WildBlue
HEALTH SOLUTIONS

Improving the Health of Texas

Health ≠ Health Care ≠ Health Insurance

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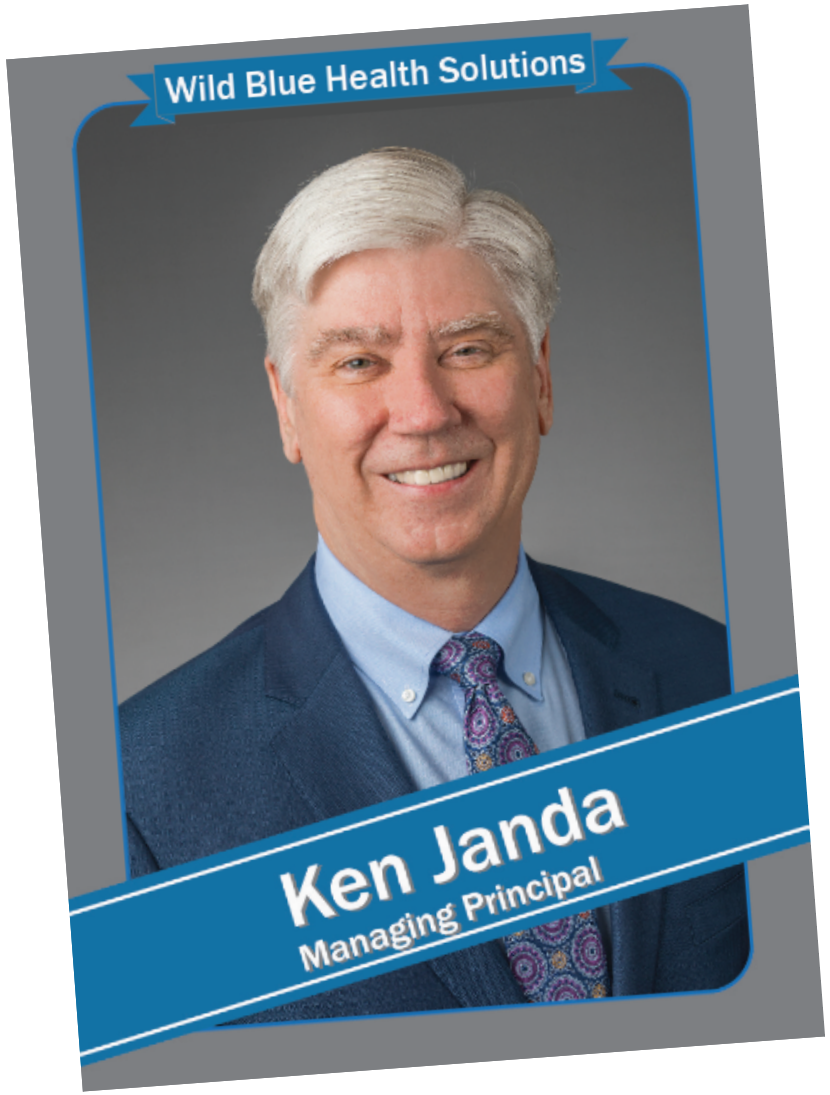
Slides at Wildbluehealthsolutions.com

About Ken



- Principal, Wild Blue Health Solutions, a strategic consultancy taking on changing care and payment models, and increasing coverage for all Texans.
- Adjunct professor at University of Houston College of Medicine and Jones Business School, Rice University
- Former CEO of non-profit health insurer Community Health Choice, focused on low-income populations
- Over 25 years experience with national health insurers Prudential, Aetna and Humana
- Health policy wonk (Rice University, Texas Medical Center, Center for Public Policy Priorities and more)
- B.A. Rice University; J.D. U of H Law Center
- Native Texan…small town roots, big-city perspectives
- Husband, father of two and grandfather of four
- Community board volunteer (San Jose Clinic, Christ Clinic and others)
- Huge baseball fan. Still loves the Astros.

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(based on work of D. Kindig, Social Determinants of Health)

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GOAL

HEALTH

Individual and Population, measured by both length and quality of life

CONTRIBUTORS

HEALTH CARE SERVICES
- Access and Quality
- Doctors
- Hospitals
- Pharmacies
- Ancillary Services

PERSONAL BEHAVIORS
- Tobacco Use
- Diet and Excercise
- Alcohol/Drug use
- Sexual Activity

SOCIOECONOMIC FACTORS
- Education
- Employment
- Housing
- Community Safety
- Transportation
- Food Security

PUBLIC HEALTH
- Water Sanitation
- Environment
- Communicable Diseases
- Immunizations

GENETICS
- Medical Research
- New Therapies

SUPPORTED BY MEDICAL EDUCATION AND RESEARCH

FINANCED BY

HEALTH INSURANCE 80%

PERSONAL PAYMENT 20%

INDIGENT, UNINSURED BAD DEBT ?

FUNDED BY

- Government
- Employers
- Individuals

- Government
- Private Philanthropy
- Individuals (e.g. Education)

INSURANCE COMPANIES? HEALTHCARE PROVIDERS?

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Social and Healthcare Spending by Country

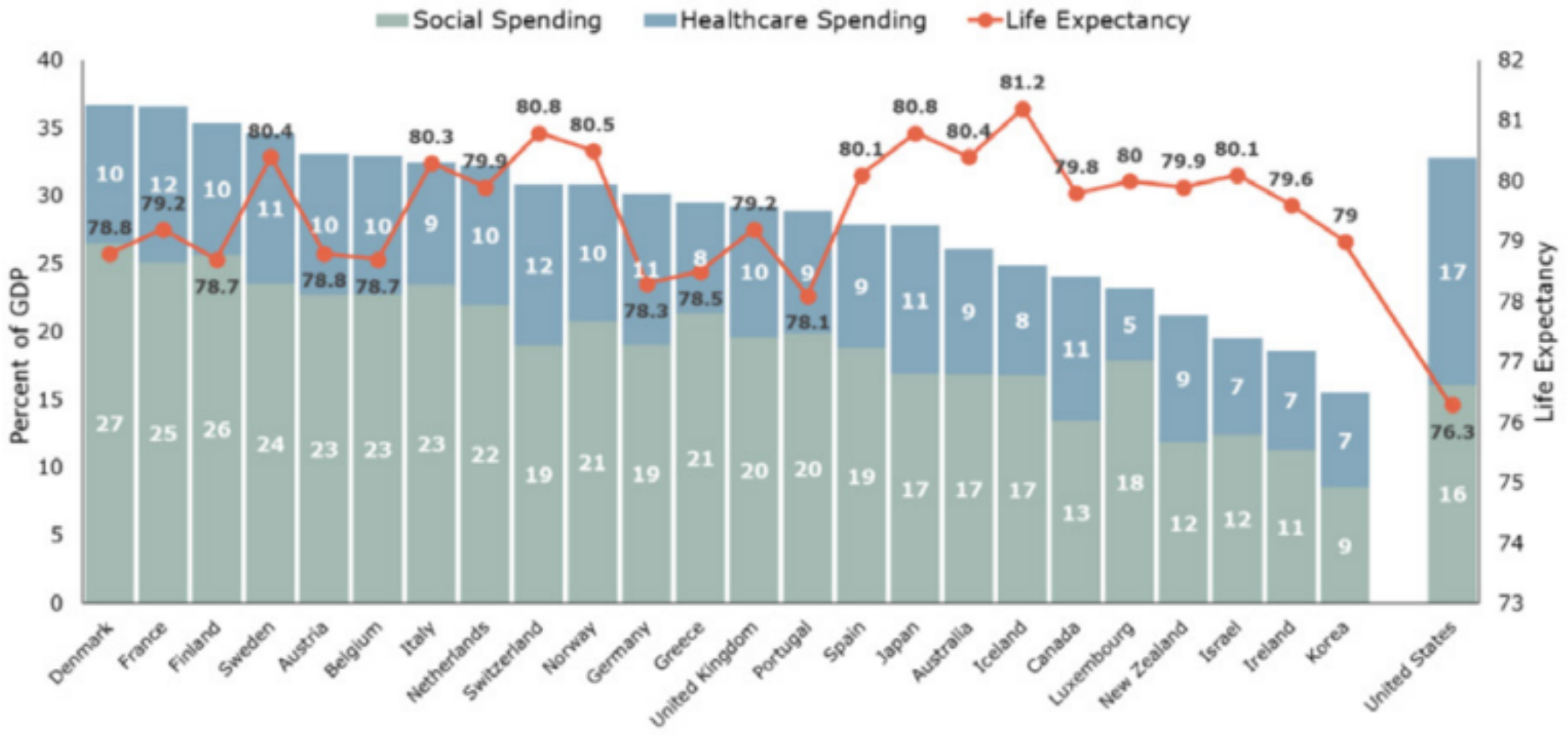

Image source: Episcopal Health Foundation, with data from Rubin, Jennifer, et al. "Are better health outcomes related to social expenditure?" Cambridge (UK): RAND Europe (2016) and OECD (2020) "Life expectancy at birth" (indicator). doi: 10.1787/27e0fc9d-en

