COMMUNITY HEALTH CHOICE

KEN'S CONCEPTS

FOR AN INFORMED HEALTH CARE CONVERSATION

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About CHC

At Community Health Choice, our mission is to improve the health of underserved residents of Southeast Texas by facilitating access to coordinated, high quality, affordable healthcare services. Our mission is achieved through:

COMMUNITY:	Collaborating with community-based Providers and organizations to improve access, quality, coordination and cost-effectiveness of services
HEALTH:	Developing programs to establish medical homes, manage heath conditions and promote wellness and preventive care
CHOICE:	Encouraging personal accountability and educated choices for individual and family health

Community Health Choice, Inc. (CHC) Maintenance Organization (HMO) licensed by the Texas Department of Insurance. Through its network of more than 5,000 doctors and 50 hospitals, CHC serves over 220,000 Members with the following programs:

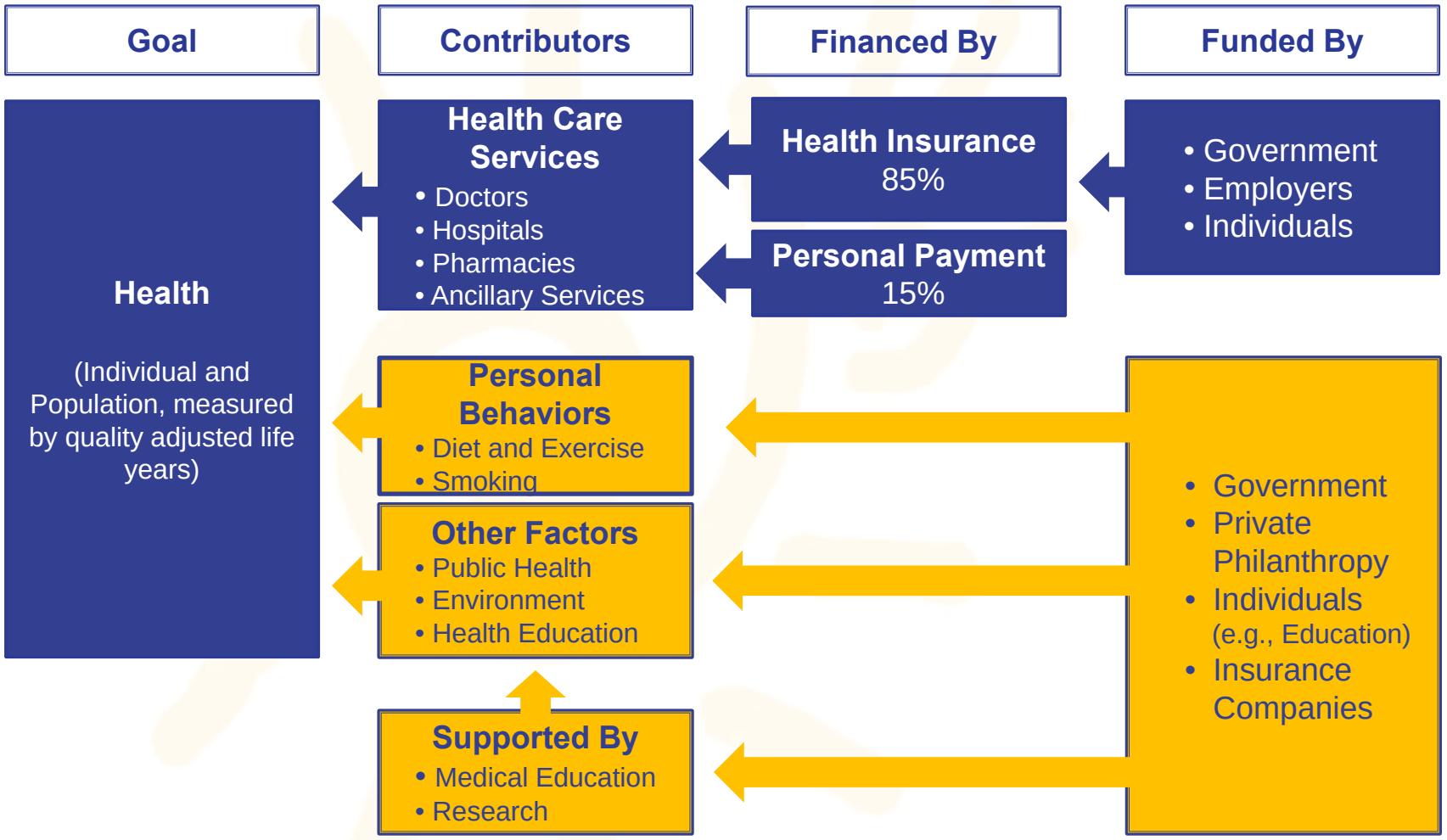
- Medicaid State of Texas Access Reform (STAR) program for low-income children and pregnant women
- Children's Health Insurance Program (CHIP) for the children of low income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR
- TexHealth Harris County 3-Share Plan that subsidizes the premiums of a limited benefit plan for previously uninsured, low-income employees of small businesses

CHC is accredited by URAC for its health plan operations. CHC offers disease management programs for asthma, diabetes, high-risk pregnancy and weight management.

An affiliate of the Harris County Hospital District (HCHD), CHC is financially self-sufficient and receives no financial support from HCHD or from Harris County taxpayers

