

How Safety Net Institutions Can Best Leverage Federal and State Health Reform

The Implications of Employment-Based Healthcare Coverage Post ACA for the Safety Net

Ray Werntz, HMPRG Board Member

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HEY, The Dragon Ain't Dead Yet!



Where We Are With Costs and Quality in 2011?

- Costs projected to rise 10% in 2011**
- Government can't block large premium increases across the country announced post March 23rd 2010**
- AHRQ reports quality is not improving as hoped**
- The *Patient Protection and Affordable Care Act (ACA)* is banking on providers to improve quality, costs and outcomes in the future**
- Systemic high costs and poor quality exacerbate access expansion and add to the burden borne by Safety Net service providers**

The Coverage Landscape

- ❑ Governments cover *95 million* and pay 50% of costs
- ❑ Employers cover *170 million* and pay 25% of costs
- ❑ Individuals and personal insurance pay the rest
- ❑ The “uninsured” are mostly workers and their families
- ❑ Employment-based coverage declined over 5% this decade
- ❑ ACA seeks to expand employment-based and individual *insured* coverage
- ❑ Is the *coverage* head *really* dead?

Some Additional Facts About Illinois Post ACA

- 11.3 million non-elderly individuals**
- 7.3 million have employment-based coverage**
- .7 million have individual coverage**
- 1.7 million are covered by Medicaid and .7-.8 million more are anticipated**
- 1.7 million are uninsured**

How Might ACA Affect Employment-Based Coverage?

- In the near term, employment-based coverage will either decline 2% (CBO) or grow 6% (Rand)**
- 78% of employers have less than 10 employees**
- The “hot spot” is 95% of employers with less than 50 employees—no penalties apply**
- Depending on future regulations and based on public statements by some notable employers, conventional employment based coverage may eventually give way to exchange-based insurance and public coverage**
- If employers withdraw what additional burdens will be shifted to the safety Net *and* where will future innovations in program design, wellness and provider contracting essential to cost management and quality improvement come from?**

Community Health Plans: Unheralded Options for Coverage

A Community Health Plan is....

“planned interaction of purchasers, consumers, providers, administrators, insurers, and community influencers of health care services for the purpose of improving health status, balancing incentives and accountabilities, seeking cost and quality efficiencies, and assuring long-term commitment among the parties”

Multi-Share Health Plans Are...

“Nationally developed, affordable, community-owned health plans designed specifically for uninsured small businesses. These co-op styled multi-share health programs have community governance, financing, and operations for consumer-oriented products. These hybrid plans (financed by private and public funds) are affordable because they can integrate public and private sector resources that share locally in both financing and risks in healthcare delivery.”

Cooperative Healthcare Plans

- ❑ *A cooperative Healthcare Plan is a nonprofit, nongovernmental firm run by its members, the consumers. In addition to insurance, successful co-ops actually provide care, own their own hospitals and have dedicated multispecialty physician groups. The goal is to restrain costs and cover more of the uninsured.*
- ❑ *Transforming health care delivery in the United States into a mission-driven, patient-centered, value-enhancing system of care will require incentives for physicians to practice in health care organizations that are accountable to patients and consumers, as well as disincentives for continuing our current fragmented fee-for-service system.. As President Lincoln emphasized in his Gettysburg Address, the U.S. is guided by the philosophy of “government of the people, by the people, and for the people.” What is needed in health care is a similar philosophy: a health system that is truly for the people. Redesigning health care so that it puts people front and center and ensures that care is patient-centered, accessible, and coordinated should be the fundamental goals of health reform. Commonwealth Fund*

Access Health- A Multi-Share Community Health Plan

- ❑ **It's not a true co-op, but in most ways acts like one**
- ❑ **Around for more than a decade**
- ❑ **Supported by HRSA and models are operating or underway in ten states**
- ❑ **Access Health is the first program of its kind and the prototype for the others**
- ❑ **It's *disruptive* innovation that challenges the health benefit plan paradigm**
- ❑ **Provides important lessons for *all* healthcare benefit plans**

