

2012 VBID Center Summit

Importance of VBID to a Consumer Operated and Oriented Plan



Agenda

- CO-OPs in Brief
- Maine Community Health Options
- Role of VBID in MCHO Development

The ACA (Section 1322) created the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of new consumer-governed nonprofit health plans

WHAT IS A CO-OP?

CO-OP Attributes

- Nonprofit - Surplus revenue must be used to:
 - Lower premiums;
 - Improve benefits;
 - Improve the quality of health care delivered to its members;
 - Repay loans awarded by the CO-OP program (and any others); and/or
 - Accumulate reasonable and sufficient reserves to provide for enrollment growth, financial stability, and stable coverage for its members
- Consumer governance
- Focus on greater accountability to consumers, payers
- Emphasis on high quality, low cost, coordinated care
- Afford access to coverage / care
- Substantial focus on Exchange
- CO-OPs are prohibited from being sold to or converting to a for-profit entity

VBID

Today's CO-OP Landscape

- CO-OP financing in the form of development and solvency loans has been awarded thus far to 23 CO-OPs in total, covering 23 states including Michigan.
- The award process is continuing on a rolling basis, with CMS/CCIIO receiving applications through Dec. 31st 2012 under the current FOA authority.

Maine's CO-OP: Maine Community Health Options

- MCHO application was sponsored by Maine's FQHCs and the Maine Primary Care Association along with additional development support from Maine Health Access Foundation
- The fundamental purpose of MCHO is to create and develop innovative forms of health care delivery and engagement so as to produce better health care value through improved health outcomes at lower total costs
- Key Drivers:
 - Foster Patient Centered Medical/Health Homes
 - Support for local systems that are effective, e.g., care management
 - Support for Shared Decision-Making
 - Integrate Behavioral Health & Oral Health through benefit design that result in better care processes and outcomes
- Operational by January 1, 2014 with Enrollment beginning October 1, 2013



A natural pairing

MCHO & VBID

MCHO Goals & Value Based Insurance Design

Work in partnership with consumers, clinicians, communities and health systems to achieve the “Triple Aim”