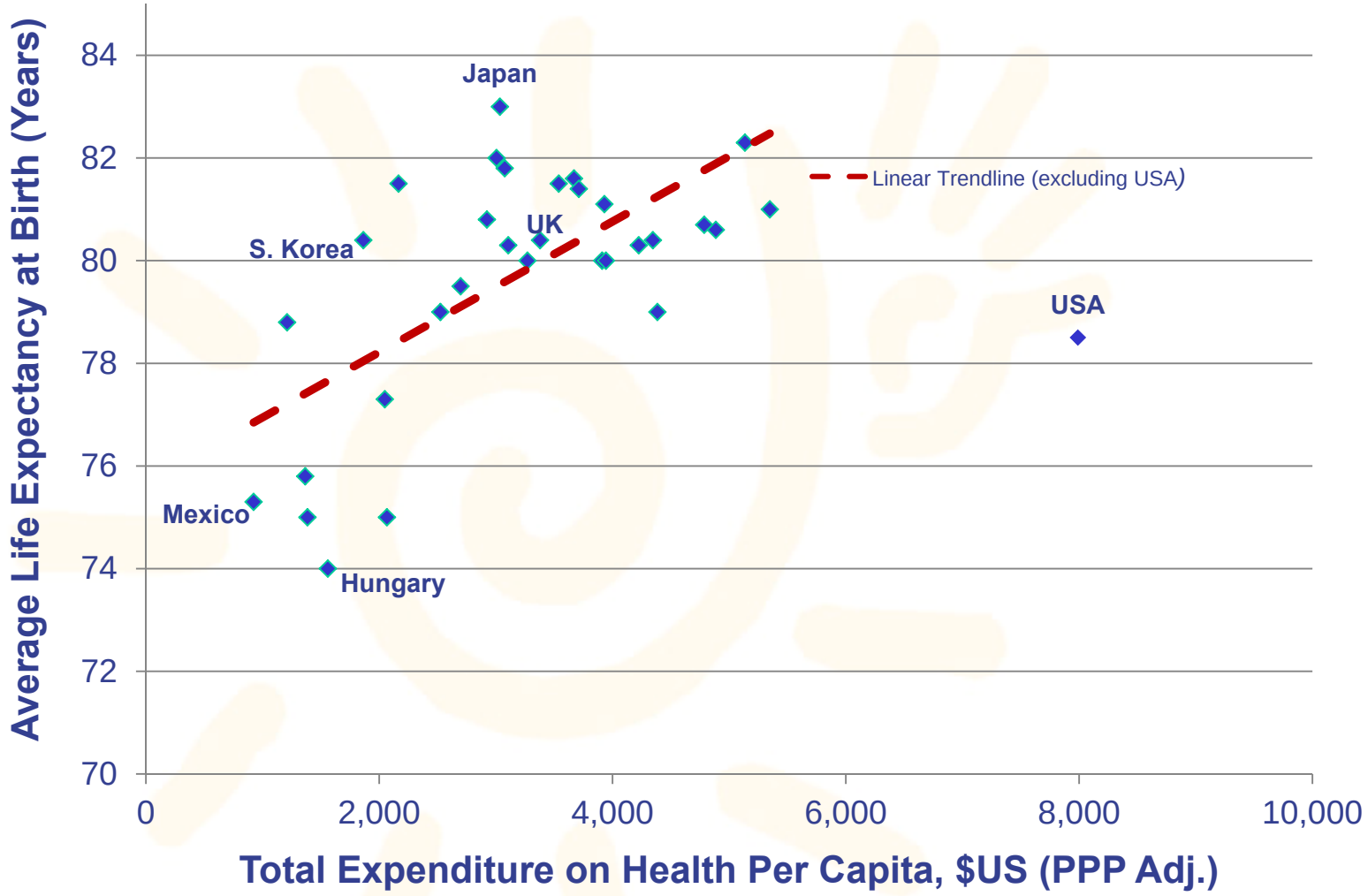
Health Policy on One Page

Health ≠ Health Care ≠ Health Insurance



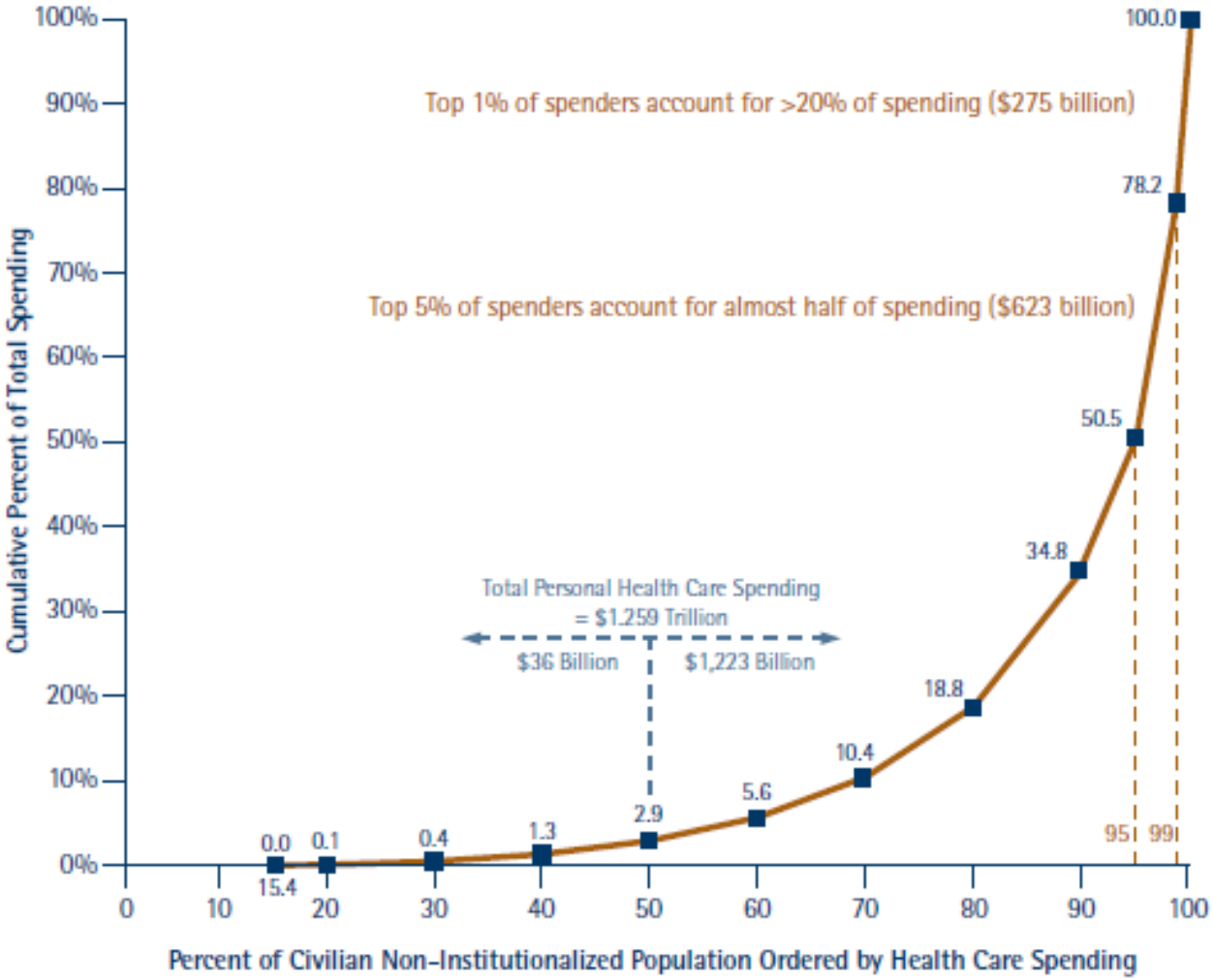
Health Care Triple Aim

Healthcare Spending per Capita vs. Average Life Expectancy



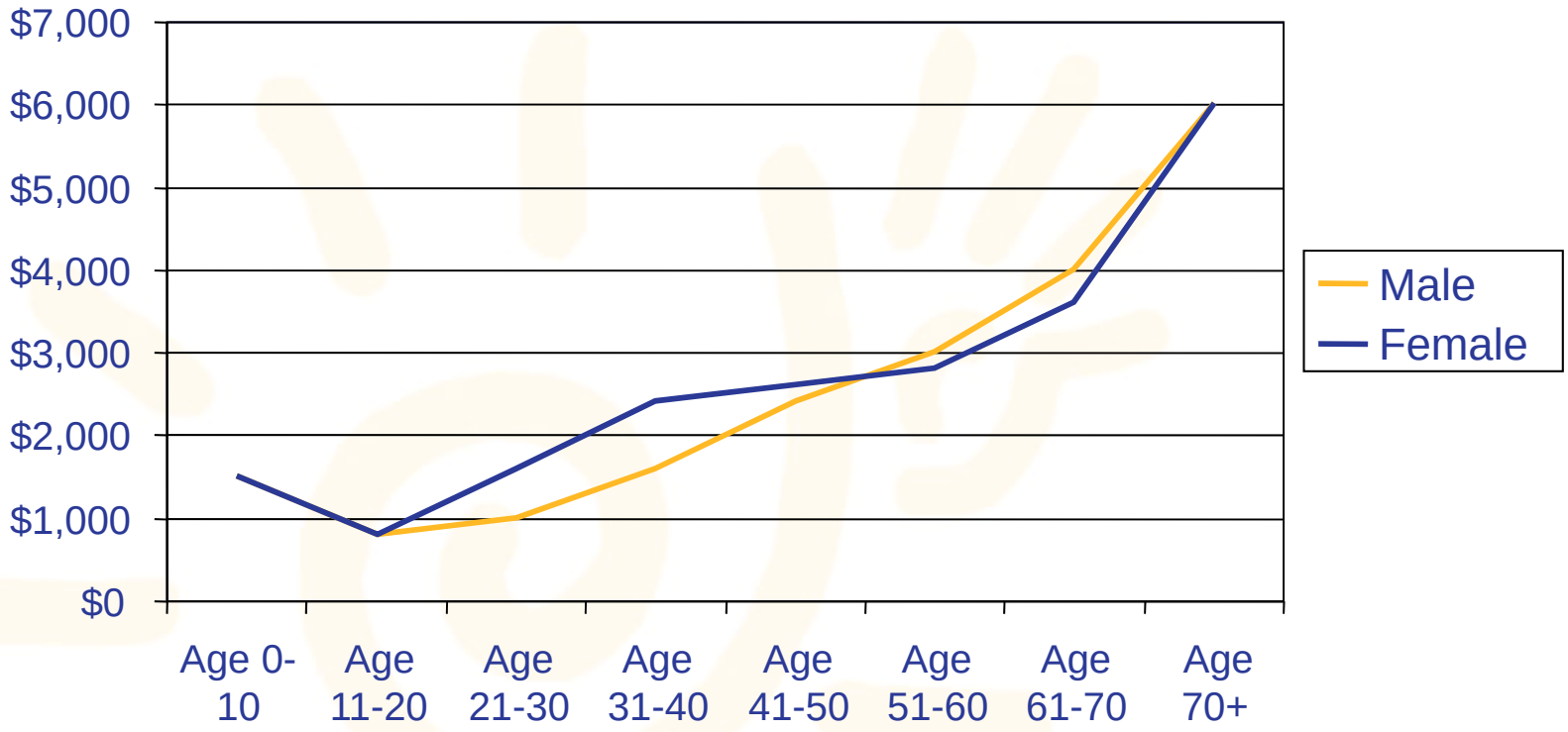
Source: OECD 2009

Cumulative Distribution of Personal Health Care Spending



NIHCM Foundation analysis of data from the 2009 Medical Expenditure Panel Survey

Health Care Costs Vary by Age and Gender



Other predictive factors:

- Behaviors – smoking, drugs/alcohol abuse, diet
- Medical conditions, blood pressure, BMI

Steps to Improve the System

We can and must make major improvements in our health system, using the triple aim goals, by:

- Improving access by covering everyone with at least some basic plan. We can't fix the cost problems with 50 million uninsured.
- Providing more coordinated (less fragmented) care.
- Reforming payment mechanisms to medical providers, to reduce over-treatment with drugs, devices and interventions that do not improve outcomes.
- Increasing personal accountability for health.
- Reducing the administrative burden of the current system.
- Stemming fraud and abuse in the healthcare system.

We have to do all of these things. There is no one, simple fix.

Access to Care

