Exploring Strategies To Fix the Private Health Insurance Market

PROFESSIONAL LEGISLATIVE STAFF SEMINAR
October 10-12, 2018 - NCSL Health Program
On the Eve of 2019 Open Enrollment, Where Does the US Stand on Insurance Coverage and What’s Next for the Marketplaces and Health Reform?

NCSL Improving Health System Performance Professional Legislative Staff Seminar, New Orleans, LA

Sara R. Collins, Ph.D., Vice President
Health Care Coverage and Access
October 12, 2018
Uninsured Rates Have Fallen in Response to Coverage Expansions, but Gains Have Flattened

Percent of individuals without health insurance*, 1997 - 2017

Notes: *At the time of interview. **2018 data is for January-March.
Some recent signs of coverage erosion

Percent of adults under age 65 who were uninsured all year

- Expansion states
- Non expansion states

Below 100% FPL, uninsured
Young adults, ages 19-25

Sources:
The uninsured rate increased in fourteen states in 2017, not all were Medicaid non-expansion states.

Change in uninsured rate, 2016-2017

Note: *Medicaid expansion status as of January 1, 2017.
Out-of-pocket Cost Protection Continues to Erode in U.S. Insurance

Percent adults ages 19-64 insured all year who were underinsured*

Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Total includes adults with coverage through Medicaid and Medicare. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace.


Marketplace premiums declined 1.5% in 39 states using HealthCare.gov in 2019

Notes: Premium changes are for the average monthly second lowest cost silver plan across the state. *Statewide individual market average rate change is only shown if an average was provided by the state through a press release. Delaware, Iowa, Nebraska, Ohio, Oklahoma, and Wyoming figures are the average on-exchange rate increases for exchange-participating insurers.

Effectuated enrollment in marketplace plans up in majority of states in 2018

Sources: Marketplace Open Enrollment Period Public Use Files for February 2017 Effectuated Enrollment Snapshot and February 2018 Effectuated Enrollment Snapshot from CMS.
Open enrollment calendar 2019 and 2020

- Nov 1, 2018: 2019 open enrollment begins
- Dec 15, 2018: Open enrollment ends for federal marketplaces and states that have not extended
- Jan 1, 2019: Coverage begins
- Jan 31, 2018: Open enrollment ends in MA (the latest deadline among 5 states with extensions)
- Sept 2019: Final rate filings due for participating insurers
- Early Summer 2019: Preliminary rate filings due for participating insurers
- Nov 1, 2019: 2020 open enrollment begins
- Feb 2020: All deadlines passed
Predictions for the Individual Market in 2019

All things equal
Continued marginal erosion in coverage, access, affordability due to public & private decision making at federal & state level, with significant variation by state.

Texas vs. Azar
Decision expected soon. If plaintiffs win, timing of ruling & appeal will matter regarding effects on individual market & coverage.

Penalty repeal & non-compliant ACA plans
Effect on marketplace enrollment in 2019 is uncertain. Size of STLD & AHP markets are unknown & will vary significantly by state, about 20 states ban/limit STLD policies, some limit AHPs. Premium tax credits will hold most enrollment in marketplaces, but growing market duality will challenge regulators.
2018 Midterms: Outcome has implications for 2019 legislation, 2020 presidential candidates’ proposals

Election Date: November 6, 2018

House
All 435 House seats are up for election this year

Senate
35 of 100 seats are up for election this year
Potential for bipartisan marketplace stabilizers?

Senators Alexander-Murray

- Reinstates cost-sharing reduction payments for two years.
- Reinstates partial amount of funding for marketplace outreach and enrollment.
- Permits the sale of “catastrophic” coverage.
- Changes 1332 waiver guidelines.

Senator Collins

- Establishes a $10 billion reinsurance plan.
- Reinstates cost-sharing reduction payments.