Access Health's Main Ingredients

- ❑ Employment-based coverage—contributions consist of 1/3 employer, 1/3 Government and 1/3 participant shares—with a “high/low” plan option to promote participant engagement
- ❑ Target micro businesses (2-49 employees)
- ❑ No pre-existing condition limitations, low deductibles and co-pays
- ❑ Covers full range of services *offered by community providers*
- ❑ Non profit, self funded architecture with *all* stakeholders on the same page
- ❑ 600 businesses and over 5000 employees since 1999; currently about 280 businesses and 1000 employees
- ❑ Costs about \$1800 annually per person versus \$5600 (Kaiser data)
- ❑ Employs a “Secret Sauce” to control costs, engage participants and optimize outcomes

Access Health...Optimizing Engagement

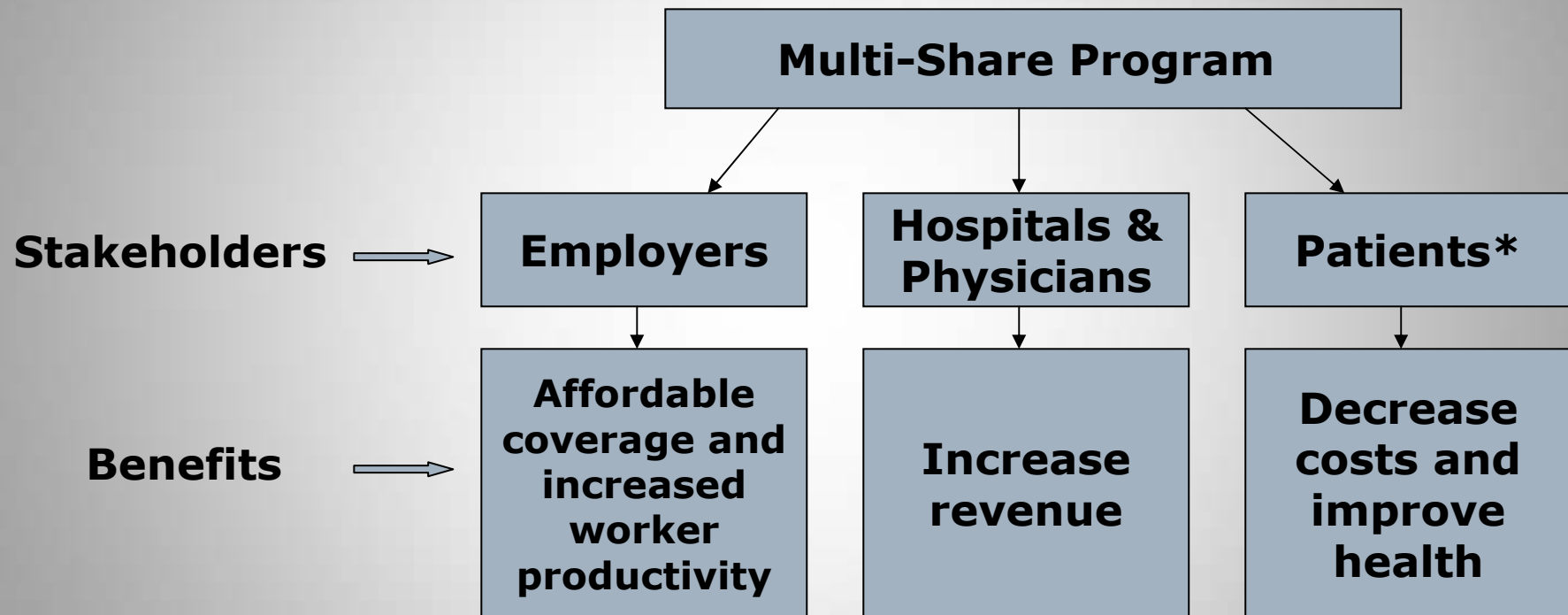
- ❑ The two plan option: the C3 program and the Standard program (higher contributions and co-payments than C3)**

- ❑ C3 requires effort from the participant:**
 - Completes HRA annually**
 - Consults Health Advisor for a personalized health action plan**
 - Attends two health classes per year**
 - Executes a “Healthier Lifestyle” contract**

Access Health's "Secret Sauce"

- All stakeholders see a benefit**
- As a quasi "public" plan, participants access publicly-financed services**
- Health Advisors activate consumer engagement in all areas of health and healthcare by focusing on *people* and not just health *problems***

All Stakeholders Win!



