of health insurance at the time when an estimated 8% of the community's residents were without health insurance. A community survey at the time reported that 17,000 children and adults in families earning less than $11.50 an hour were without health insurance. For the most part, these uninsured residents were working families employed in small businesses. These employees earned too much pay to be eligible for public assistance through programs like Medicaid, and their small business employers were unable to afford the cost of commercial coverage to offer their employees.

In the article, one of the community leaders involved in the development of the community health plan recalled the vision of the community planning effort as: "*Solutions to complex problems are best when they come from collaboration within the community"*. The community collaboration resulted in identifying several health needs and several initiatives to address those needs. One included the development of affordable health coverage for the working uninsured. The community plan they created would target 500 small businesses in the community and offer affordable health coverage. Those eligible to receive coverage through the community health plan would be; full-time and part-time W-2 wage earners making up to $11.50 per hour. Access Health Plan would also cover spouses and dependents up to 23, if they still lived at home. To avoid competition with insurance carriers, the only qualifying small businesses were those who had not offered insurance to their employees in the previous twelve months.

This all came about through the collaborative efforts of the community's providers, business and civic leadership, and uninsured residents who were collectively the real stakeholders.

"Community polls showed that 97% of the community residents believed

that all children should have access to health care, regardless of a family's circumstances."

Operating on the assumption that solutions to complex problems are best when they come from collaboration within the community, the community leaders convened meetings to discuss the community's health care access issues.

In 1999, a Michigan-based research firm conducted a survey of 200 businesses that did not provide health insurance for their employees. The typical small business without employee health coverage was a restaurant, childcare center, home health agency, or retail establishment.

Access Health Plan targeted 500 businesses in the area that have uninsured W-2 full-time employees with a median wage of up to $11.50/hour.

Access Health Plan contracts for health coverage for employees and their eligible dependents. Under certain circumstances, young adult's ages 19-23 years who live in the family home are eligible for coverage. Many young high school graduates in the community live at home and either do not attend college or attend the local business college and thus may be uninsured and eligible.

"It was also thought that Access Health Plan can be used as an economic development tool to attract new businesses to the area. While these factors have a logical relationship with program effectiveness and long-term sustainability, systematic program evaluation over time is needed to establish program effectiveness. In the end, the community's hope is that health coverage will lead to more people using medical care appropriately, which will result in better health."

In addition to the information above, listed below are the chronic disease statistics for our Plan's members in 2003:

- 66% are smokers
- 16% have diabetes
- 18% have high blood pressure
- 24% have cardio vascular diseases
- 14% have asthma

Access Health Plan was faced with a challenge to be sure. We are fond of saying "Challenge is Opportunity". And with opportunity is the excitement of change and growth.

This story takes you through a lot of the processes we went through over the fifteen years.

You will read information on building relationships; relationships with community stakeholders, the providers, employers, members, volunteers, staff and resource providers. These relationships are the “secret sauce” of Access Health Plan.

In 1999 the country struggled with the ongoing increases in health care costs. Muskegon County met that challenge. The "We Can Story" of the Access Health Plan. We can keep it affordable. We can get small employers to invest in worker health. We can empower people to invest in their health.

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