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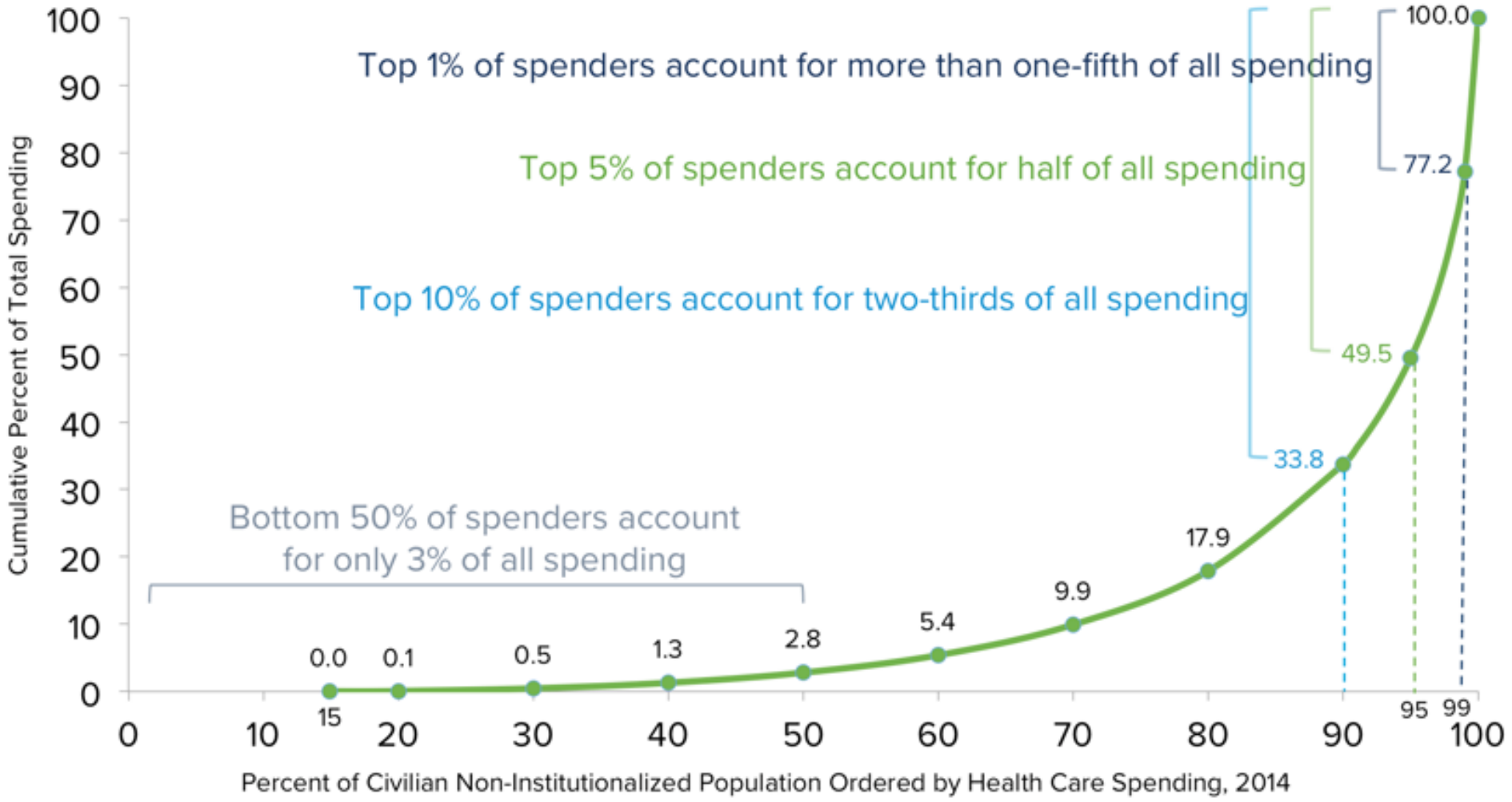
Health Care Spending is Highly Concentrated

We need insurance, but spend too much on "sick care"



NIHCM Foundation analysis of data from the 2014 Medical Expenditure Panel Survey

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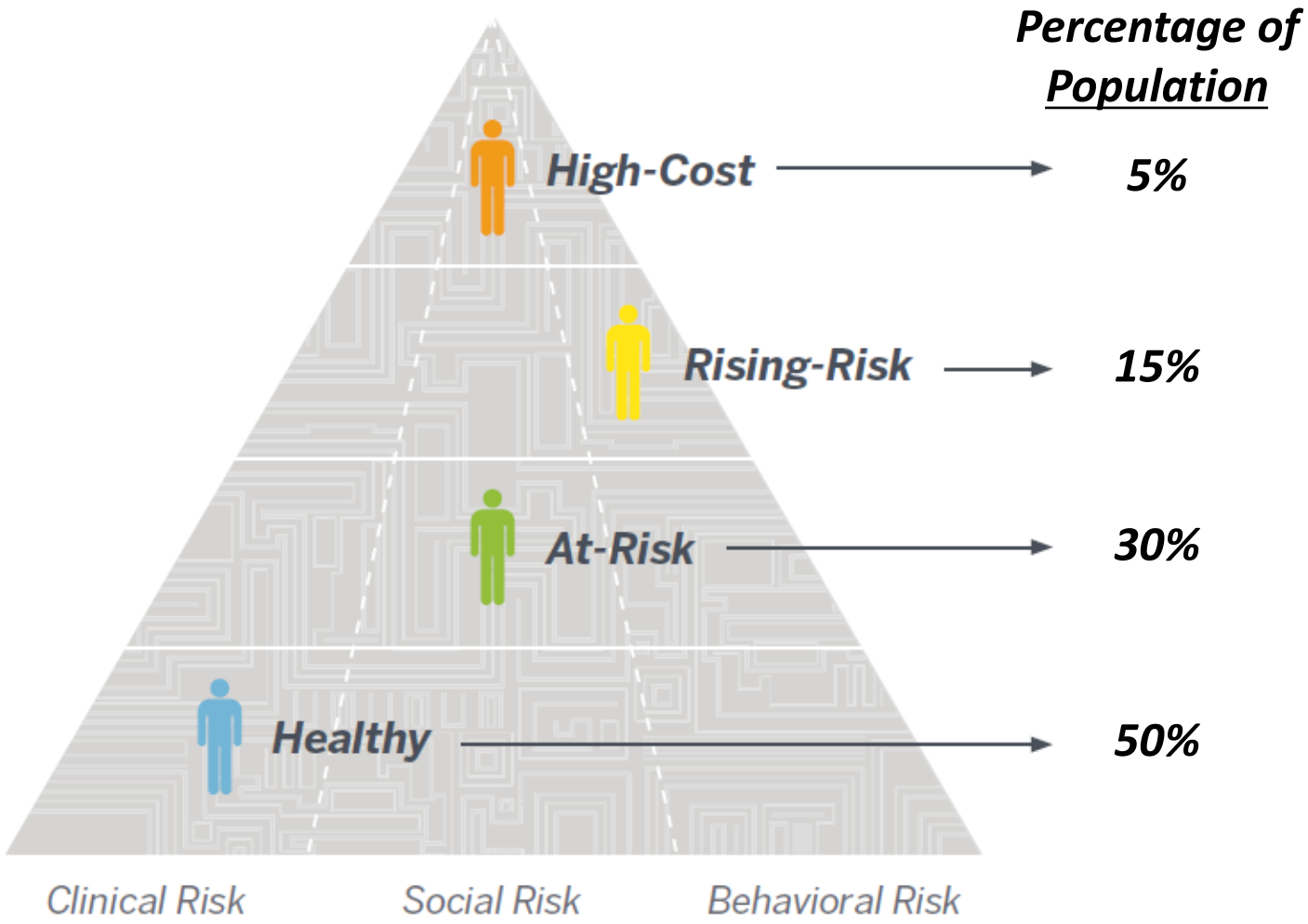
Population Health Pyramid