Access to care is several different things. We need to be clear which we are talking about, when we talk of access.

- Geographic access: how far away, transportation
- Availability of appointments/wait times
- Access to types of care (certain specialists)
- Cultural barriers, language
- Affordability

Third-party payer/managed care plans generally improve access to care when you look at all four aspects (e.g., Medicaid managed care in Texas has improved access over traditional Fee-for-Service Medicaid).

The U.S. Health Insurance Market

Sources of Health Insurance for Americans[1]

Employer-sponsored plans *(151 million and shrinking)*

- Small *(fewer than 50 employees)*
- Mid-Market *(fewer than 500 employees)*
- Large *(over 500 employees)*

Medicare *(45 million and growing)*

Medicaid/CHIP *(40 million and growing)*

Individual policies *(17 million, but half are Medicare supps)*

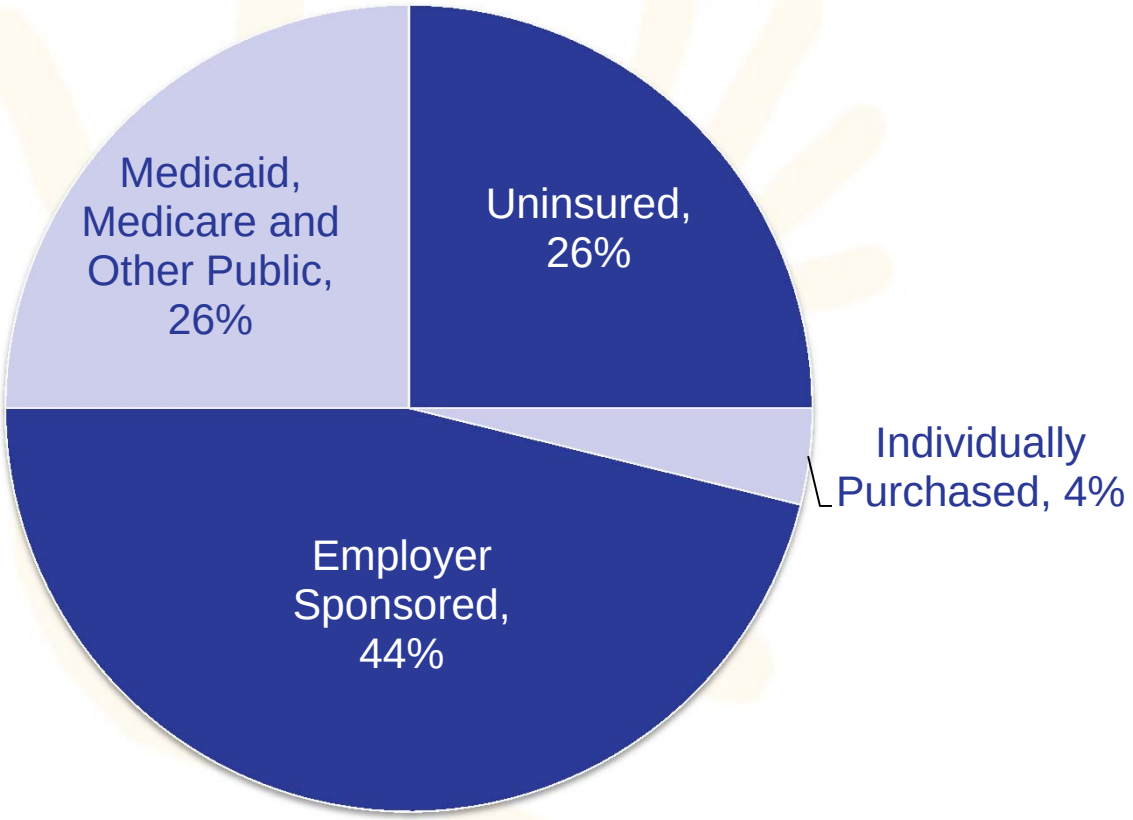
Military-sponsored plans *(7 million)*

Uninsured *(47 million and growing)*

[1] Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis: University of Minnesota, 2010.

Data recoded with the following order of priority for those with multiple sources of insurance: Medicare, Medicaid, military-sponsored, employer-sponsored, individually purchased.

Texas by Insurance Type



From www.statehealthfacts.org: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).