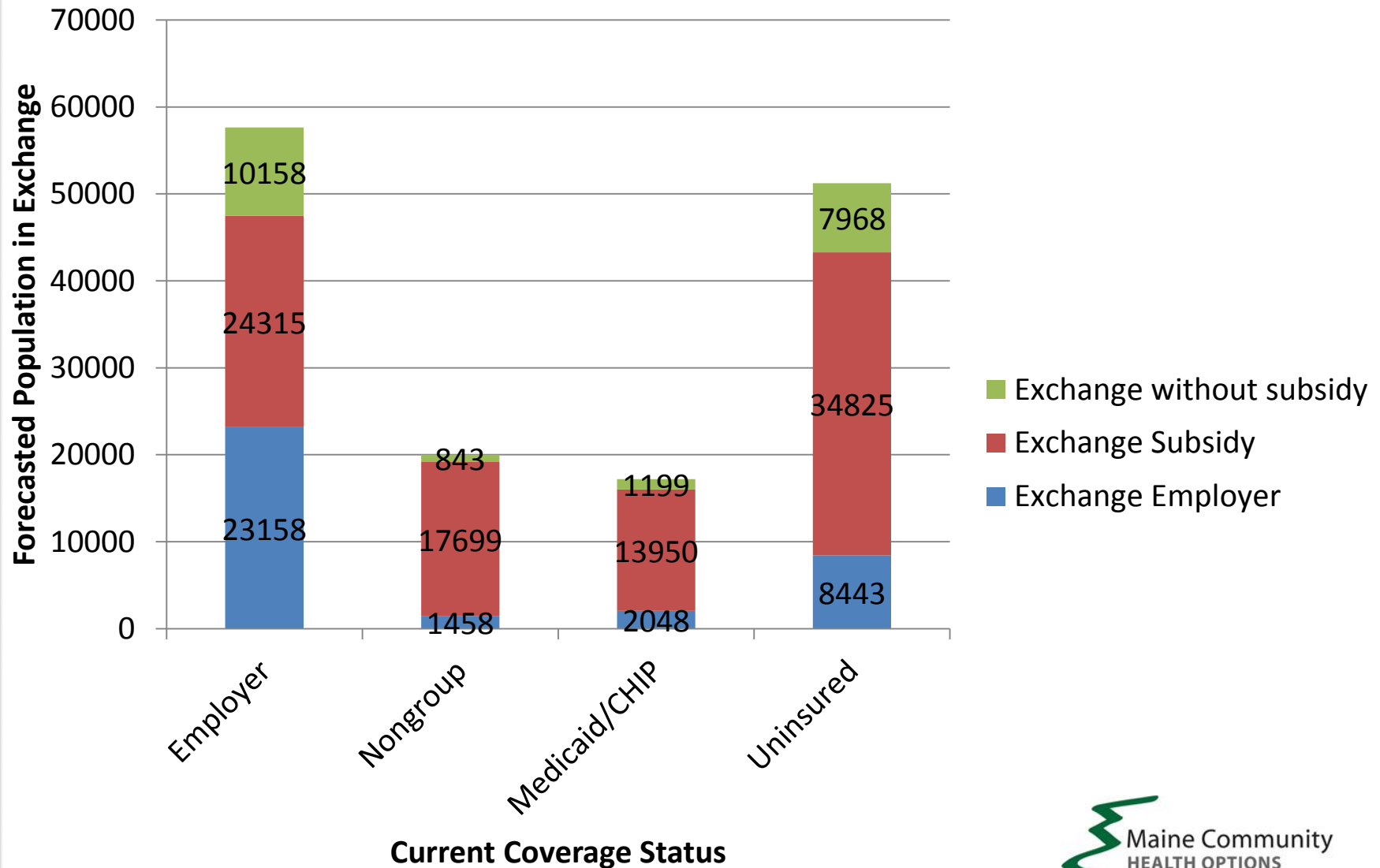
- Patient centered approach
- Focus on the prevention and management of disease
- Promotion of the value of care over the volume of care
- Payments and processes that are transparent, easy to understand and simple to administer for patients, providers, purchasers and other stakeholders
- Expand insurance coverage, and support delivery system change

MCHO benefits: Value Based Insurance Design

- The MCHO VBID focus is on big five chronic conditions, two health behaviors (tobacco use & obesity) and promotion of behavioral health integration.
- In addition, MCHO will explore:
 - inclusion of payment supports and incentives for oral health integration
 - Coordination with employee/patient assistance programs
- Pairing of clinical information with claims data for quality reporting to reinforce VBID
- Network design to feature opportunities for shared savings and shared risk

Where CO-OPs Attach: First through Exchanges.

Exchange Projections by Origin of Coverage



Who Do We Expect to Cover

2014 Membership Distribution by Metallic Plan Design

	Gold	Silver	Bronze	Total
Individual				
Exchange	17.9%	26.9%	44.8%	89.5%
Non-Exchange	0.0%	0.0%	0.0%	0.0%
Small Group				
Exchange	0.7%	1.1%	1.8%	3.7%
Non-Exchange	3.4%	2.0%	1.4%	6.8%
Total	22.0%	30.0%	48.0%	100.0%