Risk Stratification



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Population Health Measures
Commonwealth Fund State Rankings

Prevention and Treatment

- Adults without all recommended cancer screenings
- Adults without all recommended vaccines
- Diabetic adults without an annual hemoglobin A1c test
- Children without a medical home
- Children without a medical and dental preventive care visit
- Children who did not receive needed mental health care
- Children without all recommended vaccines
- Hospital 30-day mortality
- Central line–associated blood stream infection (CLABSI)
- Home health patients without improved mobility
- Nursing home residents with an antipsychotic medication
- Adults with any mental illness reporting unmet need
- Adults with any mental illness who did not receive treatment

Access and Affordability

- Uninsured adults
- Uninsured children
- Adults without a usual source of care
- Adults who went without care because of cost
- High out-of-pocket medical spending
- Employee insurance costs as a share of median income
- Adults without a dental visit

Healthy Lives

- Mortality amenable to health care
- Breast cancer deaths
- Colorectal cancer deaths
- Suicide deaths
- Alcohol deaths
- Drug poisoning deaths
- Infant mortality
- Adults who report fair or poor health
- Adults who smoke
- Adults who are obese
- Children who are overweight or obese
- Adults who have lost six or more teeth

Avoidable Hospital Use and Cost

- Hospital admissions for pediatric asthma
- Potentially avoidable emergency department visits ages 18–64
- Potentially avoidable emergency department visits age 65 and older
- Preventable hospitalizations ages 18–64
- Preventable hospitalizations age 65 and older
- Hospital 30-day readmission rate ages 18–64
- Hospital 30-day readmission rate age 65 and older
- Skilled nursing facility patients with a hospital readmission
- Nursing home residents with a hospital admission
- Home health patients with a hospital admission
- Adults with inappropriate lower-back imaging
- Employer-sponsored insurance spending per enrollee
- Medicare spending per beneficiary

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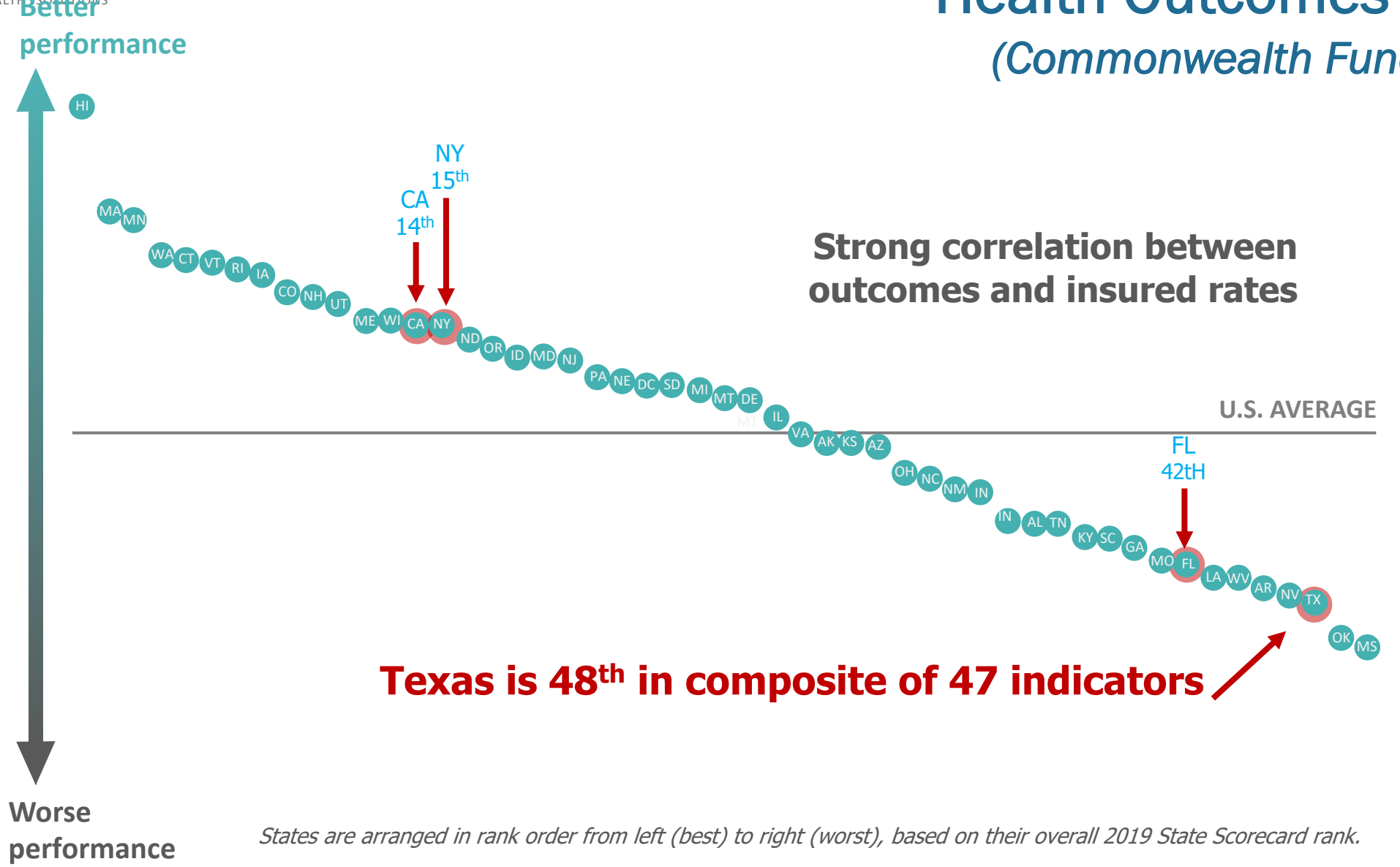
Health Outcomes by State

(Commonwealth Fund Example)