## 2020: Health Reform Principles

**Left to Right**

**Universal Coverage**

- Comprehensive coverage with little or no cost sharing
- Government bargaining power is essential to control costs

**Mixed public-private insurance**

- Competitive, regulated markets
- State flexibility with a federal floor

**Individual responsibility**

- Lower premiums through greater cost-sharing
- Considerable state flexibility
- Less regulated plan choices
### 2020: Health Reform Approaches

**Left to Right**

<table>
<thead>
<tr>
<th>Greater Federal Role</th>
<th>Greater State Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid buy-in</td>
<td>No individual mandate</td>
</tr>
<tr>
<td>Medicare for more</td>
<td>More non-ACA compliant policies</td>
</tr>
<tr>
<td>Single payer</td>
<td>State EHB flexibility</td>
</tr>
<tr>
<td>Building on the ACA</td>
<td>Fund cost-sharing reduction payments</td>
</tr>
<tr>
<td>Fund cost-sharing reduction payments</td>
<td>Reinsurance</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>Enhanced subsidies</td>
</tr>
<tr>
<td>Enhanced subsidies</td>
<td>Sen. Warren bill</td>
</tr>
<tr>
<td>Sen. Warren bill</td>
<td>Public plan fallback</td>
</tr>
<tr>
<td>Public plan fallback</td>
<td>No individual mandate</td>
</tr>
<tr>
<td>Fund cost-sharing reduction payments</td>
<td>More non-ACA compliant policies</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>State EHB flexibility</td>
</tr>
<tr>
<td>Work requirements</td>
<td>Fund cost-sharing reduction payments</td>
</tr>
<tr>
<td>Graham-Cassidy-Heller-Johnson</td>
<td>Reinsurance</td>
</tr>
<tr>
<td></td>
<td>Work requirements</td>
</tr>
<tr>
<td></td>
<td>Graham-Cassidy-Heller-Johnson</td>
</tr>
</tbody>
</table>
# Senators Graham-Cassidy-Heller-Johnson ACA Repeal/Replace Bill

## Repeals and Replaces ACA

<table>
<thead>
<tr>
<th>Repeals the ACA marketplace subsidies and federal funding for the Medicaid expansion in 2020.</th>
<th>Creates temporary block grants for states that end in 2026. States can use the funds for a wide range of purposes.</th>
<th>Repeals the individual and employer mandates. (Tax penalty repealed in 2017 tax bill.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates a waiver program for states that would allow insurers to charge people more based on their health and cut benefits like maternity care.</td>
<td>Places per capita spending limits on funding for the traditional Medicaid program.</td>
<td></td>
</tr>
</tbody>
</table>
Bills that “Build on the ACA” to “Medicare for More”

1. Consumer Health Insurance Protection Act (Senator Warren)
2. Medicare-X Choice Act (Senators Bennet-Kaine)
3. Choose Medicare Act (Senators Merkley-Murphy)
4. Medicare For All (Senator Bernie Sanders)
2018 Midterms: Governors races in 36 states

Source: RealClear Politics: 2018 Governor Races
# 2018 State Legislative Battleground Chambers