National Population Health Insurance Coverage

BY FPL AND AGE

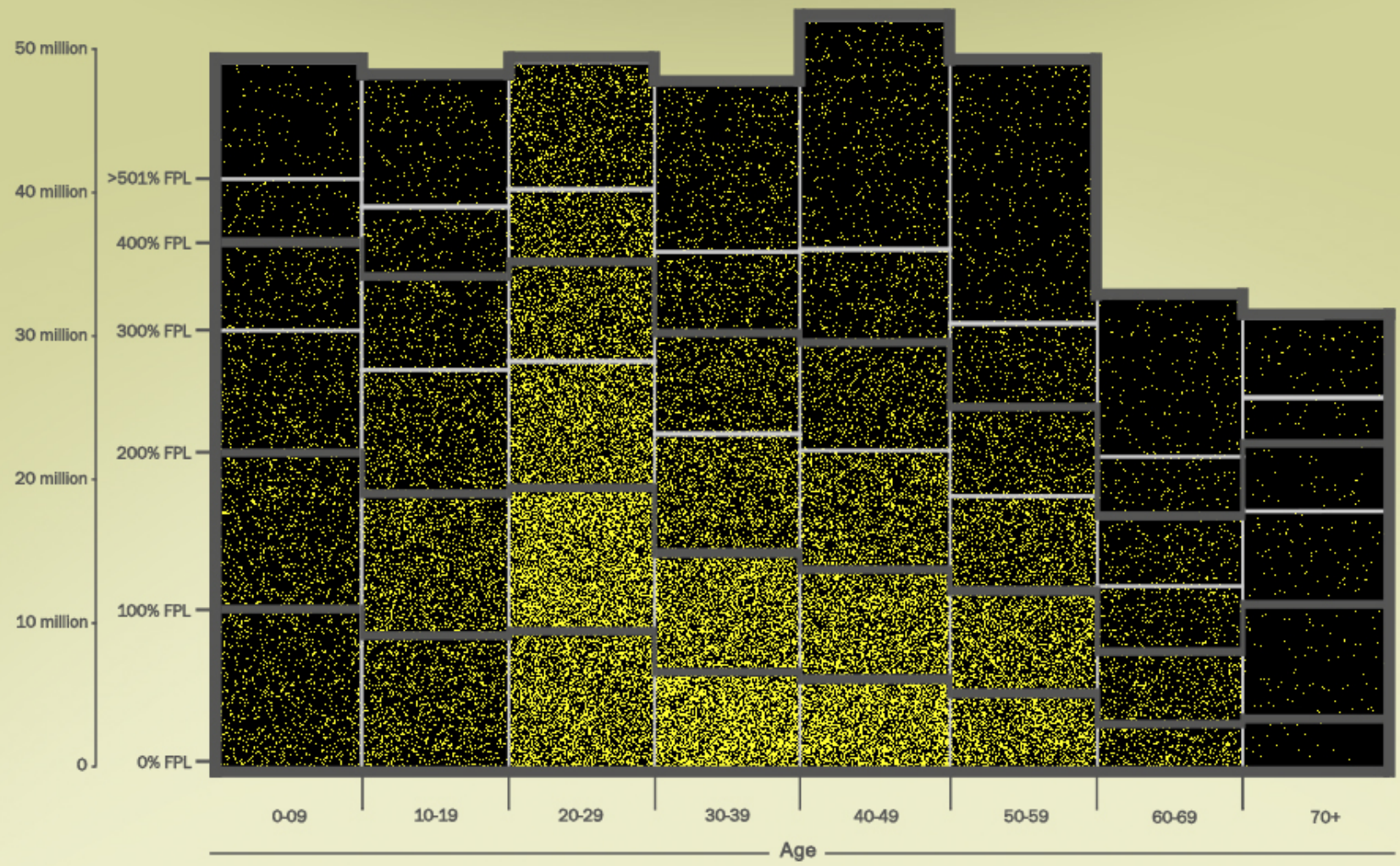
Total Uninsured Population: 47,377,796

Developed by Community Health Choice

Medicaid Members
Medicare Members
Employee Sponsored
Individual Purchased
Military Sponsored

National | State | Regional

Show All | Show Uninsured | Clear All



Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010.

Texas Population Health Insurance Coverage

BY FPL AND AGE

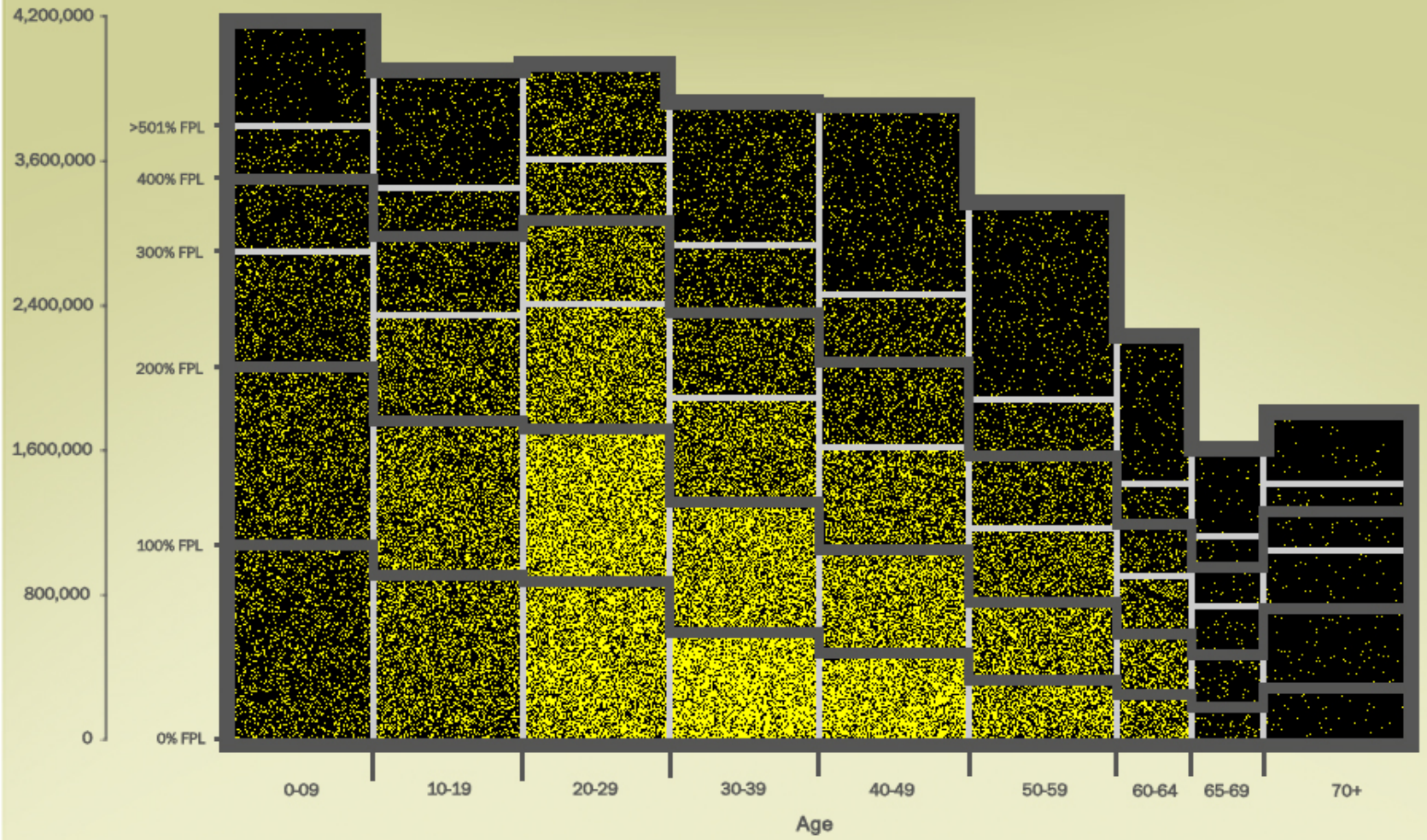
Total Uninsured Population: 6,004,865

Developed by Community Health Choice

Medicaid Members
Medicare Members
Employer Sponsored
Individual Purchased
Military Sponsored

National | State | Regional

Show All | Show Uninsured | Clear All



Steven Ruggles, J. Trent Alexander, Katie Genadulk, Ronald Goeken, Matthew B. Schroeder, and Mathew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010