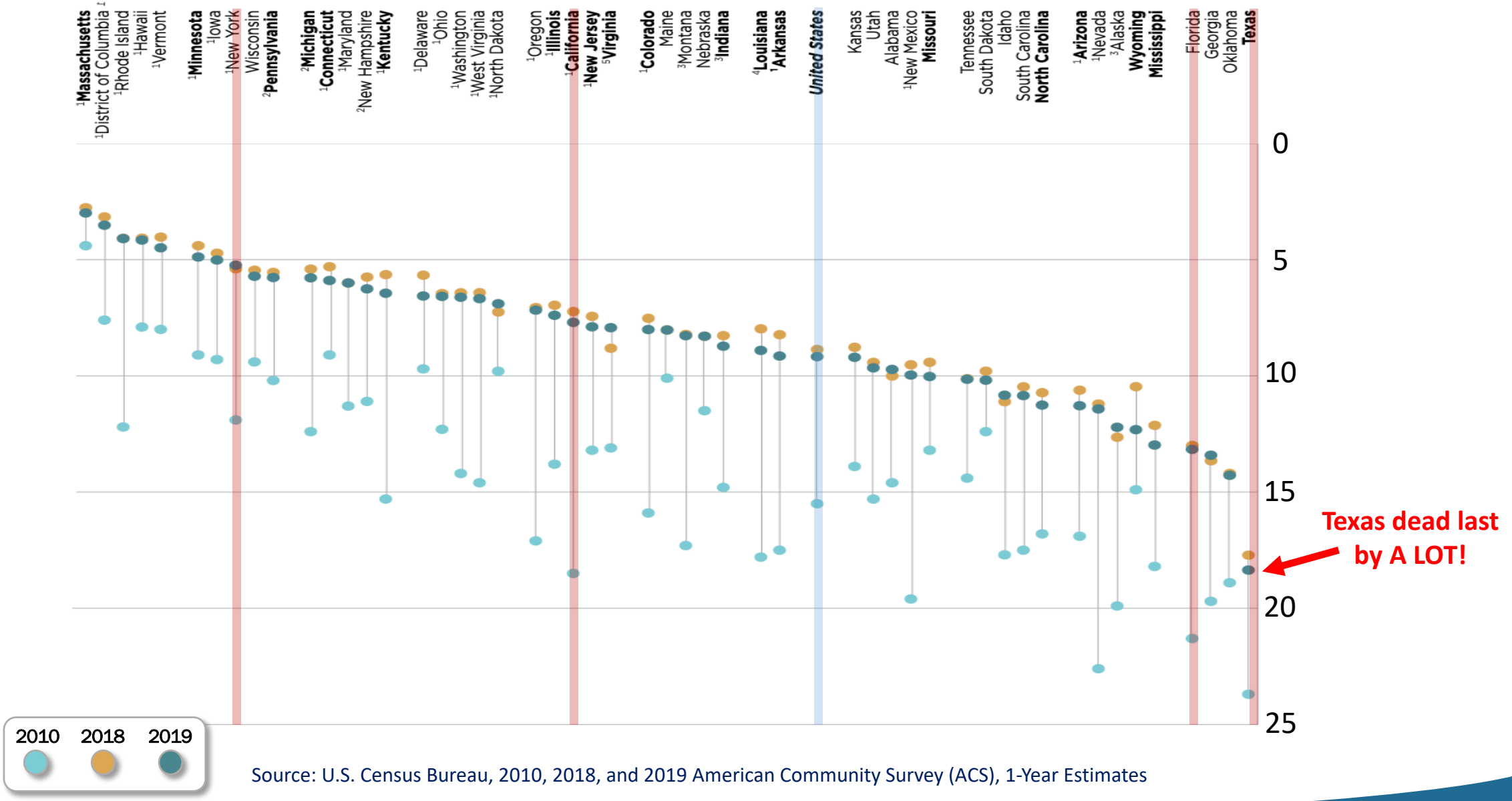


States are arranged in rank order from left (best) to right (worst), based on their overall 2019 State Scorecard rank.

Source: Commonwealth Fund 2019 State Rankings on Health System Performance

Percentage of People Without Health Insurance Coverage by State:

2010, 2018, and 2019



Texas dead last by A LOT!

Source: U.S. Census Bureau, 2010, 2018, and 2019 American Community Survey (ACS), 1-Year Estimates

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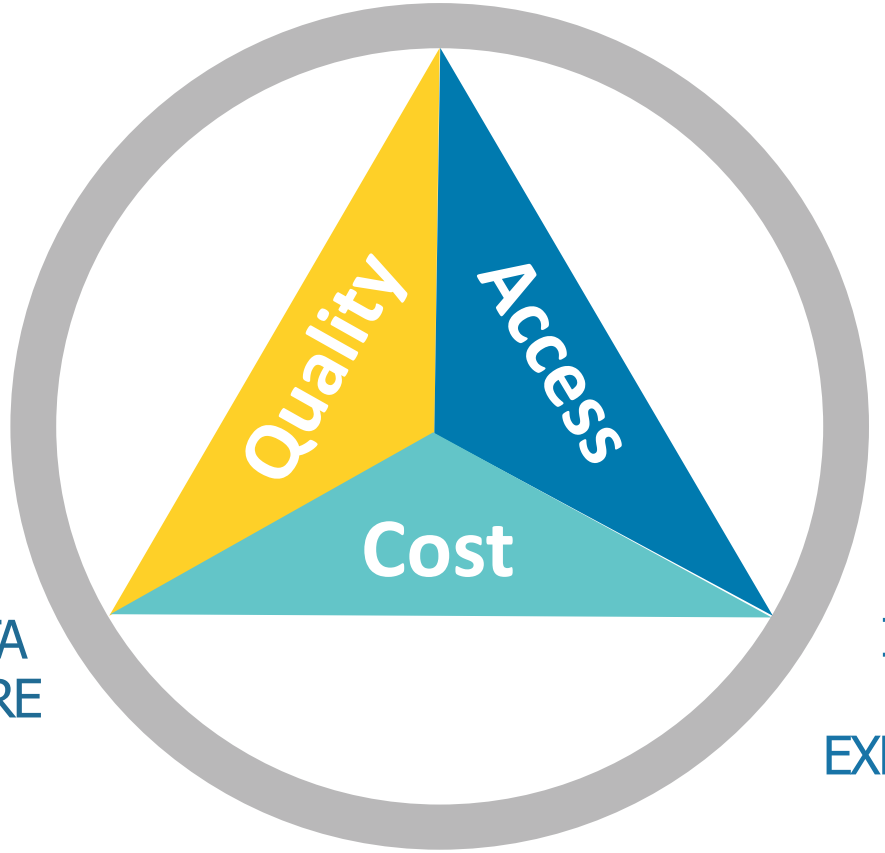
The Health Care Triple Aim, not The Iron Triangle

IMPROVING THE HEALTH OF POPULATIONS



REDUCING PER CAPITA COSTS OF HEALTH CARE FOR POPULATIONS

IMPROVING THE INDIVIDUAL EXPERIENCE OF CARE

Berwick, IHI vs. Kissick, Penn. "Infinite Needs vs. Finite Resources"

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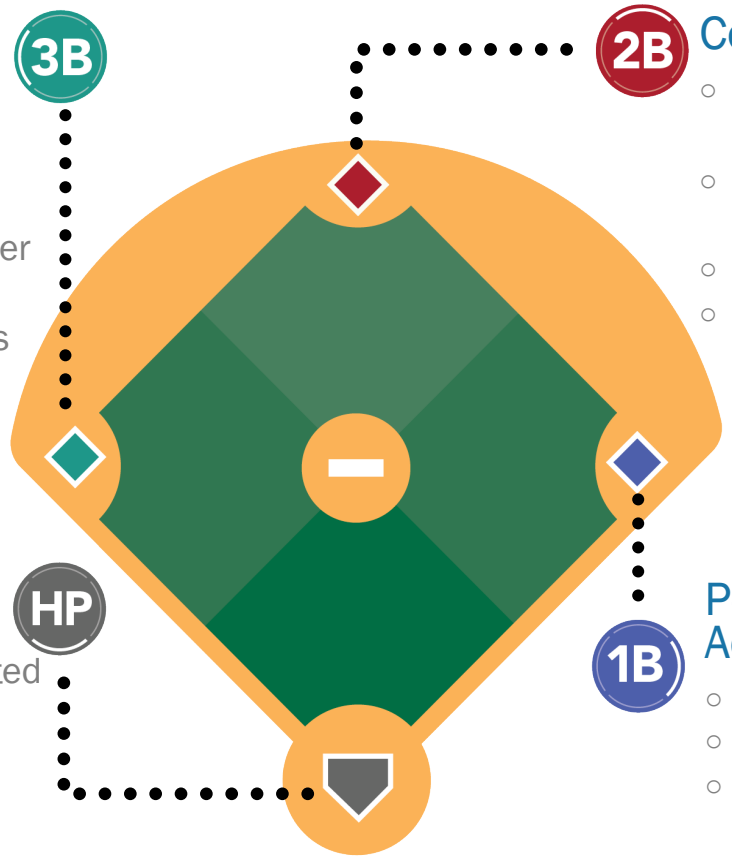
Our Goals: A Health Policy Home Run

Simplify Funding and Administration of Programs

- Reduce administrative burden through consistent program administration
- Reduce complex supplemental provider funding in government programs
- Integration/interoperability of systems
- Blended health and social funding

Slow Cost Increases through Provider Payment Reform

- Encourage coordinated, less fragmented care (medical homes, ACOs, etc.)
- Restructure provider payments to reward efficiency and quality (value-based payments)
- Assure fair payment rates across programs and providers, incl Rx



