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Accessing and Utilizing Health Insurance for Underserved Populations

Presented to

Maryland Insurance Administration and
Health Workstream of NAIC's Special Committee on Race and Insurance

October 14, 2022

Meet the Speaker

JOHN GORMAN

Chairman and Founder, Nightingale Partners

Founder and Chairman of Gorman Health Group and former Clinton appointed Asst. Director of the Health Care Financing Administration (now CMS). Board member at Health Alliance Plan in Detroit, MI and advisor for Premier Health, Nations Benefits, and Icario. Serial health care entrepreneur with 12+ successful ventures and exits. Active investor and innovator. Nationally recognized thought leader on federally funded health programs and social determinants of health investing.

Recent Notable Personal Deal Flow

Empyrean Benefit Solutions
2019 Investor/Founder

Remedy Ventures
2018 Investor/Op. Partner

Signify Health
2018 Investor/Founder

Gorman Health Group
2017 Founder/CEO

In the Press

Forbes
New York Times
Wallstreet Journal
Bloomberg
The Atlantic
Politico
Modern Healthcare

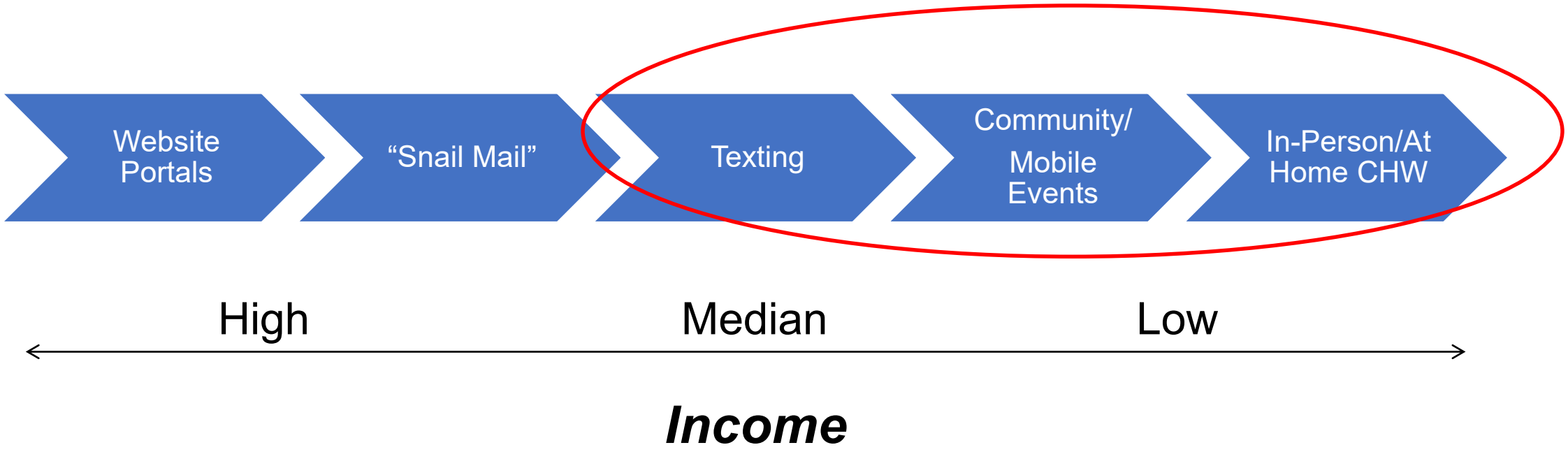
Guest Speaker/Keynote

HIMSS
Industry Collaboration Effort
RISE
EPA/CDC/HUD Working Group
Value-Based Payment Summit
ACHP
Lutheran Society
America's Physician Groups

Introduction and Overview

- Precision engagement is key to improving enrollment and benefit utilization
- Commercial insurance in steady decline; Medicare Advantage, Medicaid and Exchange remain the sole sources of revenue growth.
- Medicare Advantage and Medicaid are the biggest laboratories for social determinants of health (SDOH) supplemental benefits and innovation in member outreach and engagement.
- The lower the population income, the more engagement requires texting and people.
- Expiration of Public Health Emergency and Medicaid redetermination is biggest threat to insurance coverage.

TAKEAWAY: Precision Engagement is Key to Expanding Coverage and Benefit Utilization