Projection of Risk - and how it informs VBID efforts

Exhibit 1: Understanding the Red Zone

% of FPL	Income	Subsidy	Premiums paid				Premiums as a % of income			
			Bronze (\$3,421)	Silver (\$3,991)	Gold (\$4,561)	Platinum (\$5,131)	Bronze (\$3,421)	Silver (\$3,991)	Gold (\$4,561)	Platinum (\$5,131)
100-133%	\$12,687	\$3,737	\$0	\$254	\$824	\$1,394	0.00%	2.00%	6.50%	11.00%
133-200%	\$18,132	\$3,175	\$0	\$816	\$1,386	\$1,956	0.00%	4.50%	7.50%	10.80%
200-250%	\$24,503	\$2,276	\$1,145	\$1,715	\$2,285	\$2,855	4.70%	7.00%	9.30%	11.70%
250-300%	\$29,948	\$1,371	\$2,050	\$2,620	\$3,190	\$3,760	6.80%	8.80%	10.70%	12.60%
300-350%	\$35,393	\$629	\$2,792	\$3,362	\$3,932	\$4,502	7.90%	9.50%	11.10%	12.70%
350-400%	\$40,838	\$111	\$3,310	\$3,880	\$4,450	\$5,020	8.10%	9.50%	10.90%	12.30%
400-600%	\$54,450	\$0	\$3,421	\$3,991	\$4,561	\$5,131	6.30%	7.30%	8.40%	9.40%
600-800%	\$76,230	\$0	\$3,421	\$3,991	\$4,561	\$5,131	4.50%	5.20%	6.00%	6.70%
800-1000%	\$98,010	\$0	\$3,421	\$3,991	\$4,561	\$5,131	3.50%	4.10%	4.70%	5.20%
>1000%	\$200,000	\$0	\$3,421	\$3,991	\$4,561	\$5,131	1.70%	2.00%	2.30%	2.60%

Source: Bernene, Chris, "Finding the Profit Zone, Business Designs for the Individual Health Insurance Market," Oliver Wyman (2012) www.oliverwyman.com

Desired Impacts of VBID

- In addition to reducing downstream costs, impact of VBID
 - Right sizing health care: Paying for what matters
 - Greater investments into primary care, preventive services
 - Getting people back to work earlier, back to normal routine & family life earlier: emphasis on therapy
 - Rx: Increased patient safety and optimal utilization of pharmacotherapy. Currently for every dollar spent on Rx, another dollar spent on directly related medical misadventures due to ill effects of polypharmacy
 - Goal: Reductions in narcotics prescribed
 - Goal: Reductions in preference sensitive drugs (e.g., Nexium)
 - Emphasis on consumer engagement with positive predictors on improved eventual outcomes (e.g., weight loss prior to bariatric surgery)
 - Critical importance of behavioral health integration as support for consumer engagement
- Value over Volume – need for payment reform as well: reward extra time for those who need it

How We Say It Matters

“Value” is perceived by public at large that something is being taken away from them – this presents a communication and strategic challenge

People equate value with “bargain-basement pricing” not high-quality care

Tested statement:

“Here in our community, we are looking at ways to improve the health care that we all receive, so that we get more for the money we spend. That includes making sure that doctors understand that we want to pay for the right care, not tests that we do not need or other unnecessary procedures.”

Charlotte, N.C., woman:

“More for the money, I don't know, it sounds like you are buying bulk.”

Focus group held in Charlotte, N.C. for the Robert Wood Johnson Foundation, 1 March 2011.

Source: “Communicating about Reform,” Chuck Alston, chuck.alston@mslgroup.com

Connecting VBID with Patient Wants

What Do Patients Want?

- More time with their physicians
- Better coordinated care
- To not pay more

Takeaway 1: They actually want an ACO wrapped around a medical home. (Just don't use those phrases.)

Takeaway 2: They will engage in a conversation about the delivery and reimbursement system if they think it would give them more of what they want without costing them more.

Source: “Communicating about Reform,” Chuck Alston,
chuck.alston@mslgroup.com

Use of VBID to Facilitate CER

“Five Reasons That Many Comparative Effectiveness Studies Fail To Change Patient Care And Clinical Practice” (Article by Justin Timbie, et al., RAND Corporation, Arlington, VA)

1. **financial incentives, such as fee-for-service payment;**
2. ambiguity of study results that hamper decision making;
3. cognitive biases in the interpretation of new information;
4. failure of the research to address the needs of end users;
5. **limited use of decision support by patients and clinicians.**

“Policies that encourage the development of consensus objectives, methods, and evidentiary standards before studies get under way **and that provide strong incentives for patients and providers to use resources efficiently** may help overcome at least some of these barriers and enable comparative effectiveness results to alter medical practice more quickly.”