Uninsured by FPL*

Texas

Federal Poverty Level	Number of Uninsured	Percent of Uninsured
0%-133%	2,658,428	44%
134%-200%	1,210,422	20%
201%-400%	1,616,225	27%
>400%	604,924	10%
Total	**6,089,999**	**100%**

Houston

Federal Poverty Level	Number of Uninsured	Percent of Uninsured
-	653,350	40%
134%-200%	331,558	20%
201%-400%	462,723	29%
>400%	175,146	11%
Total	**1,622,777**	**100%**

*See page 28 for income for various percentages of federal poverty level

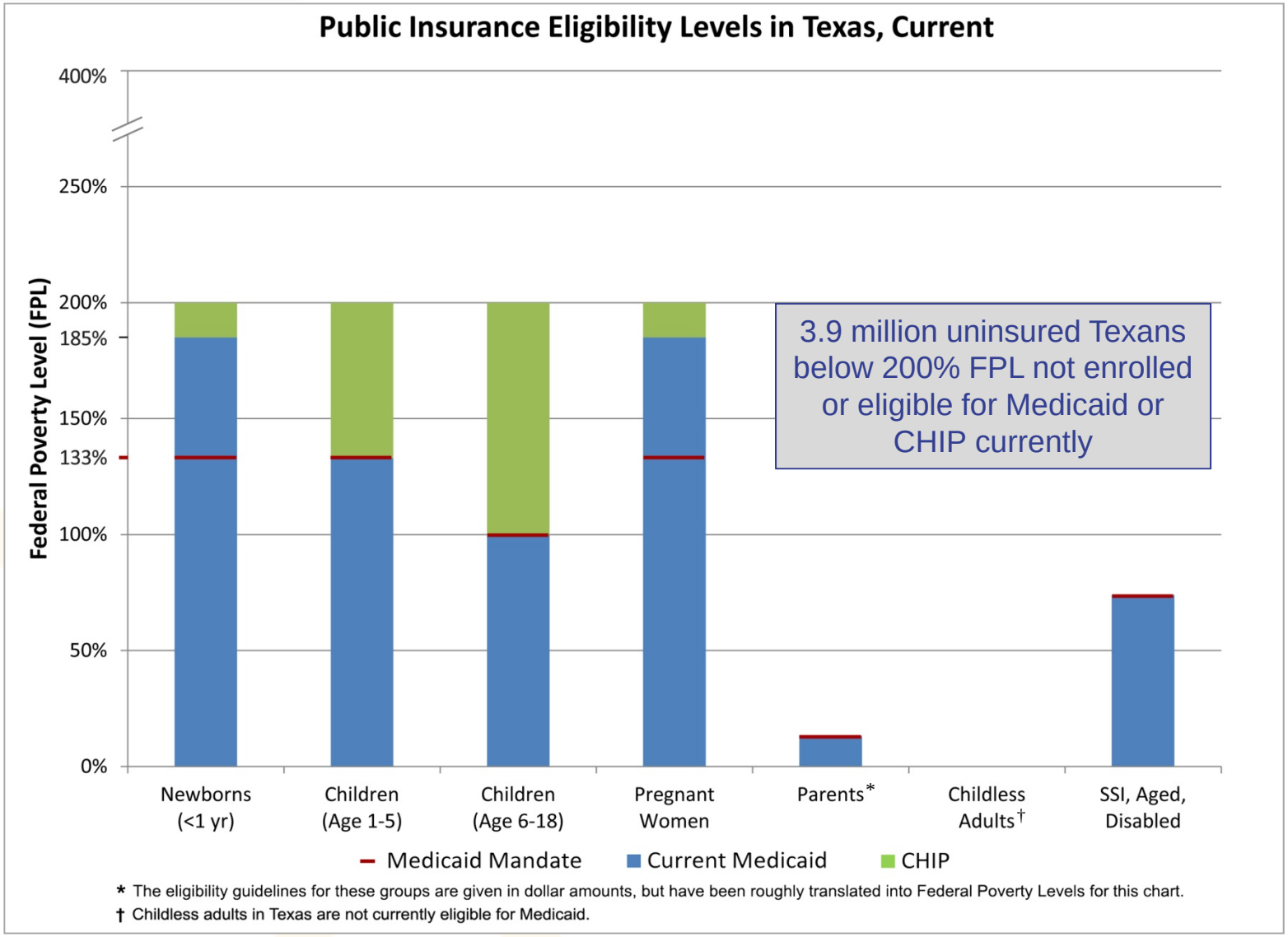
Who Are the Uninsured in Texas?

The uninsured are not one cohesive group, but several different groups needing different solutions:

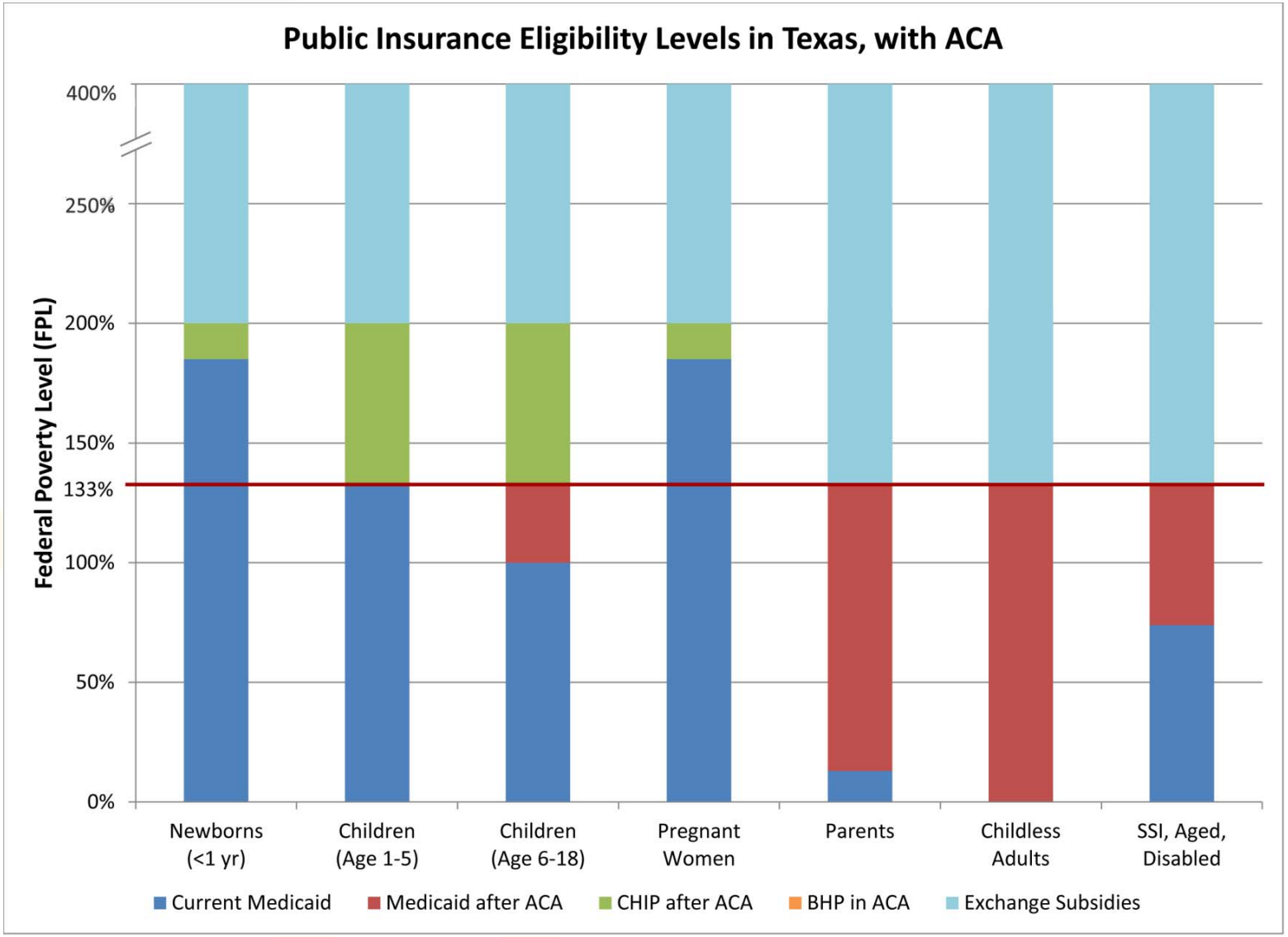
- Eligible for government programs, but not enrolled (0.8 million)
- Unemployed/very low-income, not eligible for Medicaid due to eligibility restrictions (1.3 million)
- Recent immigrants, legal or undocumented, not eligible for government sponsored plans (0.8 million)
- Denied individual coverage due to pre-existing conditions *(eliminated in 2014)*
- Work for small employers who do not offer ESI, and cannot afford an individual policy (1.1 million)
- Offered ESI, but do not sign up due to employee cost-sharing in premium; includes some willfully uninsured who can afford insurance but choose not to enroll (1.2 million)
- Part-time, seasonal or contract (1099) workers not eligible for ESI (1.0 million)