** Patients are employees and their families who chose to enroll in the program*

Health Advisors: Engagement Specialists

- Nurses, mental health professionals and other service providers**
- Wellness health coaches and educators**
- Coordinate and case manage acute and chronic health problems using such programs as the Stanford University Medical Research Program “Chronic Disease Self Management and Diabetes Self Management”**
- Coordinate and monitor a wide variety of other support services and community resources vital to health improvement, affordable and effective healthcare and optimal health outcomes**
- Focused on the worth and wellbeing of their members and the health and economic vitality of their community!**

Access Health Outcomes

- ❑ Cost trend *virtually flat* since 1999 versus 131% increase nationally
- ❑ Population health factors are improving
- ❑ Businesses are healthier
 - Improved retention
 - Lower turnover
 - Improved productivity
 - Lower absenteeism
- ❑ Stakeholder harmony

AFSCME Council 31's Innovation-Developing "Effective Patients"

- Smaller (170 employees and retirees, 400 "lives") self funded employer**
- Collectively bargained wages and benefits-generous health plan**
- Cost inflation up 11+% average per year through 2006**
- Using "mainstream" wellness**
- Cost shifting on the table - not likely to be an easy sell, though staff union negotiators were realists**
- On January 1, 2007 launched its groundbreaking Health Improvement Plan (HIP) that transformed a conventional benefit plan into a health improvement "pact"**
- Shares much in common with Access Health but is not a community plan; it's an employer sponsored ERISA Welfare Benefit Plan**

HIP's Key Features-Participants Do More, Not Pay More

- ❑ A benefit plan that acts as the “***Rules of Engagement***” - Doing more to stay healthy and actively participating in healthcare determines eligibility for the better of two available plans
- ❑ Documented accountability: ***the enrollment agreement***
- ❑ Personalized competency-building ***prescription*** and compliance monitoring emphasizing health risk reduction ***as well as*** effective use of healthcare
- ❑ Strong research-based ***incentives*** influenced by ***behavioral economics*** and ***Value Based Benefit Design*** principles
- ❑ Intensive ***care counseling*** and participant ***mentoring***
- ❑ Optimal use of ***Health Information Technology-based architecture*** that supports a ***PHR and Virtual Medical Home***

HIP Outcomes

- ❑ *They've* bent the cost curve; average monthly claims costs have been less ever since 2006 and 10% less overall
- ❑ *They* report fewer lost work days and less stress
- ❑ *They* say HIP has helped them get better healthcare
- ❑ *Their* health status has improved
- ❑ *Fewer* are at risk for high blood pressure and cholesterol
- ❑ *Many smokers* (as of 2006) use less or no tobacco

AND, in September, *they* were awarded an Honorable Mention C. Everett Koop National Health Award for 2010

Common Ground Shared by Council 31 And AH

- Cost inflation under control for several years**
- Participant contracts with plan to try to improve health and use of healthcare based on use of a personalized health improvement plan**
- Intrinsic health coaching and care counseling**
- Emphasis on health self management**
- Uses hi-lo plan options**
- Measurable improvements in population health**
- High satisfaction levels**

Some Caveats and Challenges

- ❑ **Helping participants address root causes of *all* appropriately avoidable costs and poor quality healthcare requires more research-based resources**
- ❑ **Optimal use of health information technology by participants is very challenging**
- ❑ **Partnerships with federal agencies (HRSA, AHRQ), employer coalitions, research organizations and provider associations are essential to resource development and improvement**
- ❑ **Insurance industry resistance**
- ❑ **Employer inertia with regard to disruptive innovation**
- ❑ **Myriad of unresolved legal questions**
- ❑ **Alternatives to Exchanges and Medicaid depend on status and interpretation of ACA Sections 1322 (Co-ops) and 1332 (state innovation waivers)**

Key Takeaways

- ❑ The Access goal *won't be met* without eliminating appropriately avoidable costs and improving healthcare quality and outcomes
- ❑ What employers do in the future *will dramatically affect* the Safety Net and Medicaid
- ❑ Relying on the Exchanges and Medicaid expansion *may not* solve the access problem and frustrate needed innovation
- ❑ Consumers *must be held more accountable* for addressing the root causes of appropriately avoidable costs and poor quality healthcare which they can control