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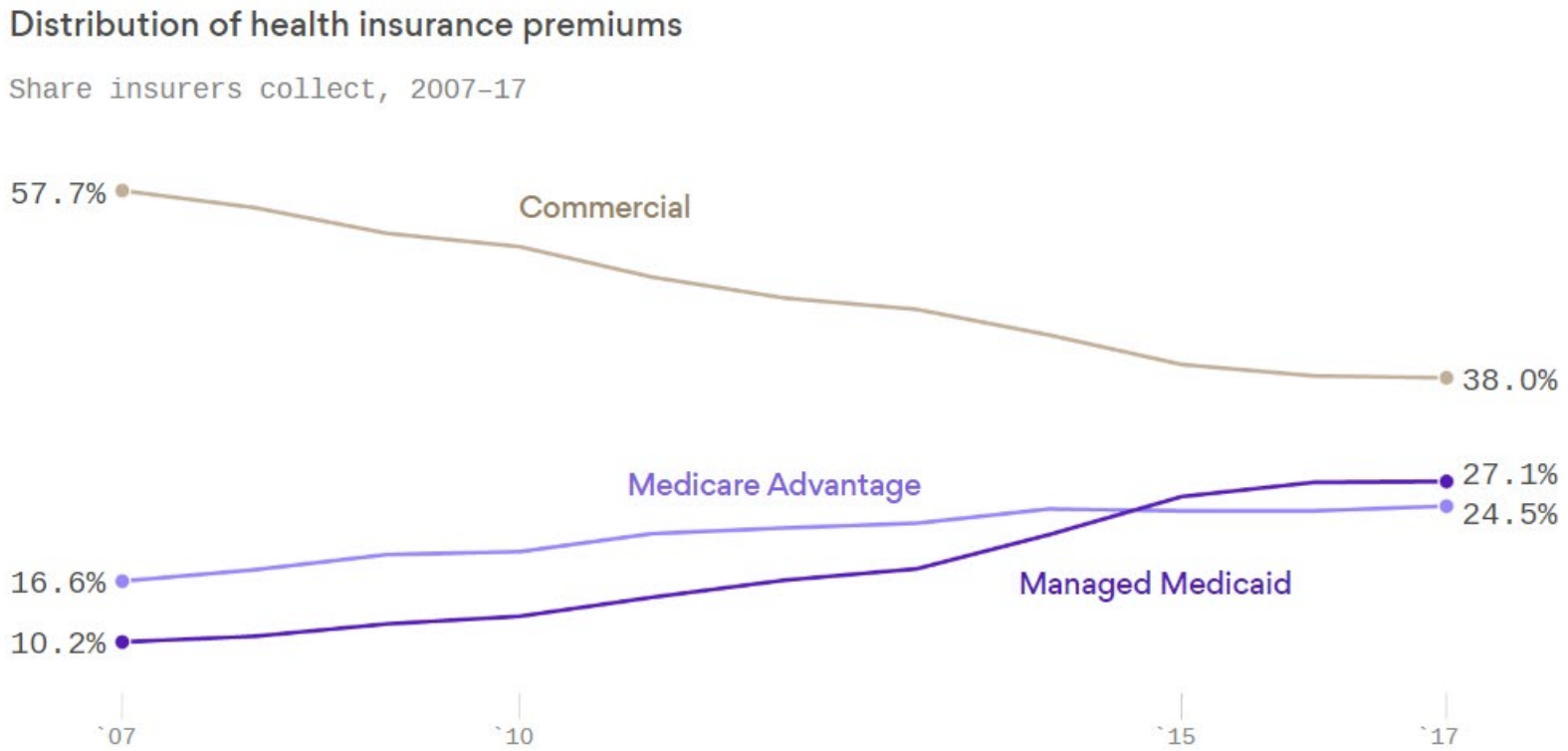
Commercial Insurance Declining; Gov. Programs Surging



Adapted from Lane et al., 2018, "Best's Market Segment Report: U.S. Government-Related Health Insurance Business Continues to Grow Despite Risks"; Chart: Axios Visuals

Biggest Threat to Coverage: Medicaid Redetermination

Between **5.3 million and 14.2 million people** could lose Medicaid coverage following the end of the continuous enrollment requirement, according to a KFF survey from May 2022

States expect an average of **13% of Medicaid enrollees to be disenrolled** following the end of the continuous enrollment requirement (with estimates ranging from 8% to over 30%), a KFF survey from January 2022 found

A MACPAC report from 2021 found that **8% of Medicaid and CHIP beneficiaries disenrolled and reenrolled** within a year (churn)

The unwinding of the Public Health Emergency is an opportunity for states to minimize enrollment loss and churn with better data and coordination with Health Insurance Exchanges.

State Approaches to Unwinding the PHE

CMS guidance: States must adopt a "risk-based approach" when prioritizing pending eligibility and enrollment actions

Time or Age-Based	Prioritize based on the length of time the case has been pending
Population-Based	Prioritize based on characteristics of cohorts likely to remain eligible, become eligible for greater Medicaid benefits, or become ineligible
Hybrid	Combination of the population and time-based approaches
State-Developed Approach	Requirements: Maintain coverage of eligible individuals, minimize ineligible individuals remaining enrolled, achieve a sustainable renewal schedule, and meet the 12-month unwinding timeline

Most states pursuing a **hybrid approach** by planning for a time/age-based approach while layering on a population-based approach flagging specific populations for early or late renewal

Actions to Take to Minimize Enrollment Loss and Churn

CMS views Medicaid continuous enrollment unwinding as two phases:

Phase 1

Prepare for the renewal process and educate Medicaid & CHIP enrollees about the upcoming changes

Phase 2

Ensure Medicaid beneficiaries take the necessary steps to **renew coverage, and transition to other coverage** if they lose eligibility

In **Phase 1**, what does **prepare** mean for actions to take now?

- Ensure beneficiary contact information is up-to-date
- Drive awareness and educate beneficiaries on the redetermination process

Work with providers, care navigators, engagement experts, and utilize outreach channels to help spread the word

General Approach to Risk Stratification and Mitigation

Identify groups at risk for gaps in care with coverage loss

Use data to understand those who may be going through a course of treatment (ex: cancer care) or are receiving services and support that require continuation