Uninsured estimates are extrapolated from 2010 Health and Human Services Projections.

Medicaid/CHIP Eligibility, Current



Medicaid & Subsidies in ACA



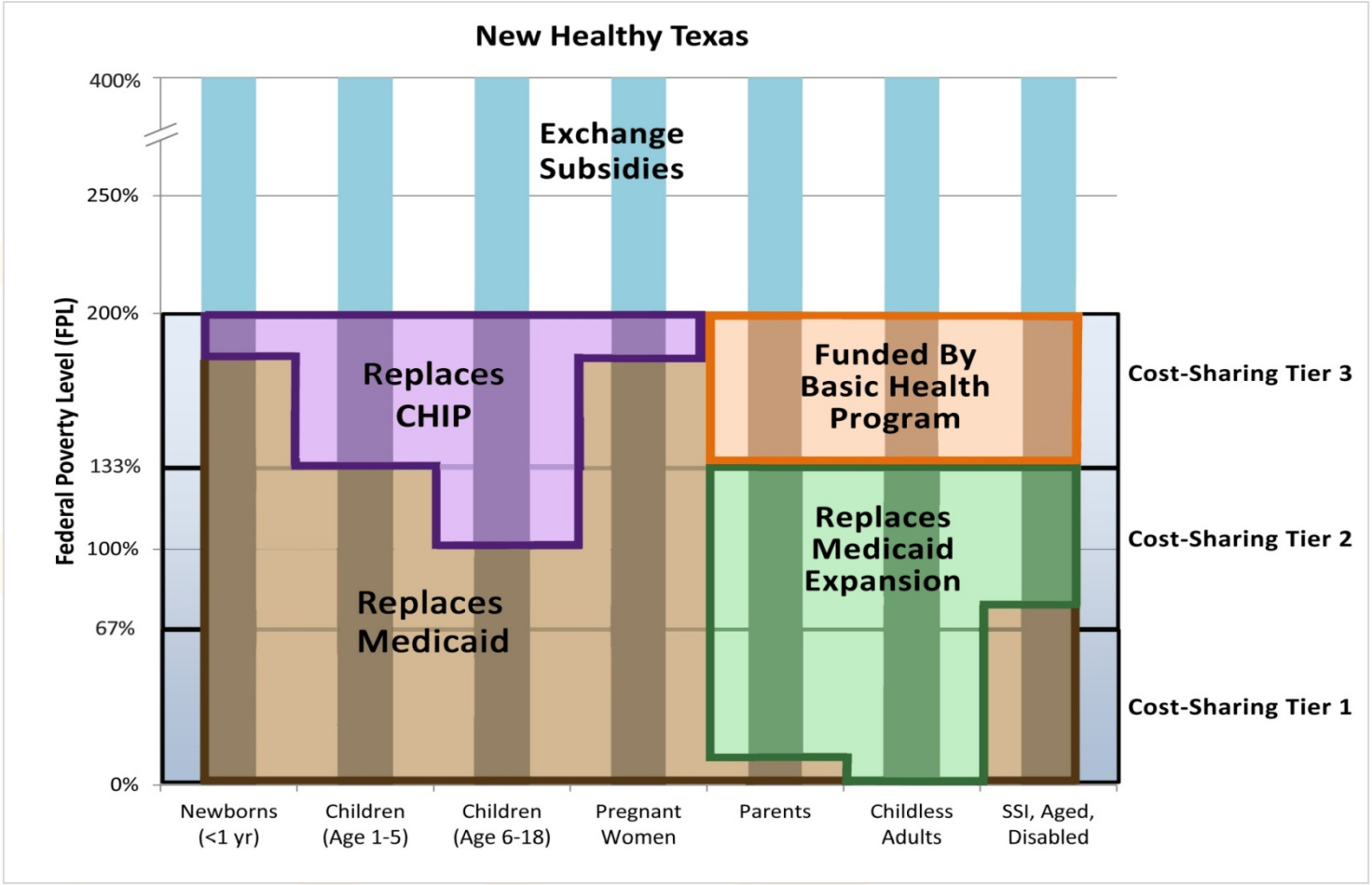
Ideas for a New Healthy Texas

A Uniquely Texas Market-Based Approach

Key Components:

- Replace Medicaid, CHIP, and other fragmented state and county indigent care programs with one integrated program
- One program covers all legal residents under 200% of FPL, with same benefits but varying levels of cost-sharing/subsidy
- Base benefits on Texas-specific Essential Health Benefits
- Utilize existing 20 Medicaid/CHIP contracted managed health plan infrastructure–easy to implement and control costs
- Keep families together by enrolling parents of Medicaid/CHIP children
- Keep federal tax dollars in Texas: draw down federal funds available for Medicaid expansion and other programs
- Supplement local indigent care dollars with federal dollars
- Implement Texas-specific insurance connector for people over 200% of FPL

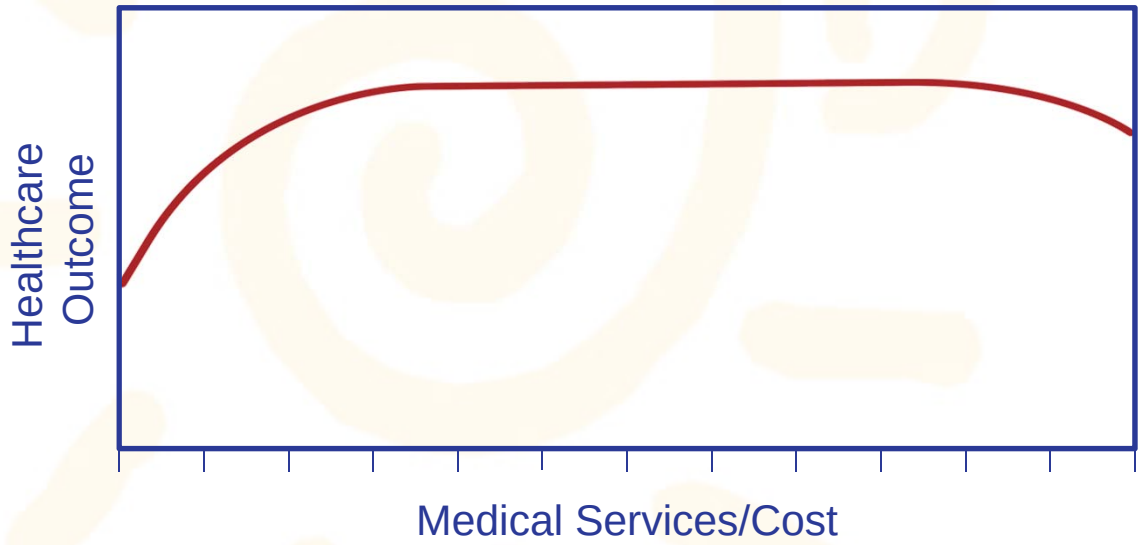
A Healthy Texas Program Example



Health Care Utility Curve

Diminishing Marginal Utility in Health Care

- More services do not necessarily improve outcomes
- More costly technologies do not necessarily produce better outcomes
- Patients have limited ability to compare outcomes to cost (i.e., value)