A Call For Action

We view our establishment of a CO-OP as an opportunity – an opportunity to develop a new model of providing health insurance coverage that entails **payment reform, reinvestment into primary care, and lower administrative costs** with savings passed directly on to the businesses and subscribers themselves as the controlling entity of the non-profit CO-OP.

For more information:

Maine Community Health
Options:

<http://www.maineoptions.org>

The Center for Consumer
Information & Insurance
Oversight:

[http://cciio.cms.gov/programs/
coop/index.html](http://cciio.cms.gov/programs/coop/index.html)

CO-OP Funding Opportunity
Announcement (FOA) at:

<http://www.grants.gov> (CFDA
93.545)

CO-OP Final Rule at:

<http://www.regulations.gov>



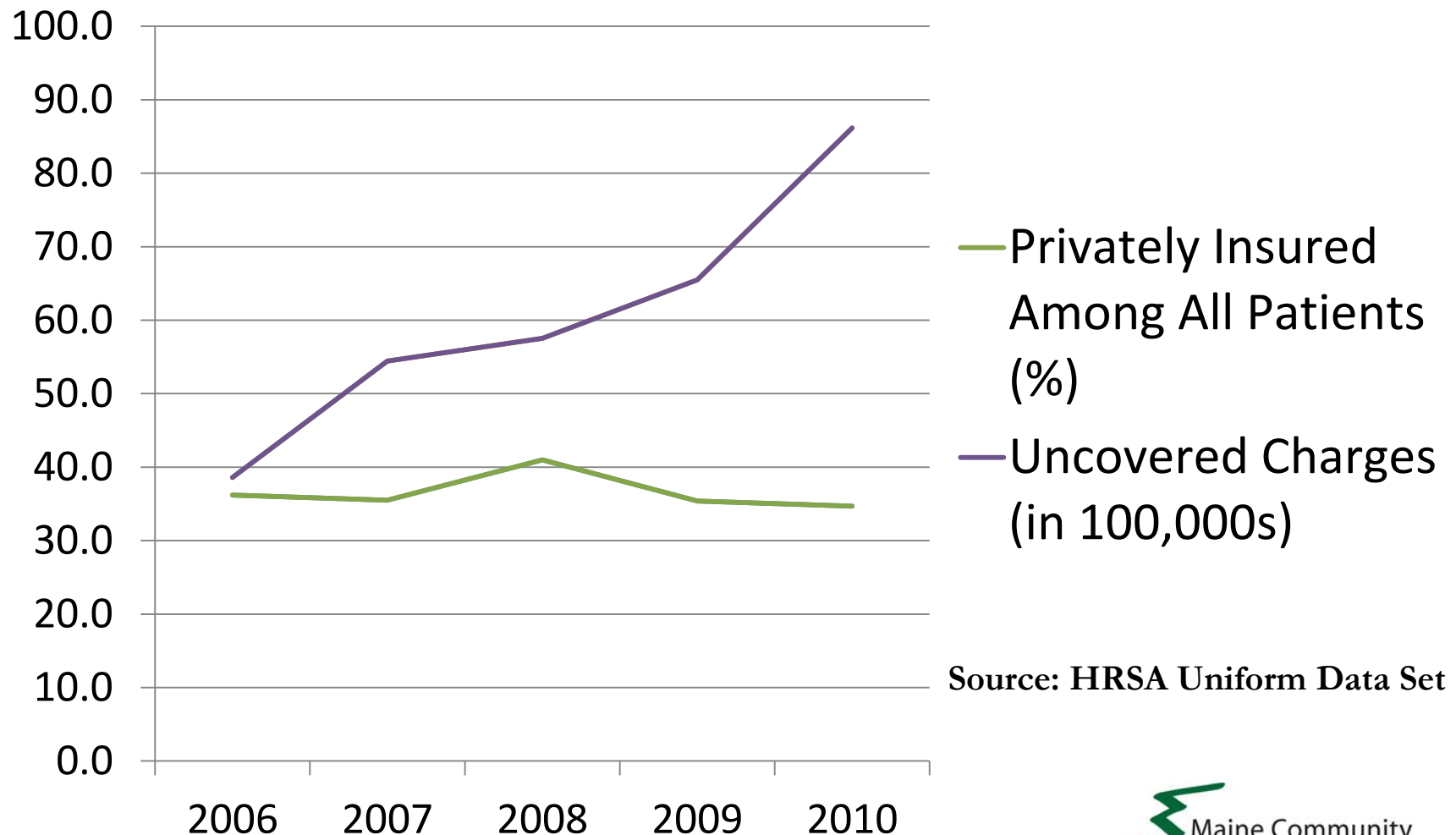


Thank You

**Kevin Lewis, CEO
Maine Community Health
Options
70 Lincoln Street, Suite 1-C
Lewiston, ME 04240
207-754-9516
klewis@maineoptions.org**