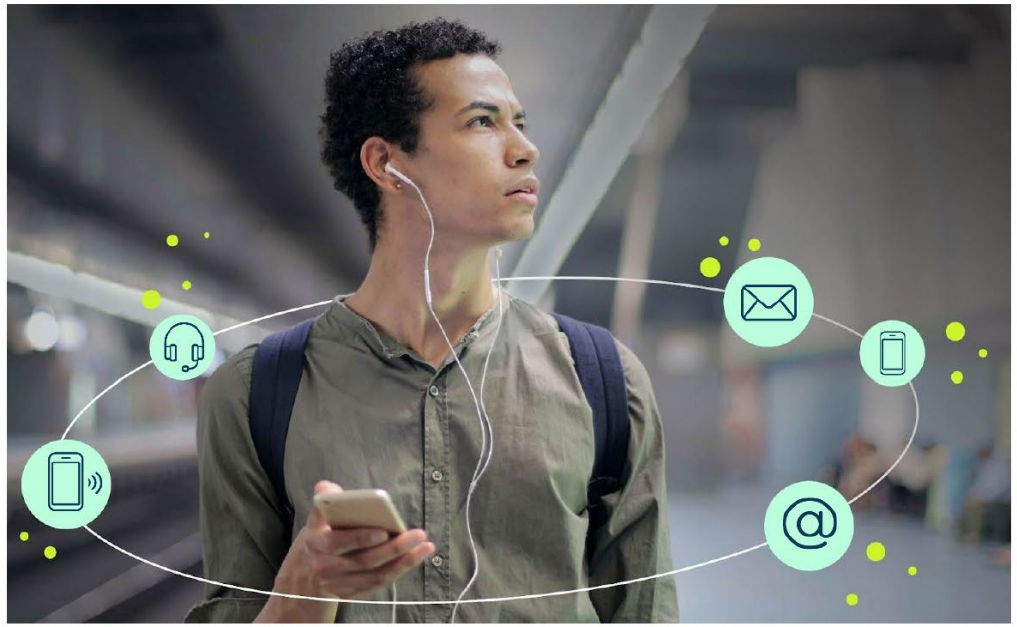
Understand which states have extended coverage for pregnant and postpartum

Stratify population to understand communication needs and requirements (language, race, ethnicity, culture), especially with high-risk populations

Allow appropriate periods of time for people to respond depending on health literacy needs

Enrollees with LEP and/or disabilities at greatest risk of coverage loss and benefit underutilization

Verifying Member Contact Information

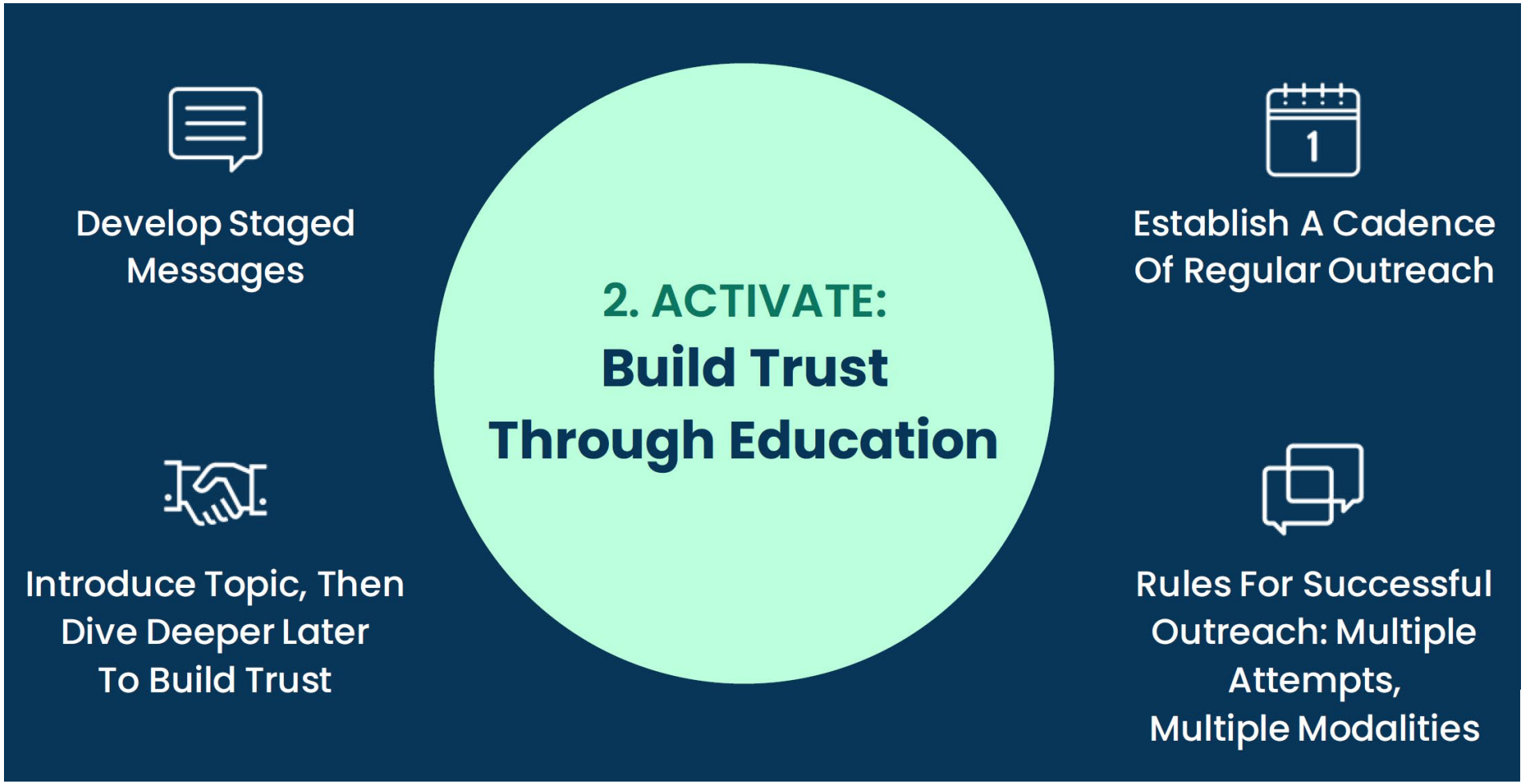


- ✓ States may update the beneficiary record if they verify the accuracy of the new contact information
- ✓ Encouraged to contact the beneficiary via other modalities such as email, text message, and telephone
- ✓ Managed care plans can only provide updated contact information received directly from or verified by the beneficiary, and not from a third party or other source

It is the *states, not managed care plans*, that need to verify the accuracy of the contact information.