Cost = Price x Volume

Key Formula of Managed/Coordinated Care

Utilization Rate (Volume)

x Unit Cost (Price)

= Total Cost

Generally, the U.S. has either higher utilization rates or pays a much higher cost per unit than other countries *(often both higher price and more volume),* but outcomes are roughly the same.

Saving money in the US system is more easily done by eliminating services that do not improve outcomes (reducing utilization) than cutting prices (though some price cutting for diagnostic testing, medical devices and other things are certainly needed).

Health Insurance vs. Prepaid Health Care

Insurance

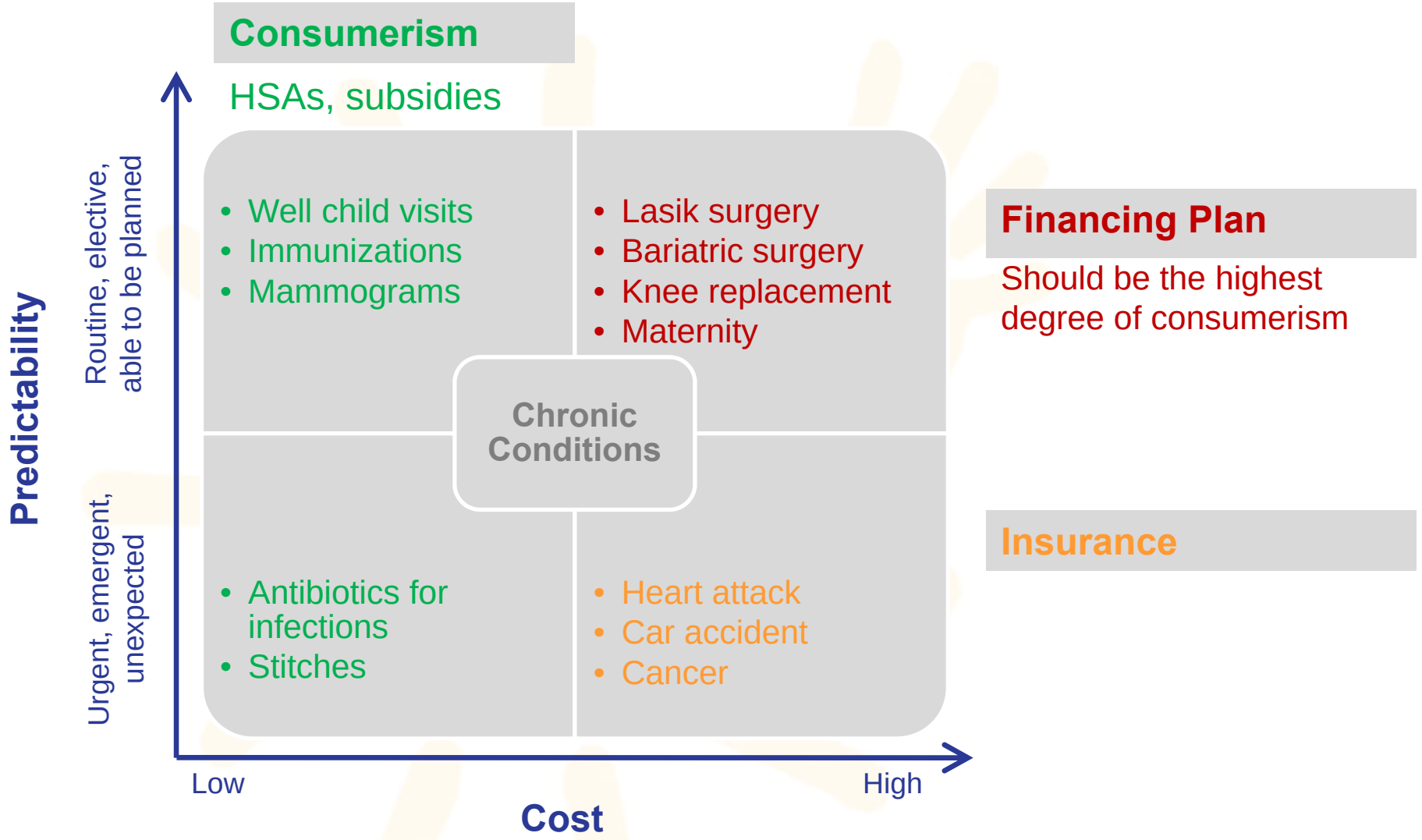
Coverage by contract whereby one party agrees to indemnify another against a specified, unexpected material loss

Prepaid Health Care

Coverage by contract where one party pays another to receive free or highly subsidized routine health care service for one set monthly fee

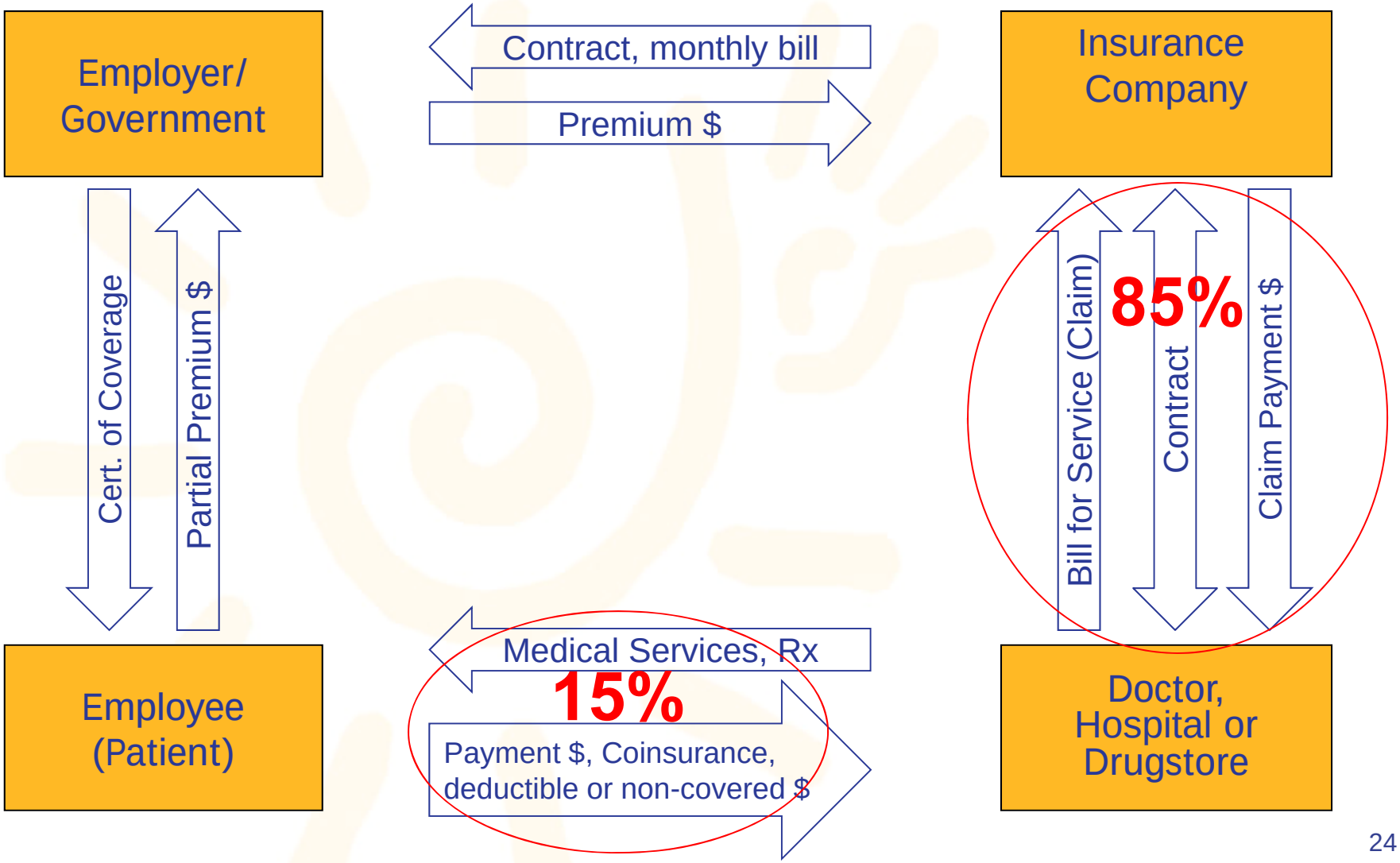
The Affordable Care Act requires insurers to sell and consumers to purchase a combination of health insurance and prepaid healthcare services.