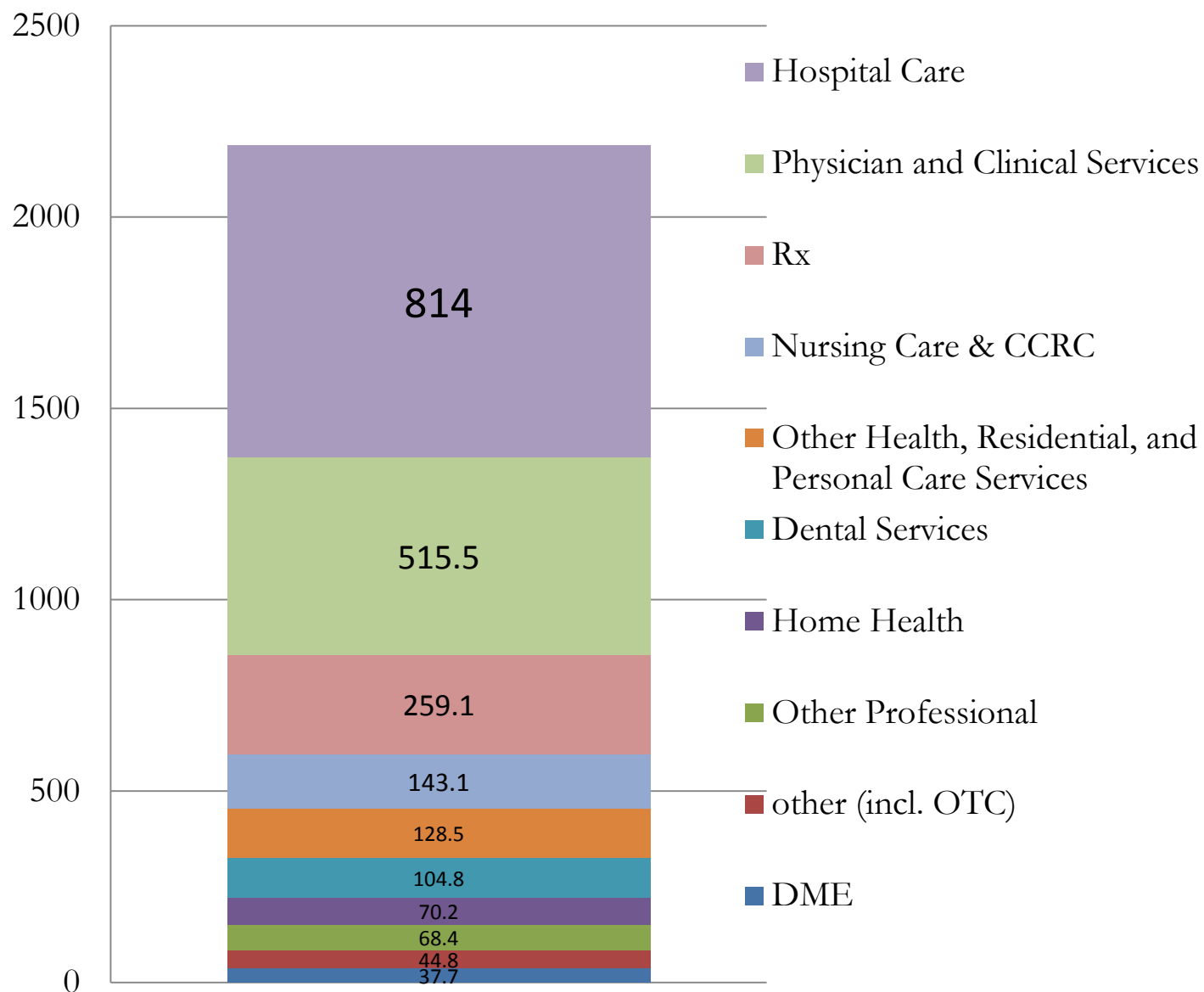
EXTRA SLIDES

Maine FQHC experience with commercial insurers, 2006-2010



Source: HRSA Uniform Data Set

US 2010 Health Care Spending, in \$ Billions



Unsustainable Health Care Spending

- Maine’s current health care costs account for 22.4% of GDP (Maine Development Foundation, Measures of Growth)
- National health spending is assumed by Deloitte to grow an average of 6.5% per year through 2021 unless we take significant action
- Significant Cost Driver: Obesity
 - ❖ Medical costs of obesity doubled from \$78.5 billion in 1998 to \$147 billion in 2008. The rise in obesity prevalence accounted for 89 percent of the increase in obesity spending that occurred during this period
 - ❖ *“Across all payers, obese people had medical spending that was \$1,429 greater than spending for normal-weight people in 2006.”* Overall, obesity increases costs by 37 percent.

Exchanges promise competition, choice, clout

- Compare/Select QHPs that meet benefit design, consumer protection and other standards
- Increase competition
- Lower costs for individuals by increasing the size of the risk pool
- CBO estimates reduced premiums for the same benefits compared to prior law
 - Coverage expansion ➡ healthier risk pool ➡ **7-10% reduction**
 - Economies of scale ➡ **another 7-10% reduction**

Changing Marketplace

- New individual market dynamic: “Approximately two-thirds of buyers in the market will purchase on state-sponsored exchanges, and the remaining one-third through a variety of other channels.” (Oliver Wyman)
- Deloitte projections nationwide:
 - Uninsured declines from 52 million in 2012 to 32 million in 2021
 - Health Insurance Exchange grows to **30 million** by 2021
 - Exchange volume grows to account for 83% of the individual market in 2021