Coverage for Everyone

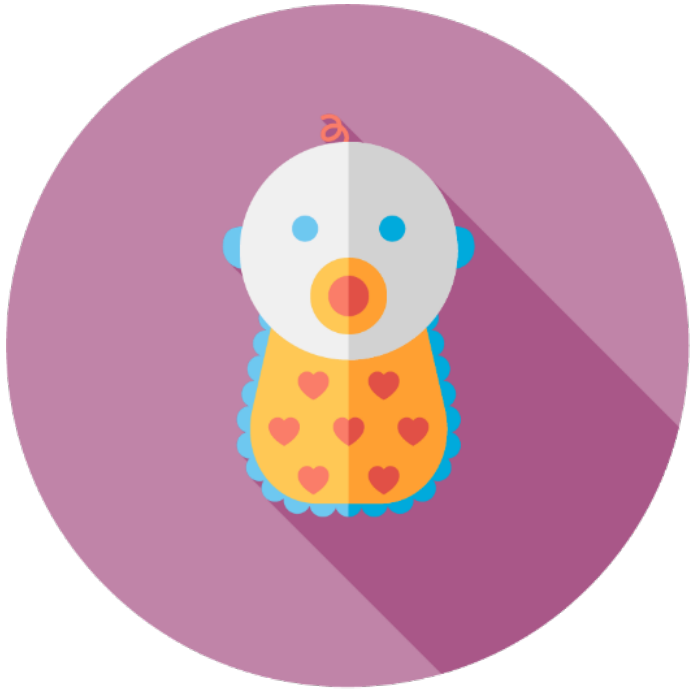
- A basic benefit plan for all based on age, income, disability
- Choices and ability to "buy up" for additional services
- Everyone in the pool
- Subsidies based on age and income

Personal & Community Accountability for Health

- Healthy behaviors
- Community/social determinants
- Choices, transparency and consumerism
- Everyone pays something: based on income

Final Thoughts

The future of Texas' health, for our children and grandchildren, depends on our actions



Texans love our liberty, but health is dependent on "e pluribus unum"

Thank you!

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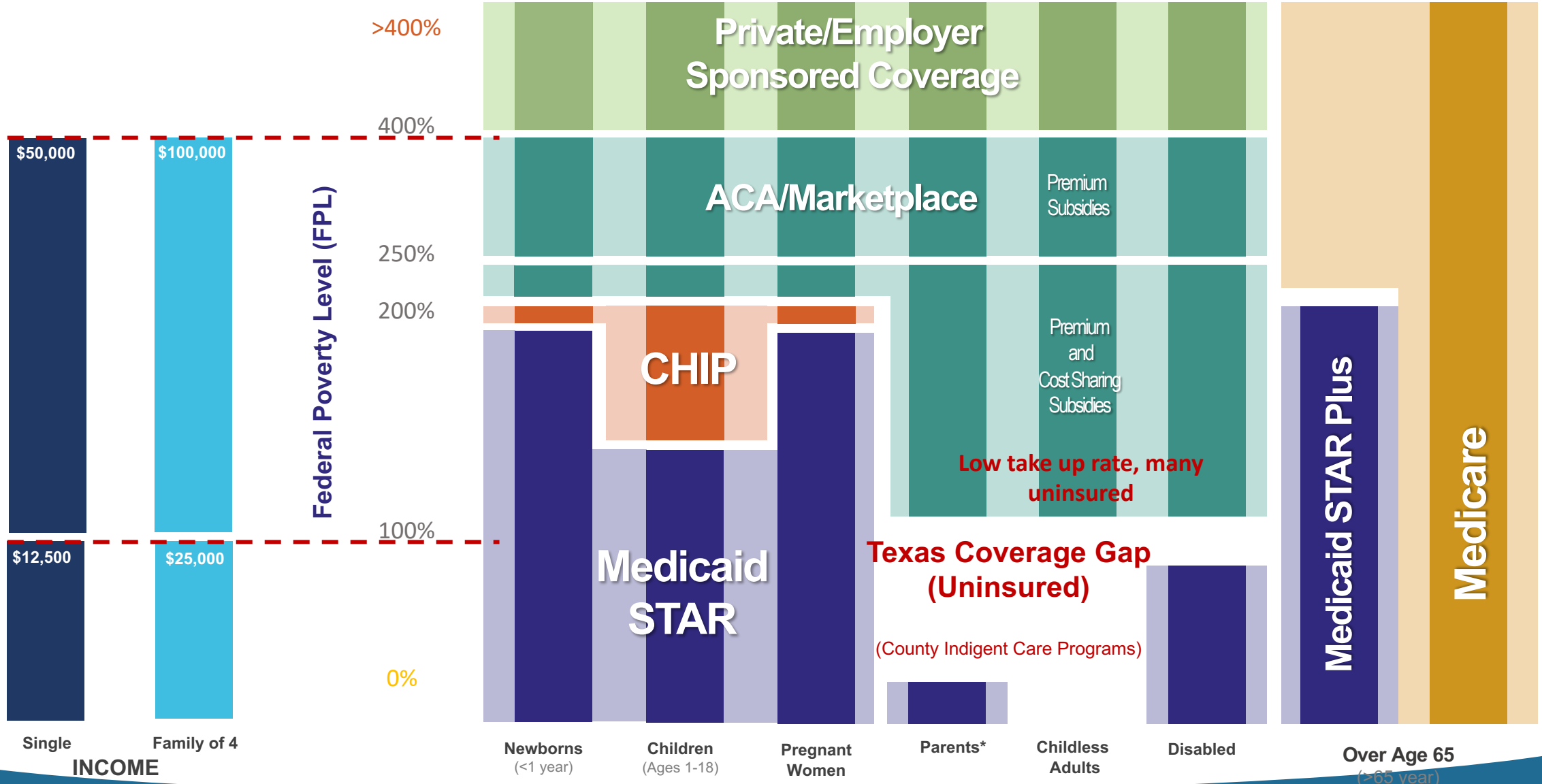
Additional slides

Texas Health Insurance is Too Complicated

Predominant Coverage by Age and Income- Texas



Who are these uninsured people?