A Model for Health Care Financing



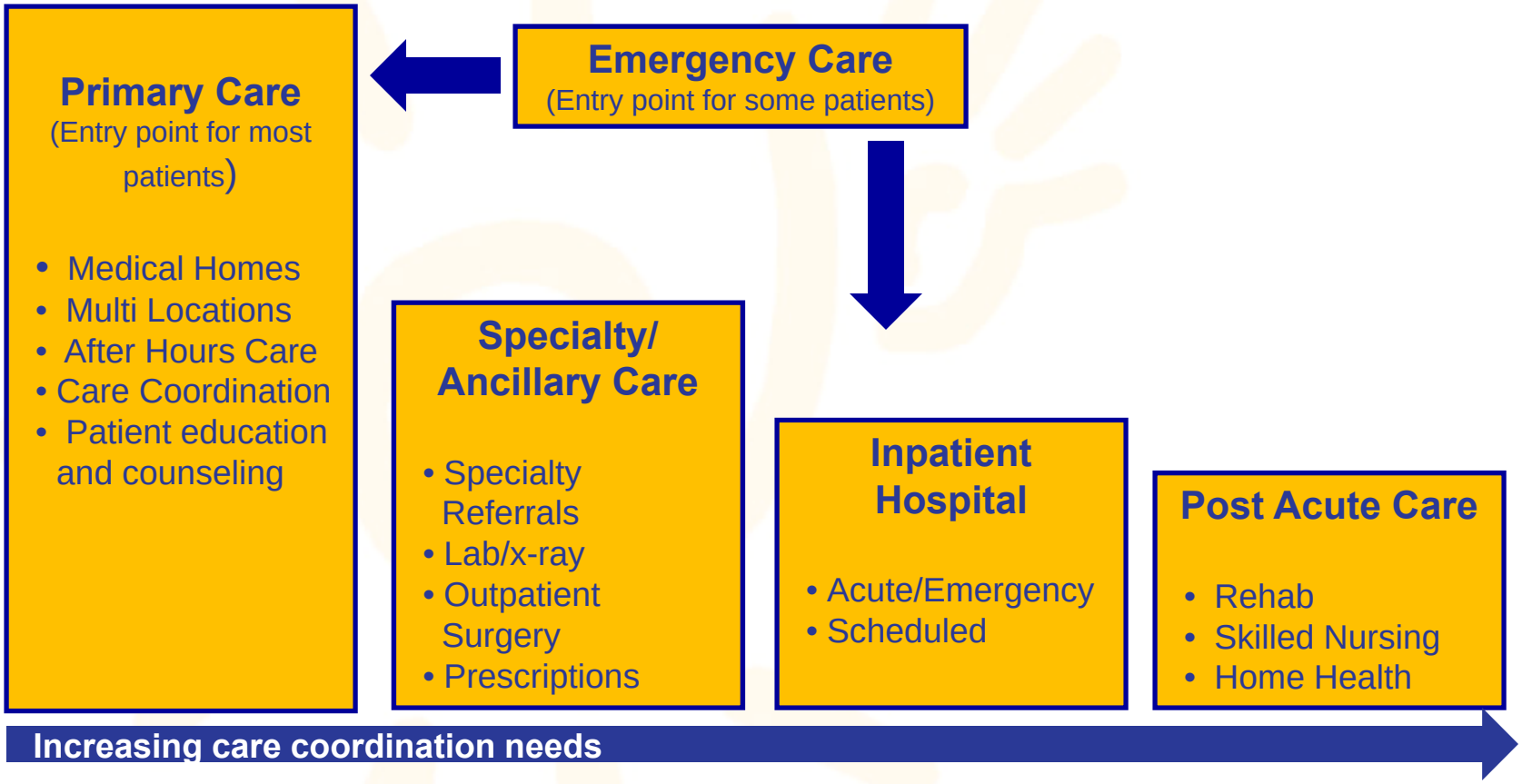
Moral Hazard of Third (Fourth?) Party Payer System

Managed Care Transactions



Integrated, Coordinated Care

Integrated organizations like Accountable Care Organizations (ACOs), if paid bundled fees, capitations or paid for outcomes should control costs better than current fragmented systems, while producing better outcomes.



Reforming Provider Payments

To control costs and improve quality at the same time, we must change the financial incentives for providers of care

- Reduce or eliminate fee-for-service payments to reduce over-utilization of services *(the more you do, the more you make)*
- Payment for care coordination
  - Bundled payments per episode of care
  - Global payments for risk-adjusted population
  - Providers should accept management risk (resource use) versus prevalence (insurance) risk of populations
- Pay for outcomes/quality
- Transparency of any additional payments for research, medical education, uncompensated care, etc.

Patient Accountability

Patients must have more “skin in the game”

- Employer movement to defined contribution from defined benefit will encourage engagement and options
- Migration from employer-sponsored to individually-purchased insurance will result in more pure insurance, higher deductibles, HSAs, etc.
- Value-based plan design to have lower cost-sharing for highly valuable services
- Overt differentiation between prepayment of routine services and “insurance”
- Premium incentives for personal behaviors: smoking, obesity
- Modify EMTALA to make it easier for hospitals to redirect patients from emergency rooms

Who's Eligible for Safety Net Programs?

Income for various percentages of federal poverty level (FPL)

Family Size	100% FPL	133% FPL	185% FPL	200% FPL	400% FPL
	Annual Income				
1	$11,170	$14,856	$20,665	$22,340	$44,680
2	$15,130	$20,123	$27,991	$30,260	$60,520
3	$19,090	$25,390	$35,317	$38,180	$76,360
4	$23,050	$30,657	$42,643	$46,100	$92,200

Questions & Discussion

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www.CHCHealth.org/KensCorner