<table>
<thead>
<tr>
<th>Chamber</th>
<th>Seats up in 2018</th>
<th>Margin</th>
<th>Majority share of seats</th>
<th>Last time party control changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska House of Representatives*</td>
<td>All 40</td>
<td>D + 4</td>
<td>55%</td>
<td>2016</td>
</tr>
<tr>
<td>Arizona State Senate</td>
<td>17 / 30</td>
<td>R + 4</td>
<td>56.7%</td>
<td>2002</td>
</tr>
<tr>
<td>Colorado House of Representatives</td>
<td>All 65</td>
<td>D + 9</td>
<td>56.9%</td>
<td>2012</td>
</tr>
<tr>
<td>Colorado State Senate</td>
<td>17 / 35</td>
<td>R + 2</td>
<td>51.4%</td>
<td>2014</td>
</tr>
<tr>
<td>Connecticut House of Representatives</td>
<td>All 151</td>
<td>D + 9</td>
<td>53.0%</td>
<td>1986</td>
</tr>
<tr>
<td>Connecticut State Senate**</td>
<td>All 36</td>
<td>D + 0</td>
<td>50%</td>
<td>1996</td>
</tr>
<tr>
<td>Delaware State Senate</td>
<td>10 / 21</td>
<td>D + 1</td>
<td>52.4%</td>
<td>1974</td>
</tr>
<tr>
<td>Florida State Senate</td>
<td>20 / 40</td>
<td>R + 7</td>
<td>57.5%</td>
<td>1994</td>
</tr>
<tr>
<td>Maine House of Representatives</td>
<td>All 151</td>
<td>D + 4</td>
<td>49.0%</td>
<td>2012</td>
</tr>
<tr>
<td>Maine State Senate</td>
<td>All 35</td>
<td>R + 1</td>
<td>51.4%</td>
<td>2014</td>
</tr>
<tr>
<td>Minnesota House of Representatives</td>
<td>All 134</td>
<td>R + 21</td>
<td>57.5%</td>
<td>2014</td>
</tr>
<tr>
<td>Michigan House of Representatives</td>
<td>All 110</td>
<td>R + 17</td>
<td>57.3%</td>
<td>2010</td>
</tr>
<tr>
<td>Michigan State Senate</td>
<td>All 38</td>
<td>R + 17</td>
<td>71.1%</td>
<td>1982</td>
</tr>
<tr>
<td>Nevada State Senate</td>
<td>11 / 21</td>
<td>D + 2</td>
<td>47.6%</td>
<td>2016</td>
</tr>
<tr>
<td>New Hampshire House of Representatives</td>
<td>All 400</td>
<td>R + 43</td>
<td>54.0%</td>
<td>2014</td>
</tr>
<tr>
<td>New Hampshire State Senate</td>
<td>All 24</td>
<td>R + 4</td>
<td>58.3%</td>
<td>2010</td>
</tr>
<tr>
<td>New Mexico House of Representatives</td>
<td>All 70</td>
<td>D + 7</td>
<td>54.3%</td>
<td>2016</td>
</tr>
<tr>
<td>New York State Senate*</td>
<td>All 63</td>
<td>R + 1</td>
<td>50.8%</td>
<td>2010</td>
</tr>
<tr>
<td>Washington House of Representatives</td>
<td>All 98</td>
<td>D + 2</td>
<td>51.0%</td>
<td>1998</td>
</tr>
<tr>
<td>Washington State Senate</td>
<td>24 / 49</td>
<td>D + 1</td>
<td>51.0%</td>
<td>2012</td>
</tr>
<tr>
<td>Wisconsin State Senate</td>
<td>18 / 33</td>
<td>R + 3</td>
<td>55.0%</td>
<td>2010</td>
</tr>
</tbody>
</table>

*This chamber is controlled by a minority party coalition because some members of the party with the numerical majority caucus with the minority party.

** This chamber was evenly divided 18-18 following the 2016 elections. Democrats maintain an effective majority because Lieutenant Gov. Nancy Wyman (D) can cast tie-breaking votes.

State Legislation on Public Plan and Single-Payer Options, as of Sept. 2018

CA: Single-payer, active bill
NV: Medicaid buy-in, failed
CO: Single-payer ballot, failed
NM: Medicaid buy-in, active
VT: Single-payer, effort failed
NY: Single-payer, active bill
RAND analysis of Healthy NY Act

- Single-payer approach could increase coverage and lower total health spending, but ONLY if state slows growth in provider & administrative costs
- Taxes replace premiums and most out-of-pocket costs, but most of tax burden falls on top 5% of income distribution.
  - While costs fall for most residents, the viability of financing depends on very few people, who may try to avoid the tax, e.g. moving.
- Significant administrative and legal issues in absorbing existing coverage into one plan:
  - Three different federal waivers for Medicare, Medicaid and marketplace.
  - Potential challenges by self-insured employers under ERISA; e.g. How would people who work in NY but live in NJ and CT get coverage?

Why Did Vermont’s Single-Payer Effort Fail?

• Overall cost and average tax increase for state residents was key stumbling block.

• Legislators balked at tax increases.

• Not easy to explain to constituents that tax increases would substitute for current costs, when those costs are hidden in employer plans.

• Legislators worried that taxes would increase with rate of growth in health care costs.
Federal and State Medicaid Buy-In Proposals

• Senator Schatz (HI) bill: allow states to offer a public plan option on the marketplaces developed through state Medicaid programs.

• NV assemblyman Mike Sprinkle proposed a public insurance option, Medicaid-like plan, offered through the marketplace. Gov Sandoval vetoed last June.

• NM legislature established a study committee to develop a proposal.