Identify, Activate, Optimize Member Engagement

Identify, Activate, Optimize Member Engagement



Identify, Activate, Optimize Member Engagement

How One Health Plan is Taking Action

Overview

A health plan wants to connect with members ahead of the 60 days' notice from CMS

Challenges

Some members have undeliverable addresses

Some members speak English as their second language

Some members are new to Medicaid since COVID

Approach

Tailored multi-channel outreach

Work with external partners to develop multi-channel outreach strategy that builds trust without abrasion

Leverage multiple data sources to fill in contact info gaps

Use tailored content that addresses the specific needs of individuals with different backgrounds and SDoH barriers

Progress

Entire population receiving first notice to update contact information

5 different communication channels used

5 languages/content sets

50%+ members receiving outreach

icario

Mitigating Coverage Losses

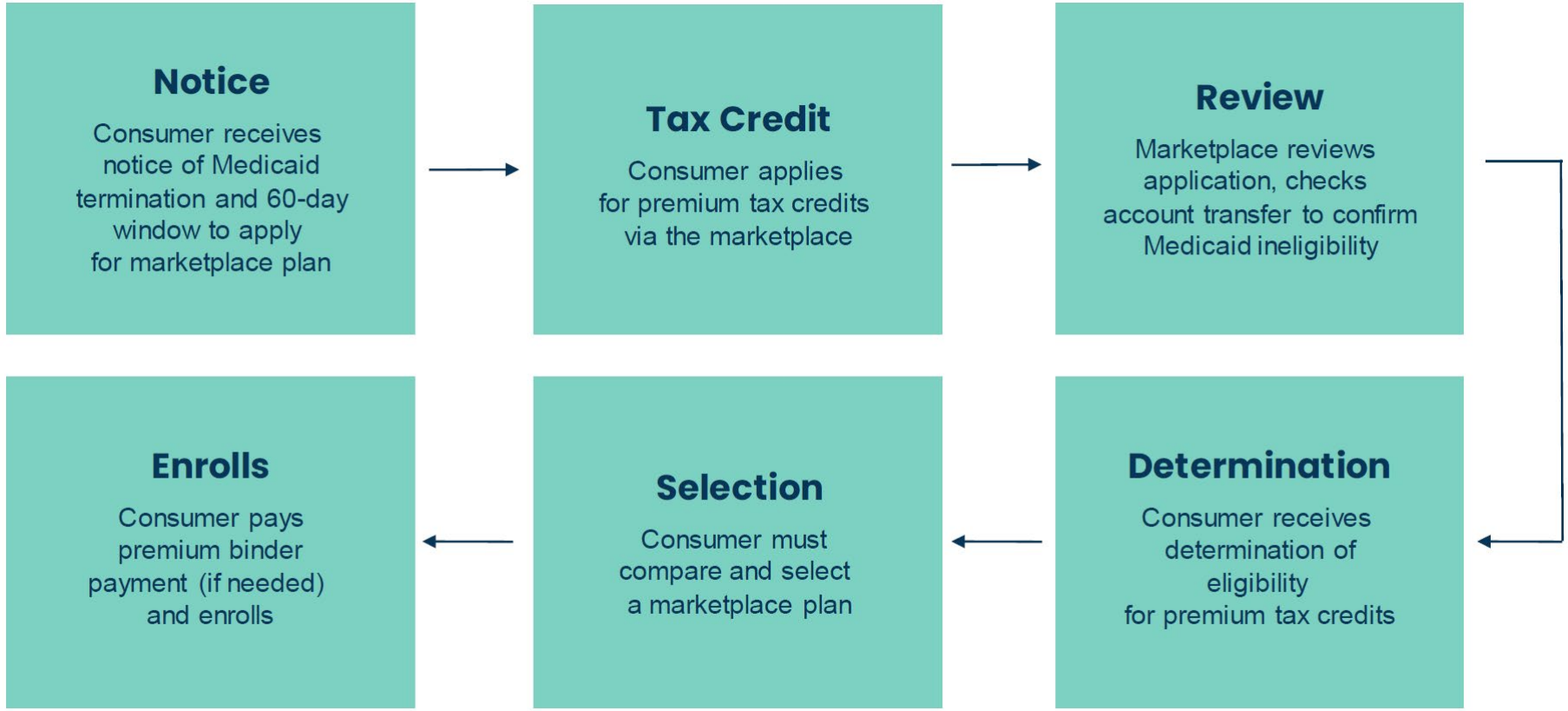
States should coordinate with the federally facilitated marketplace (FFM) or engage their state-based marketplace (SBM) to facilitate coverage transitions:

- Coordinating with local entities including exchanges to help smooth coverage transitions and minimize coverage loss
- Reinforcing important messages, such as availability of affordable and comprehensive coverage alternatives to Medicaid

Plans should:

- Understand who newly qualifies for or is on Medicare and connect to an available D-SNP plan for better benefit coordination
- Continue education on available plans and alternatives to Medicaid for those that no longer qualify

Medicaid to Exchange Workflow



Source: Sabrina Corlette and Maanasa Kona, "Mitigating Coverage Loss When the Public Health Emergency Ends: The Role of the Affordable Care Act Marketplaces," *To the Point* (blog), Apr. 26, 2022. https://doi.org/10.26099/qzxs-1r33; https://www.commonwealthfund.org/blog/2022/mitigating-coverage-loss-when-public-health-emergency-ends