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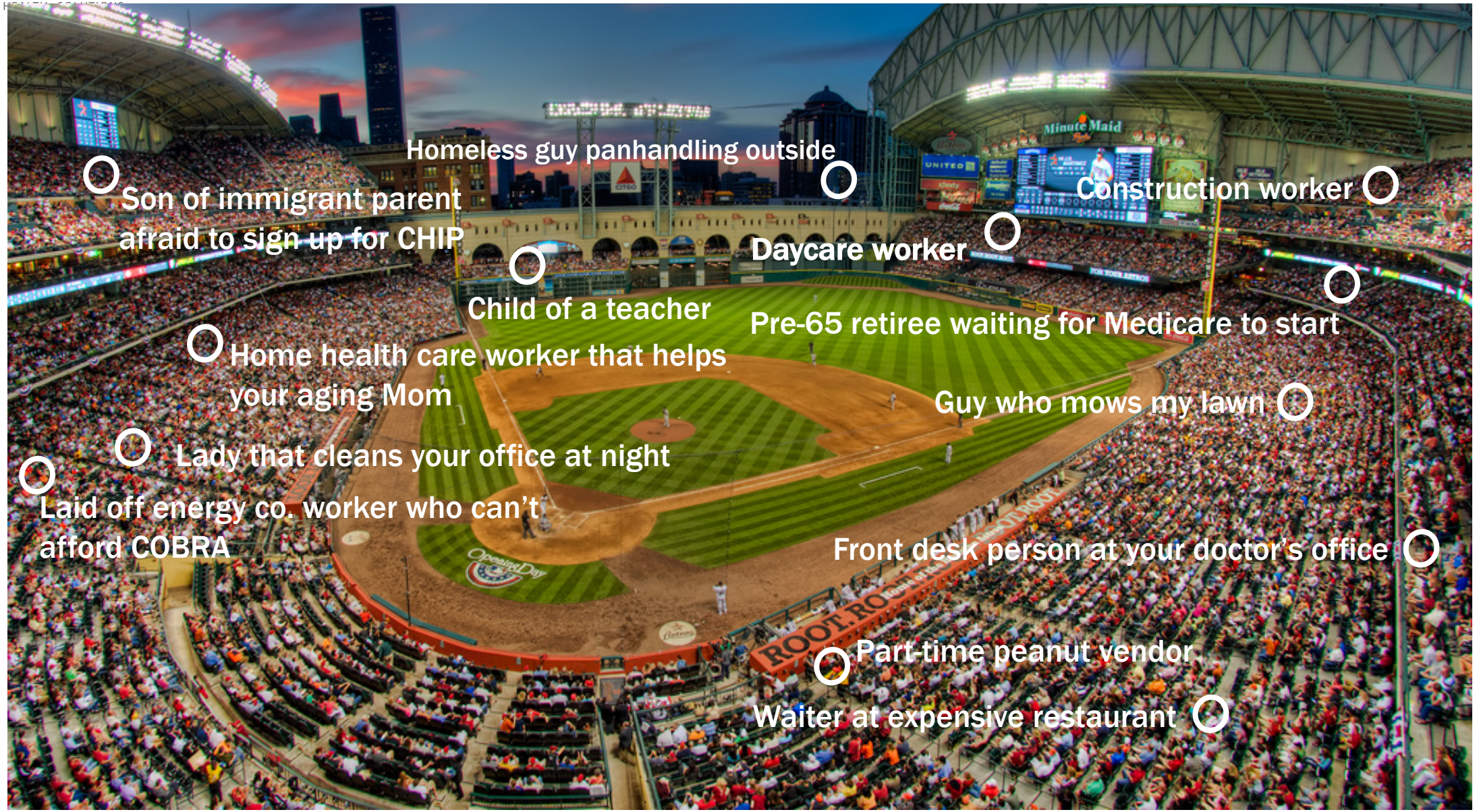
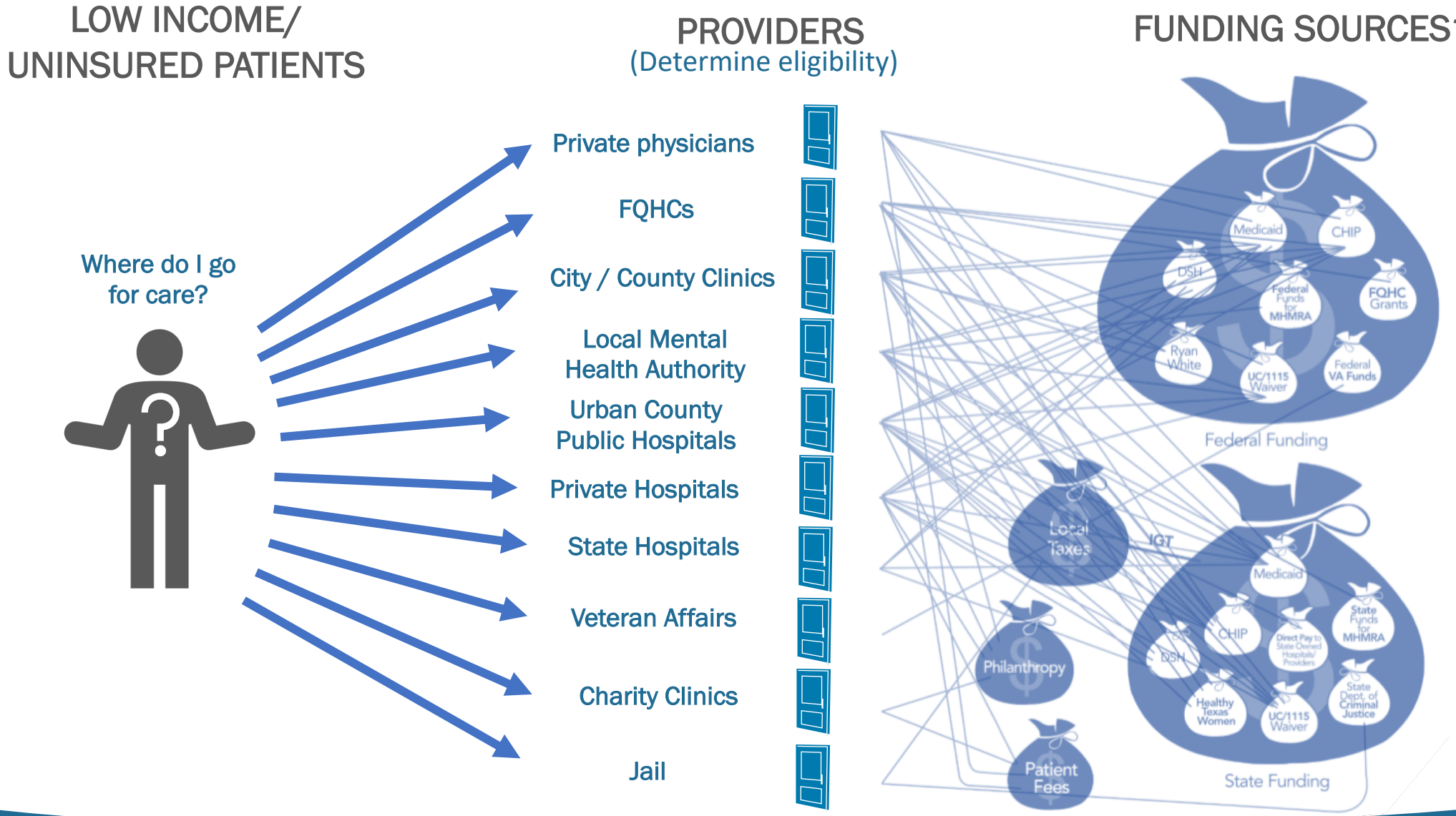


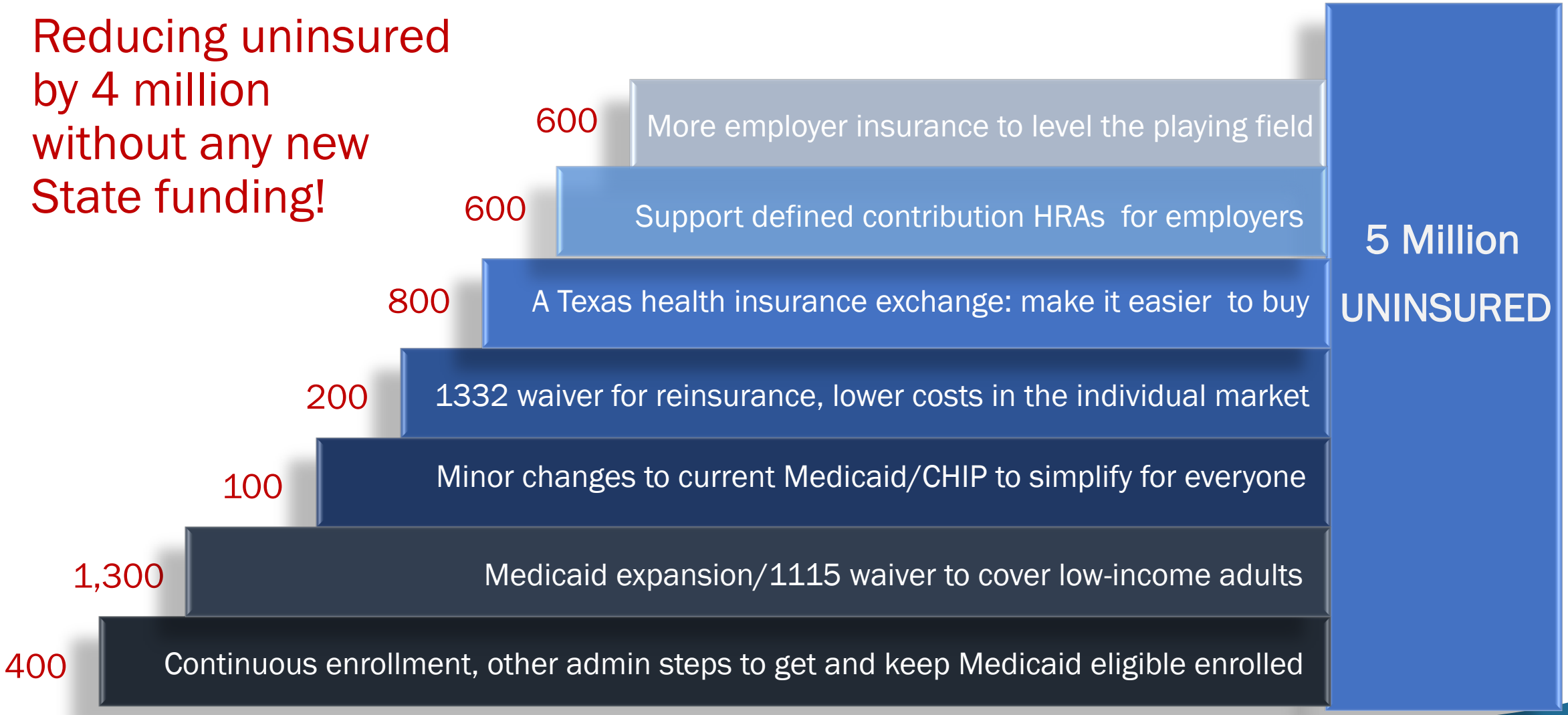
We Pay for the Uninsured:
Inefficient Financing and Poor Outcomes (Coverage is Better)