• Issues:
  • Variable interest across states, 17 haven’t yet expanded
  • State Medicaid programs would assume responsibility for premium setting and taking on the risk of the pool, many may not have resources or expertise
  • Some MCOs offer marketplace plans already, others may be hesitant to offer and bear risk.
Resources


National Conference of State Legislatures

Improving Health System Performance

by Kevin Lucia, JD

Individual Health Insurance Markets:
Key Options for States

October 12, 2018
Overview

• Health Insurance Marketplaces
  • Trends in 2018 and 2019

• Federal regulatory changes

• State responses to market trends, regulatory action and other issues
2018 Premiums, Insurer Participation, Enrollment, Uninsured Rates

• **Premiums**
  - Unsubsidized individual market premiums rose substantially in 2018
  - Average increases (40-year-old):
    - Lowest cost silver plan: 32%
    - Lowest cost gold plan: 19.1%
  - Consumers eligible for subsidies largely insulated from these increases; those above 400% FPL hit with full cost

• **Insurer Participation**
  - Fewer insurers participating in 2018: Avg. 3.5 carriers per state
    - Down from 4.3 carriers in 2017, 5.6 carriers in 2016

• **Enrollment**
  - 11.8 million plan selections through the ACA marketplaces
    - Down from 12.2 million in 2017

• **Uninsured Rate**
  - Declined by more than 1/3 since full ACA implementation in 2014
    - Slightly higher in 2017 at 10.6%, from a low of 10.4% in 2016
Expectations for 2019

• What’s happened?
  • Individual mandate penalty repealed
  • Federal regulatory changes promoting non-ACA-compliant coverage
  • Reduced funding for marketplace outreach, enrollment
  • No federal legislation to stabilize markets

• What are we likely to see?
  • Premiums: Filed rates are mixed, many level or decreasing
  • Carrier participation: Indications of increased competition in some markets
  • Enrollment: Likely stable, risk of decrease
  • Increased marketing of non-ACA-compliant plans – See “Views From the Market: Insurance Brokers’ Perspectives on Changes to Individual Health Insurance”
What Is Your State Doing to Affect Access to Adequate Health Insurance?

Commonwealth Fund dashboard, available at:
https://www.commonwealthfund.org/blog/2018/understand-how-consumers-are-faring-individual-health-insurance-markets-watch-states
State Responses to Market Trends: Reinsurance

- State-run reinsurance programs can draw down federal “pass-through” funding with a Section 1332 waiver
- Proven mechanism for mitigating premium increases by spreading costs of high-cost enrollees
  - Temporary federal reinsurance program under the ACA reduced premiums in 2014-16.

- State-operated reinsurance programs draw on mix of state and federal funds
  - States that are setting up their own programs → premium decreases ranging from 8% - 30%
  - On average, feds are covering about 64% of program costs
  - Seven states have programs in place (Alaska, Minnesota, Oregon) or approved for 2019 (Maryland, Maine, Wisconsin, New Jersey)
Section 1332 Waivers

• Key Considerations
  • States need:
    • Statutory authority to apply for waiver
    • State source of funding (depending on proposal)
  • Waiver programs must satisfy “guardrails” that maintain ACA affordability, accessibility, comprehensiveness standards
    • Must also be budget neutral to the federal government
  • Application process can be lengthy – planning needs to start early (time to consider 2020 waivers is now)

• Types of Waivers
  • Reinsurance
  • More options for sole proprietors
    • Rhode Island will seek to allow sole props to purchase through state’s small biz marketplace (waiver application not yet developed)

• Broader changes? Not yet.
Other State Response to Market Trends: Increasing Availability of Low Premium, Limited Benefit Plans

- **Idaho**: state-based health plans
  - Original proposal would have allowed sale of plans that do not comply with many federal standards
  - HHS signaled it would step in to enforce federal law. Discussions ongoing...