Medicare Advantage's Stunning Growth

Medicare Advantage Enrollment and Growth Projections, 2015-2030

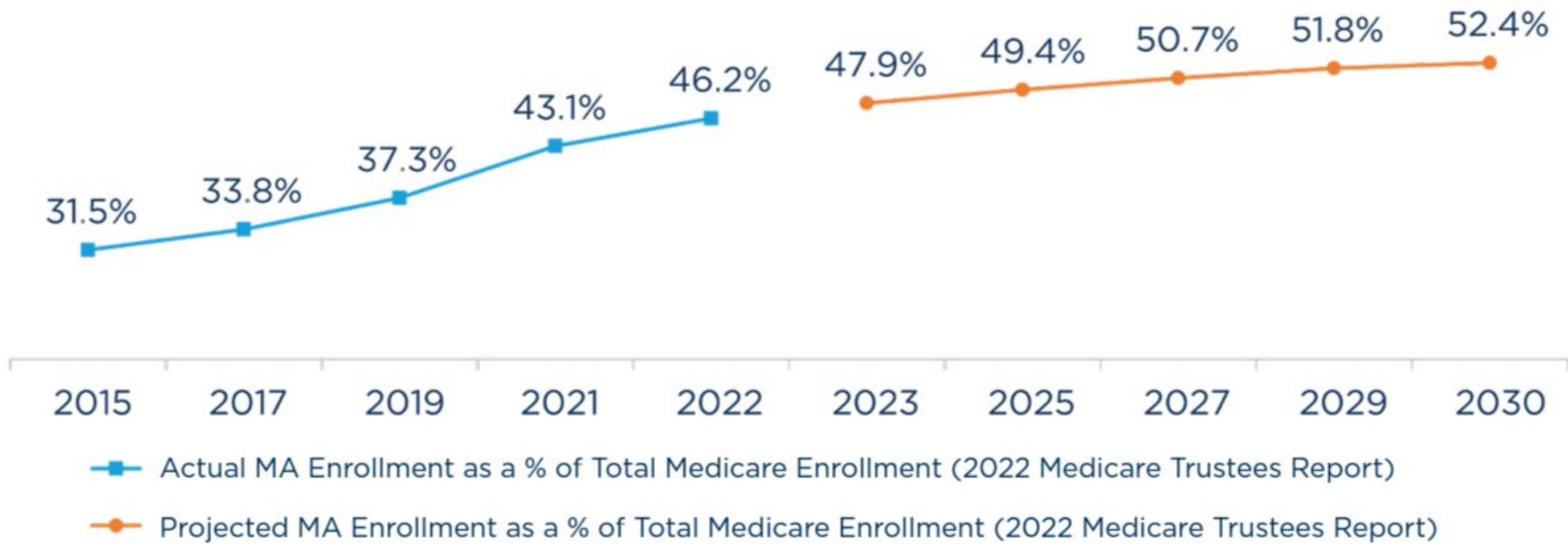


Figure 4. 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (Table IV.C1), June 2022

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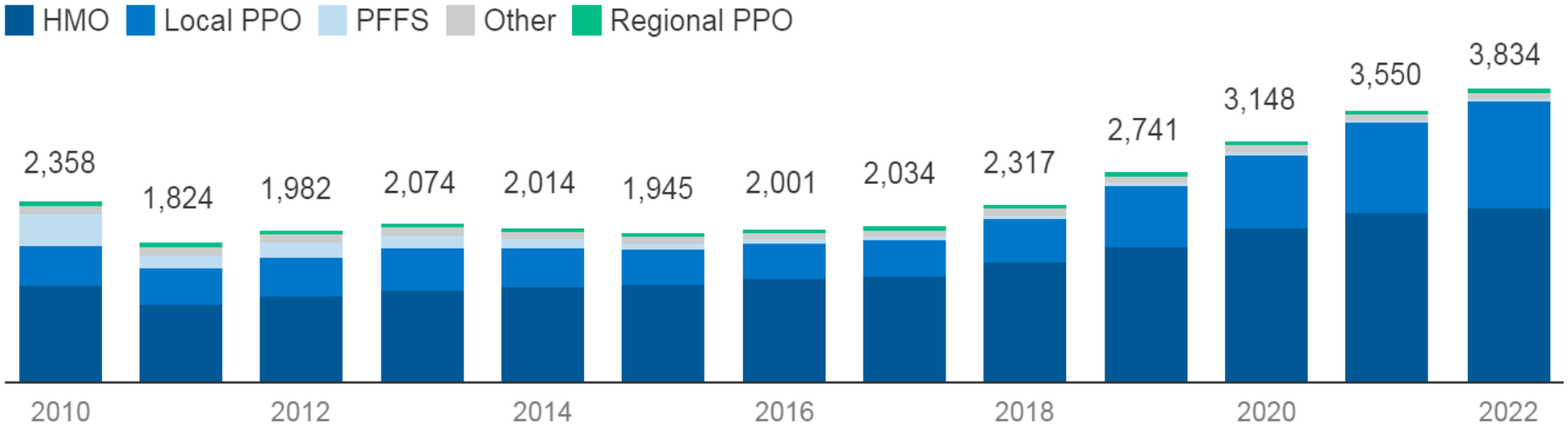
MA Plan Availability Growing

More Medicare Advantage plans are available in 2022 than in any other year

Number of Medicare Advantage plans generally available by plan type, 2010-2022



NOTE: Excludes SNPs, EGHPs, HCPPs, PACE, and MMPs. Other category includes cost plans and Medicare MSAs. Numbers may differ from previous publications in cases where the Landscape File for the year was updated after initial publication.
SOURCE: KFF analysis of CMS Landscape files for 2010-2022. • PNG