Seven Steps to a Comprehensive Texas Solution

(without new State funding)

Reducing uninsured by 4 million without any new State funding!



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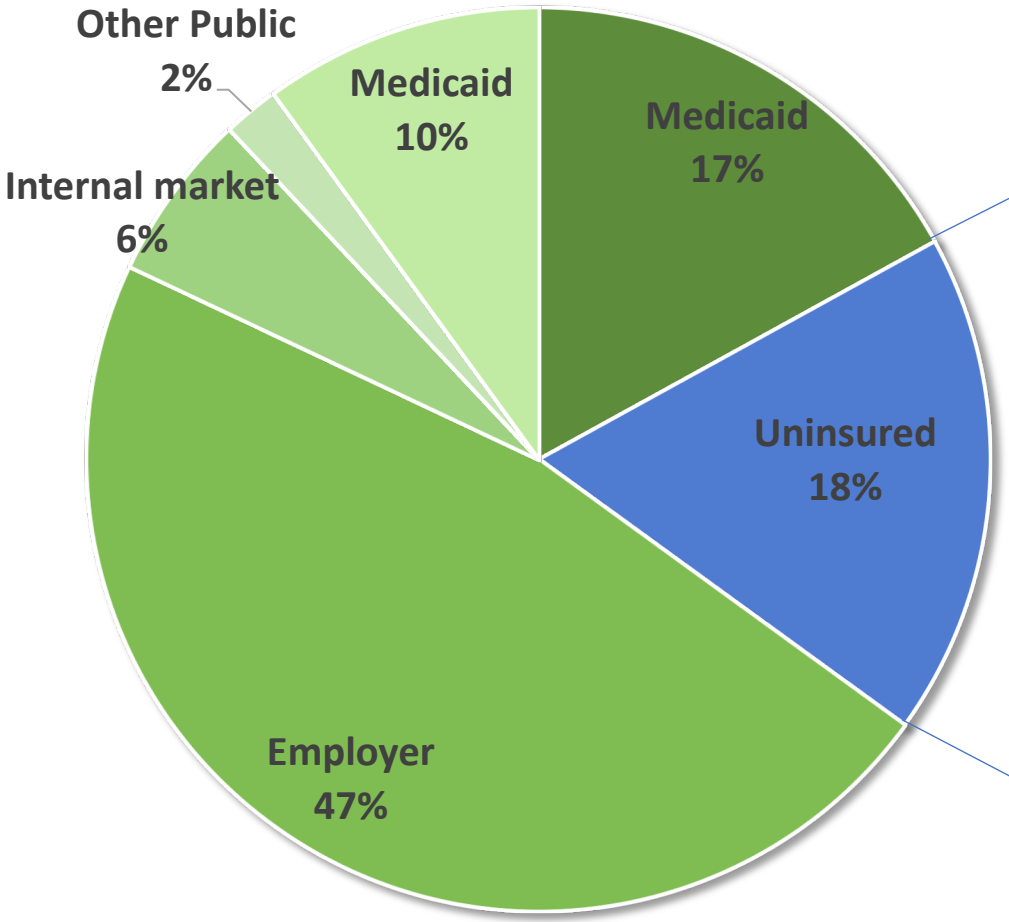
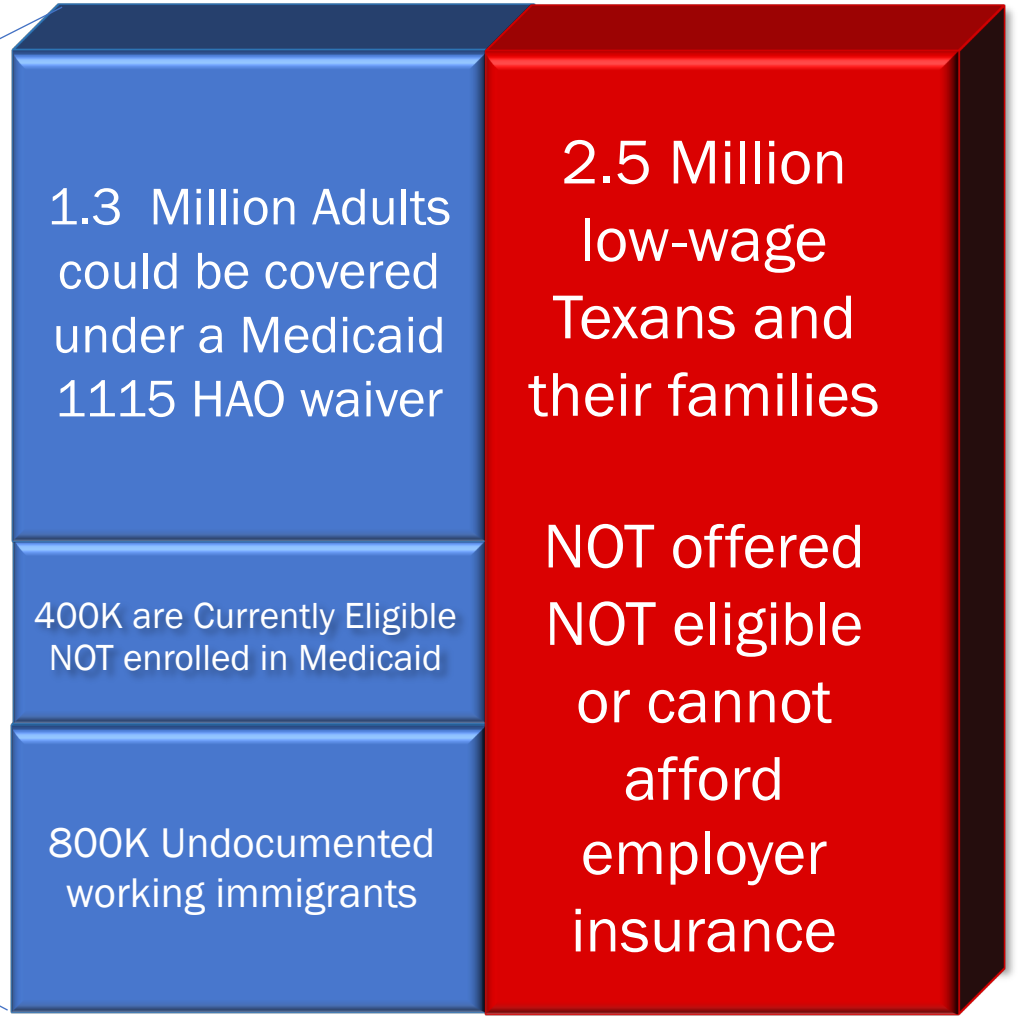
Five Million Uninsured Texans

(Pre-COVID… Now nearly 6 million?)