- **Iowa, Tennessee**: Farm Bureau coverage
  - Excludes coverage offered by a nonprofit ag organization from the definition of insurance
  - Coverage is not subject to ACA standards
  - State regulation limited to oversight of the TPA

- **Colorado**: Broadening eligibility for catastrophic coverage?
  - New statute requires study of likely effects and authorizes submission of 1332 waiver to implement
State Responses To Increasing Availability of Alternative Coverage Options

• Executive Order
  • Association Health Plans (Final Rule)
  • Short-term Plans (Final Rule)
  • HRAs (Rule in Development)

• Other Alternative Coverage Options
  • Health Care Sharing Ministries
  • Direct Primary Care Arrangements
Association Health Plans

• What are they?
  • Health plan sponsored by an employer-based association (e.g. professional or trade group); single, large employer status, exempt from state regulation of individual and small group market rules
    • Risks to individuals
    • Risks to providers, other issuers
    • Risks to markets (mitigated by other options available to small employers)

• What changed under the new federal rule?
  • Easier to qualify for single, large employer status
  • Allows membership by self-employed individuals
  • Bans use of health status in eligibility and premiums but allows use of other factors
  • Raises possibility of future federal preemption
Association Health Plans

• New federal framework, but states “retain broad authority”

• State options:
  • Adhere to federal default approach
  • Require plans to play by same rules as broader market
  • Limit membership to small businesses
  • Reduce risk of market segmentation
  • Assert jurisdiction over out-of-state AHPs
  • Ensure state regulators have tools and resources for oversight and enforcement
Short-Term Plans

• What are they?
  • Gap-filler coverage for situations now addressed with special enrollment periods and guaranteed issue under ACA; exempt from ACA market rules
    • Risk to individuals
    • Risk to market: exacerbated by mandate penalty repeal

• What changed under the new federal rule?
  • Extend allowed term to less than 12 months (up from 3 months)
  • Allow renewals that extend duration of coverage to 36 months
  • Require notice to consumers
Short-Term Plans

• Examples of exclusions under policy offered by UnitedHealthcare Golden Rule Insurance Company:
  • No benefits are payable for the following expenses:
    • Hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day;
    • Treatment of mental health disorders or substance abuse including court-ordered treatment for programs, except as provided in the policy/certificate;
    • Diagnosis or treatment of nicotine addiction.

• Policy available in multiple states, but “coverage will be determined by the master policy issued in Arkansas and subject to Arkansas law.”
Short-Term Plans

• New federal framework, but states “retain broad authority”

• State options:
  • Adhere to federal default approach
  • Require plans to play by the same rules as the broader market
  • Limit duration of coverage (including consecutive policies) to shorter periods
  • Reduce risk of market segmentation
  • Improve transparency and oversight
State Action to Encourage Consumers to Maintain Health Coverage

• Credits to reduce the cost of premiums or cost sharing
  • Additional help for those at lower incomes who receive federal subsidies (e.g., Massachusetts, Vermont)
  • Assistance for those who are currently unsubsidized (e.g., Minnesota in 2017)

• Requirement to maintain coverage
  • Details can be customized
    • What types of coverage satisfy the requirement?
    • Penalty amount
    • Exemptions
    • Where to allocate penalty funds?

• New Jersey: New coverage requirement effective in 2019
  • Penalty supports state reinsurance program
Protections for People with Preexisting Conditions

• Federal law currently prohibits insurers from denying coverage, excluding benefits, or charging a higher premium based on a person’s health status

• If plaintiff states or the federal government prevail in Texas v. United States, these rules go away

• Four states have similar protections in state law that would remain in force.

• Most states do not – See "Lawsuit Threatens Affordable Care Act Preexisting Condition Protections But Impact Will Depend on Where You Live"
Other Areas of State Flexibility: Benefit Requirements

• ACA requires issuers in the individual and small group markets to cover 10 categories of “Essential Health Benefits”
  • Benefits are defined by reference to a state-selected benchmark plan (chosen among 10 options)

• New federal rule gives states more options to define their benchmark plan for 2020 and beyond
  • Illinois: revised benchmark to address opioid crisis

• Some states may select benchmark through regulatory process. Others may prefer (or be required by state law) to do so via legislation.
Other Areas of State Flexibility: Addressing Surprise Medical Bills

- Consumers face unexpected charges from out-of-network providers (a version of balance billing)
  - E.g., consumer obtains care at in-network ED or hospital, but is treated by an out-of-network anesthesiologist
- No federal rules limiting consumer exposure to surprise bills
- Fewer than half of states have laws that shield consumers
  - About a half dozen have a comprehensive approach that:
    - Prohibit balance billings;
    - Incorporates payment standards to ensure fair compensation for providers
Other Areas of State Flexibility: Provider Networks

- States are the traditional regulators of health plan provider networks

- The ACA established federal standards for marketplace health plans
  - Does not displace state regulation
  - Feds have ceded oversight of this standard to the states