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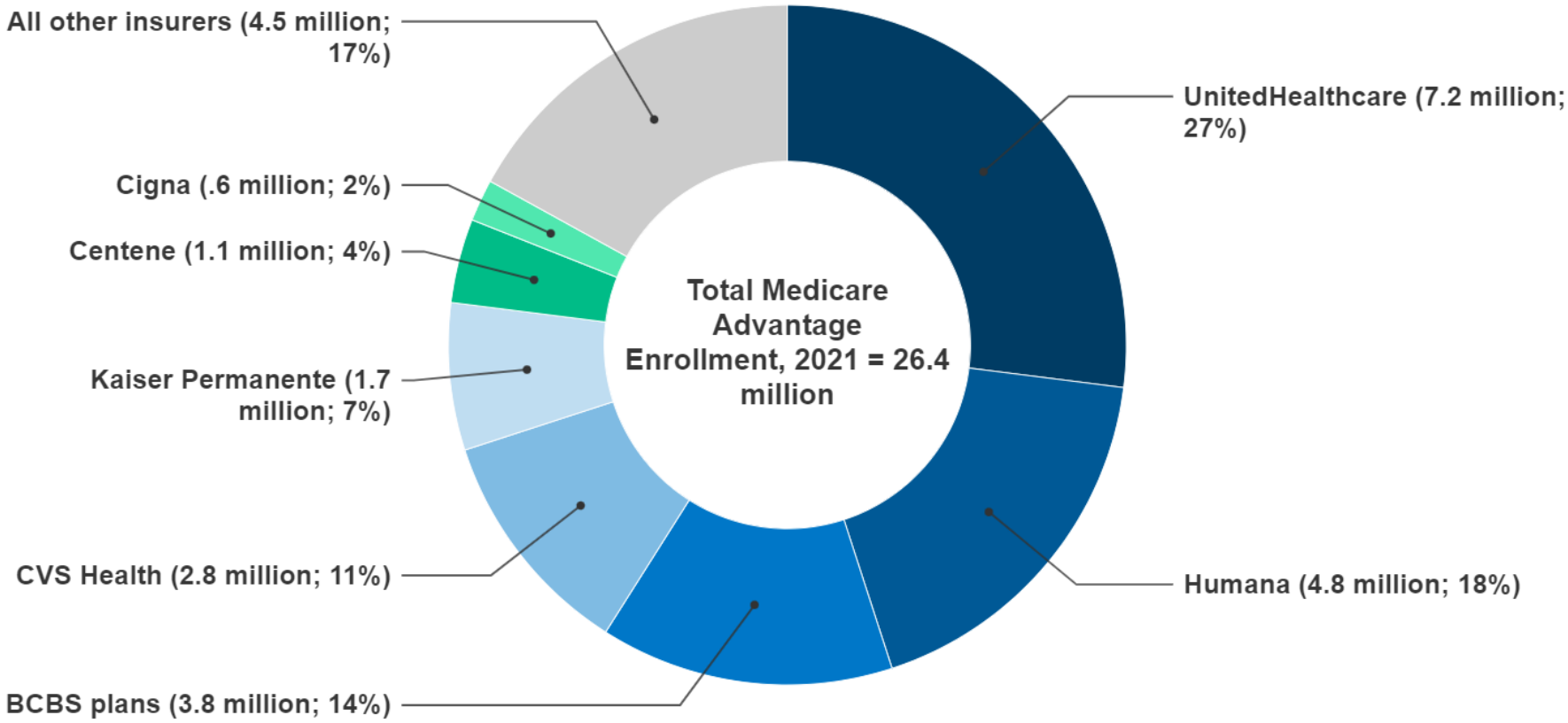
MA Enrollment by Firm or Affiliate, 2021



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are 2% of total enrollment. Percentages may not sum to 100% due to rounding.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2021. • PNG