Implications of Other Buzz Words

Chuck Alston's findings:

- “Eliminating waste,” “increasing efficiency” or even “saving money” sparks fear of rationing care that they want – and feel they need – but that may be expensive
- Feelings that care will be cheapened, or that time with physician will be cut or – worst of all – that the care that they want could be curtailed is threatening. It shuts down the conversation.
- Hospitals are on red alert to reduce readmissions to avoid Medicare penalties
- Communicators need to be on red alert to not make it sound like the hospital or health system wants to ration care

DON'T focus keeping people out of the hospital

DO focus on the solution -- improving care for patients when they return home -- because it will be seen as a benefit

Source: “Communicating about Reform,” Chuck Alston, chuck.alston@mslgroup.com

Natural Affinity with PCMH



“The doctor-patient relationship is the foundation for messaging about quality improvement or delivery and payment reform. Start here and build out.”

**Source: “Communicating about Reform,”
Chuck Alston, chuck.alston@mslgroup.com**

Importance of PCMH

- Group Health Cooperative in Puget Sound: 29% reduction in ER visits
- Community Care of North Carolina: savings of \$135 million in Medicaid and SCHIP costs
- Genesee Health Plan's Healthworks PCMH model: reduced IP by 15% and ER visits by 50%
- Johns Hopkins' PCMH model: annual savings of \$1,364 per Medicare patient
- Qliance experiment:
 - 65% reduction in ER visits
 - 43% reduction in hospital days
 - 66% reduction in specialist visits
 - 63% reduction in advanced radiology
 - 82% reduction in surgeries
 - Double the regional average for primary care visits

Source: Sandra Wood, The Medical Home Bends Cost Curve, Benefits Quarterly, 3rd Quarter 2012

The Road Ahead