- NAIC has adopted a network adequacy model act
  - Requires stronger disclosures by plans concerning network development and operation
  - Bolsters authority of state regulators to decide whether a network is adequate
  - Sets rules designed to improve accuracy of provider directories
Thank You

Kevin Lucia, J.D., M.H.P.
Research Professor
Georgetown University
Center on Health Insurance Reforms
kwil@georgetown.edu
Exploring Strategies to Fix the Private Health Insurance Market

Wesley Miller
Director of Health Policy & Association Plans
for
Korey Harvey, J.D.
V-P and Deputy Counsel
Blue Cross and Blue Shield of Louisiana
Former
Deputy Commissioner
Louisiana Department of Insurance
Uniquely Positioned: A Catalyst for Change

- Enhance collaboration between insurers and doctors/hospitals, enabling better care
- Move to a value-based payment system and more accountability
- Increase cost and quality transparency
- Improve patient engagement
- Improve health outcomes
What Data Should Power Our Learning?

Current
- Member Eligibility
- Customer Service/Care Management Interactions
- Customer Service Data
- Social Media
- ADT Feed
- Member Survey
- Electronic Health Record (EMR)
- Lab Results

Future
- Gene Bank
- Mobile Health

Additional Data
- Risk Scores/Groupers
- Predictive Models
- Gaps in Care
- Cost/Quality Measures
- Outcomes Evaluation
Predictive Modeling Cycle

**Goal**: Always improve, whether the modeling, action or outcomes.
# Summary of Predictive Models

<table>
<thead>
<tr>
<th>Description</th>
<th>Risk of Hospitalization</th>
<th>Risk of Emergency Department Visit</th>
<th>Risk of Readmission</th>
<th>Customer Service Complaint Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization in the next 6 months</td>
<td>Emergency department visit in the next 6 months</td>
<td>Readmission in the next 1 month</td>
<td>Complaint to Customer Service in next 1 month</td>
<td></td>
</tr>
<tr>
<td>1.5x more likely to predict unplanned admission than commercial DxCG in high-risk group</td>
<td>1.35x more likely to predict an emergency department visit than commercial DxCG in high-risk group</td>
<td>Matching a daily auth-derived hospital census file with risk score to notify providers</td>
<td>Between 200 and 350 members identified as high-risk each week</td>
<td></td>
</tr>
<tr>
<td>PPV* in High Risk Group (Top 1,000)</td>
<td>45%</td>
<td>70%</td>
<td>45%</td>
<td>70%</td>
</tr>
</tbody>
</table>

*PPV: Positive Predictive Value; obtained during modeling
Actionable Insights

By identifying at-risk members in advance, nurses and other clinical staff can intervene sooner:

- Health coaching
- Care coordination
- Education
- Self-care support
- Mobilizing
  - Home care
  - Transportation
  - Transition support
  - Social supports

Positive Predictive Value by ROH Risk Tier

<table>
<thead>
<tr>
<th>Risk Tier</th>
<th>PPV</th>
<th>Odds of Inpatient Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>38.3%</td>
<td>1 : 2.6</td>
</tr>
<tr>
<td>Medium Risk</td>
<td>5.6%</td>
<td>1 : 17.9</td>
</tr>
<tr>
<td>Low Risk</td>
<td>0.7%</td>
<td>1 : 142.9</td>
</tr>
</tbody>
</table>

Average PPV 1.1%

38 out of 100 high-risk members would have medical inpatient admit in next 6 months
6 out of 100 medium-risk members would have medical inpatient admit in next 6 months
Less than 1 out of 100 low-risk members would have medical inpatient admit in next 6 months
Success Stories

Case Study #1
• 56-year-old male physician
• Congestive heart failure, hypertension, kidney transplant fail, 11 emergency department visits, 8 inpatient admits
• Outreach by onsite nurse
• Goals: Compliance with medical management
• Care coordination: Physical therapy services that fit his schedule

Case Study #2
• 41-year-old female
• Diabetes, 3 emergency department visits
• Outreach by telephonic case manager, who:
  • Notified provider of inability to pay for insulin and co-pays
  • Connected member to financial resources
• Outcome: Member is compliant with medication and able to afford office co-pays

No further hospitalizations at this time for either member.