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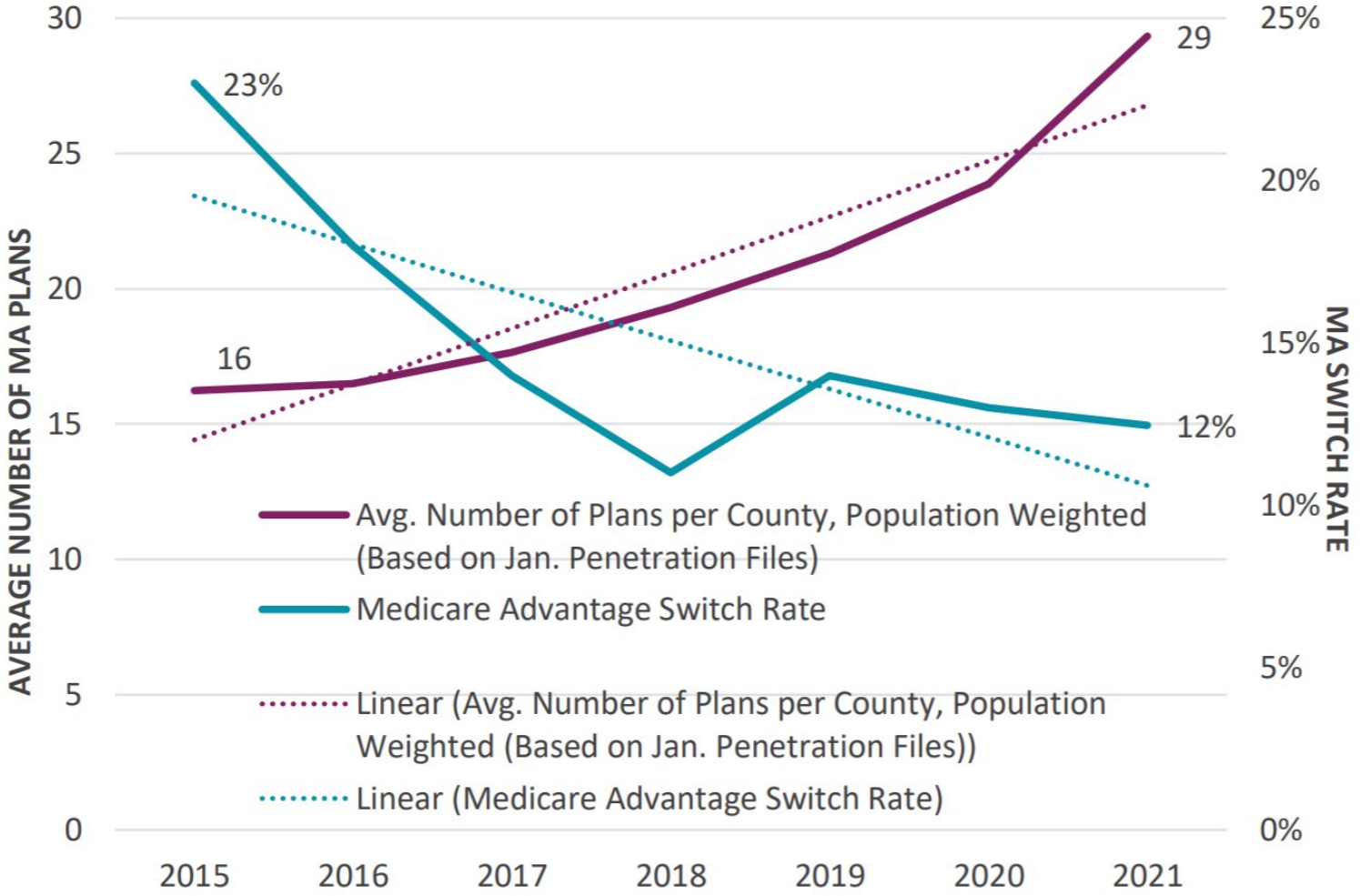
Number of MA Plans and MA Switch Rates, 2015-21