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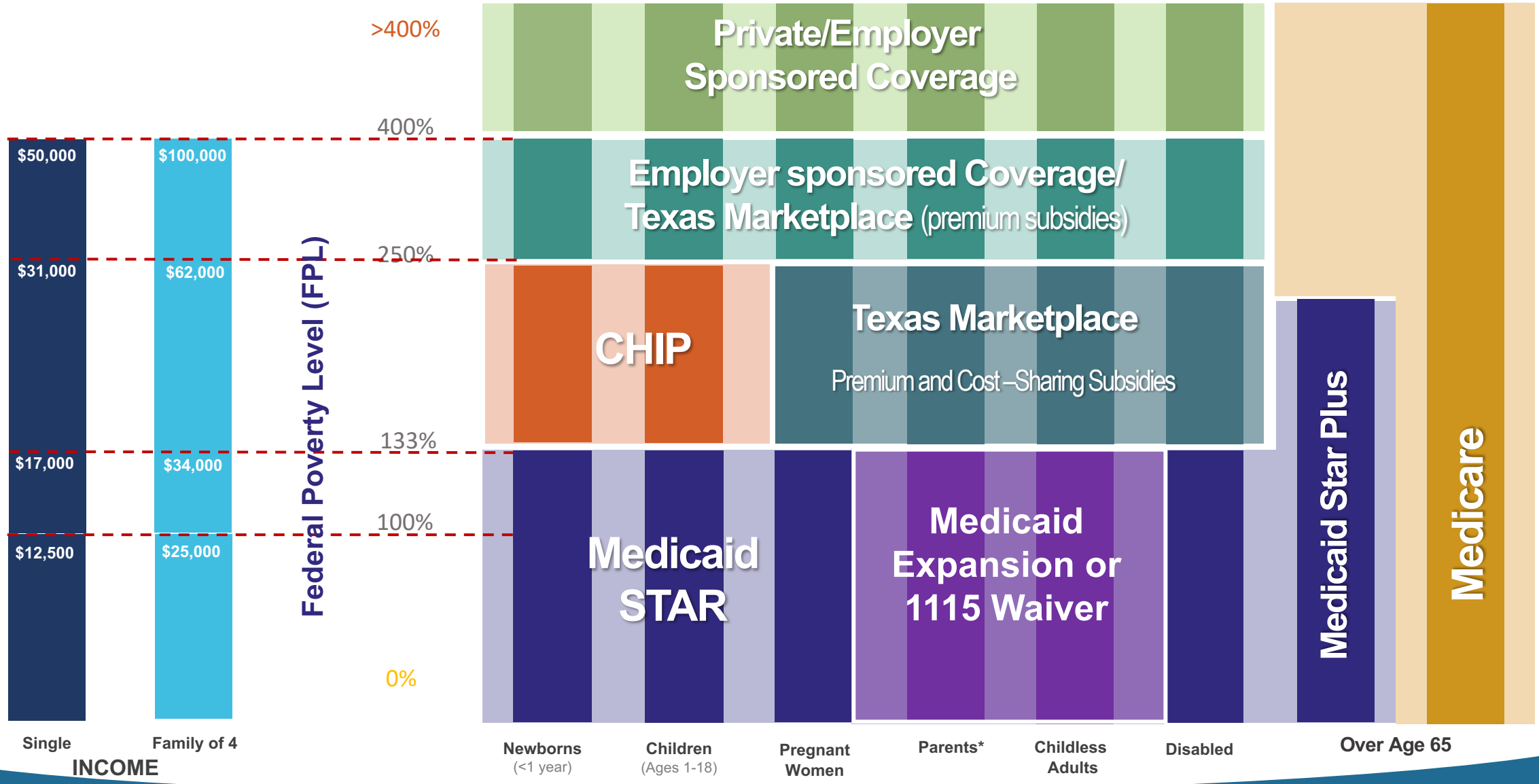
A New Vision for Health Insurance In Texas

Comprehensive Approach Across Age and Income



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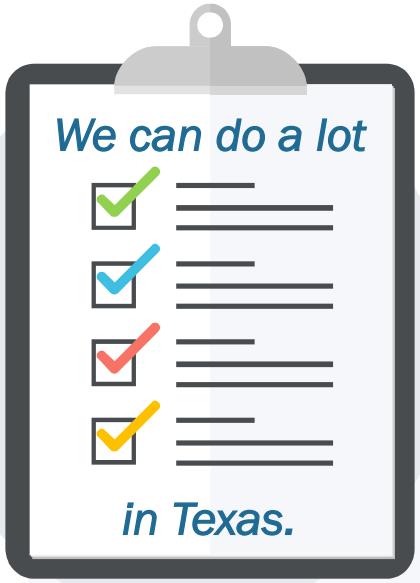
A Texas Solution to Medicaid Expansion

Coverage to reduce disparities. Support providers. Save State $ in budget.

- Poor health is big contributor to unemployment, poverty
- Rural and urban safety net providers desperately need funded patients
- 90% paid with federal dollars, 10% state share from offsets or provider fees. $1 billion budget savings?
- Can be done with flexibility, new 1115 waiver



- Address institutional racism
- Current funding for uninsured is a complex mess, focused on providers not patients
- 1115 waiver DSRIP coming to end. Need to act now!
- Coverage allows better measurement of results, value

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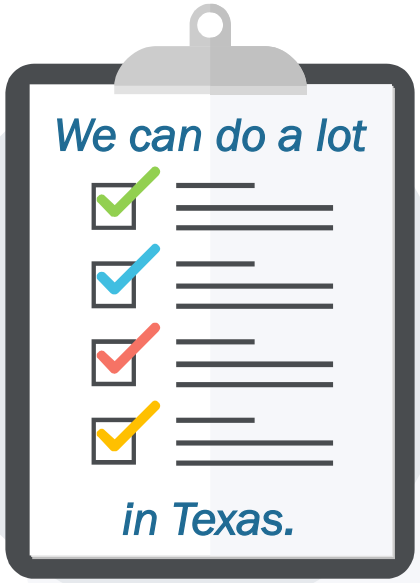
Why a Texas-based Insurance Exchange?

Lower Marketplace premiums. A better experience. Cover more people.

- Medicaid expansion covers low-income adults now in FFM*, lowers risk profile and premiums
- 1332 waiver for reinsurance lowers costs in the individual marketplace
- Defined contribution HRAs from employers increases funds for workers, supports "gig" economy
- Workers have more plan options, with ACA protections, increases take-up rate



- Texas exchange would push insurers to lower rates, less confusing plans
- Texas exchange fees lower than FFM, additional reduction in premiums or funding source for reinsurance
- Work closely with brokers to increase employer and employee buy-in
- Advertising, navigators and promotion of coverage not done currently

**Federally Facilitated Marketplace: healthcare.gov*

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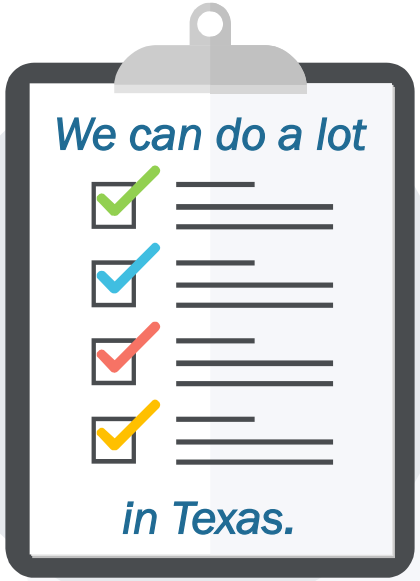
2nd to 3rd Base: Administrative Improvements

Administrative improvements will lower costs and improve patient and provider satisfaction

- Reduce provider payment variation between Medicaid, other programs
- Improve systems interoperability to simplify for providers, insurers
- End surprise provider billing
- Consistent eligibility and enrollment requirements across multiple programs



- Reduce complex, opaque supplemental payment programs using Medicaid funds
- Reduce provider payment, administrative rule variations between plans
- Increase transparency of payment rates
- Fix provider participation and directory issues

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Don’t leave us stranded on 3B

Cost is a Big Issue for Everyone

…but it’s hard to slow cost growth unless everyone is covered

- Administrative simplification and standards across segments
- Simplify financing and increase transparency to reduce provider cost-shifting (price discrimination)
- Payment reform: pay for value, not volume
- Encourage insurers to compete on premiums in all segments
- Recognize that market forces can’t do it all: Regulate certain Rx drug prices, hospital-based physicians

HP