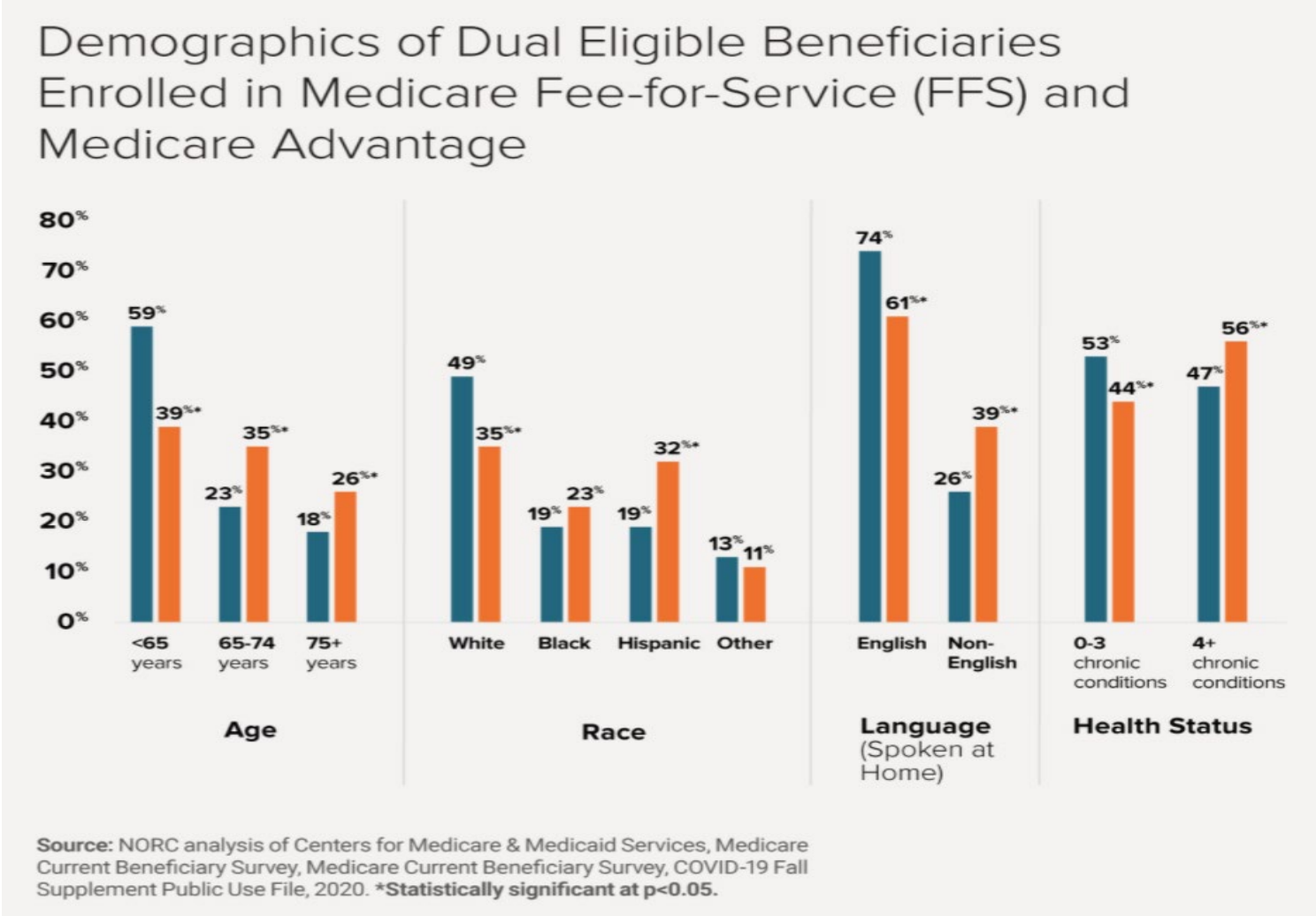


**Deft analysis of 2015-2021 CMS Medicare Advantage landscape data.

Dual Eligibles: The Insurance Industry's Biggest Opportunity

Dual Eligible

- People enrolled in Medicare and Medicaid.
- 12.2 million people
- Medicare pays covered dually eligible beneficiaries' medical services first, because Medicaid is generally the payer of last resort. Medicaid may cover medical costs Medicare may not cover or only partially covers.



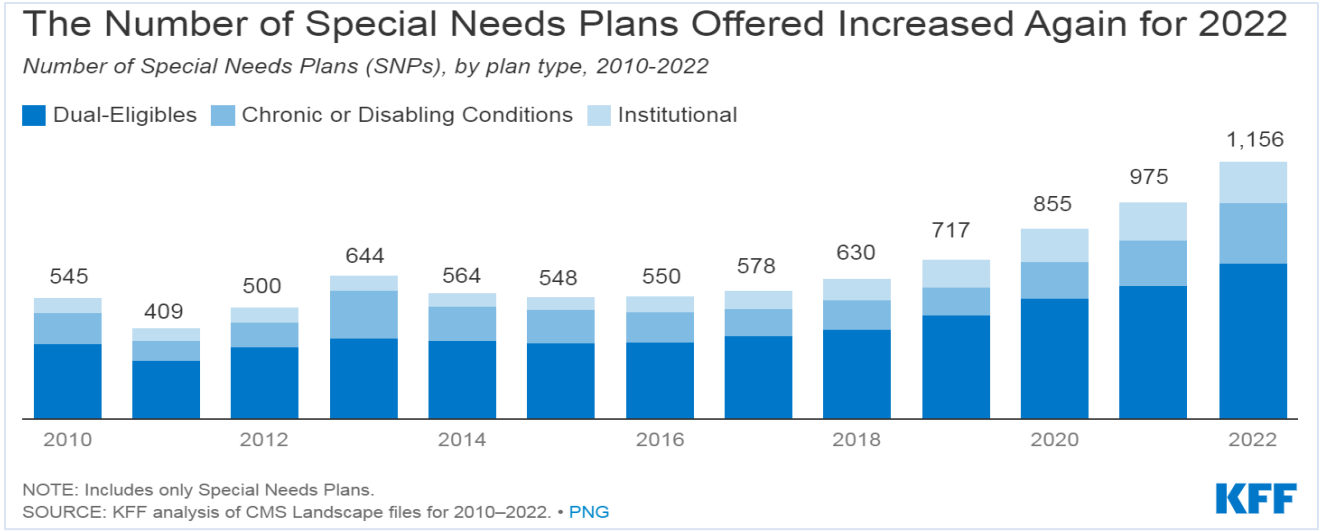
Special Need Plans (SNPs) are Growing Rapidly

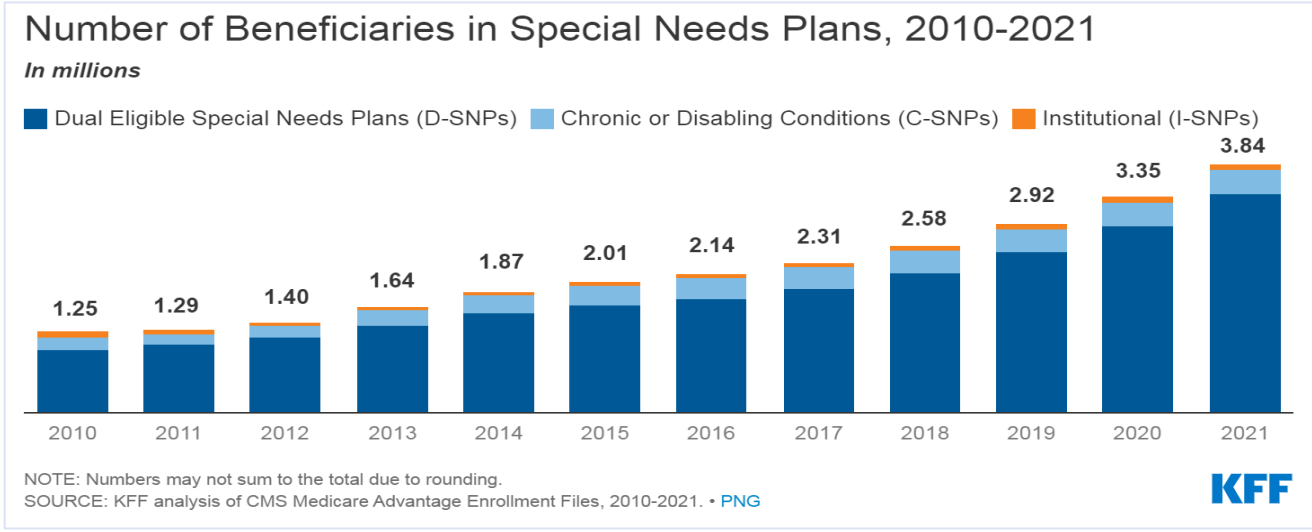
Special Needs Plan

1) People who live in certain institutions (like nursing homes) or who live in the community but require nursing care at home

2) People who are eligible for both Medicare and Medicaid (duals)

3) People who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia).





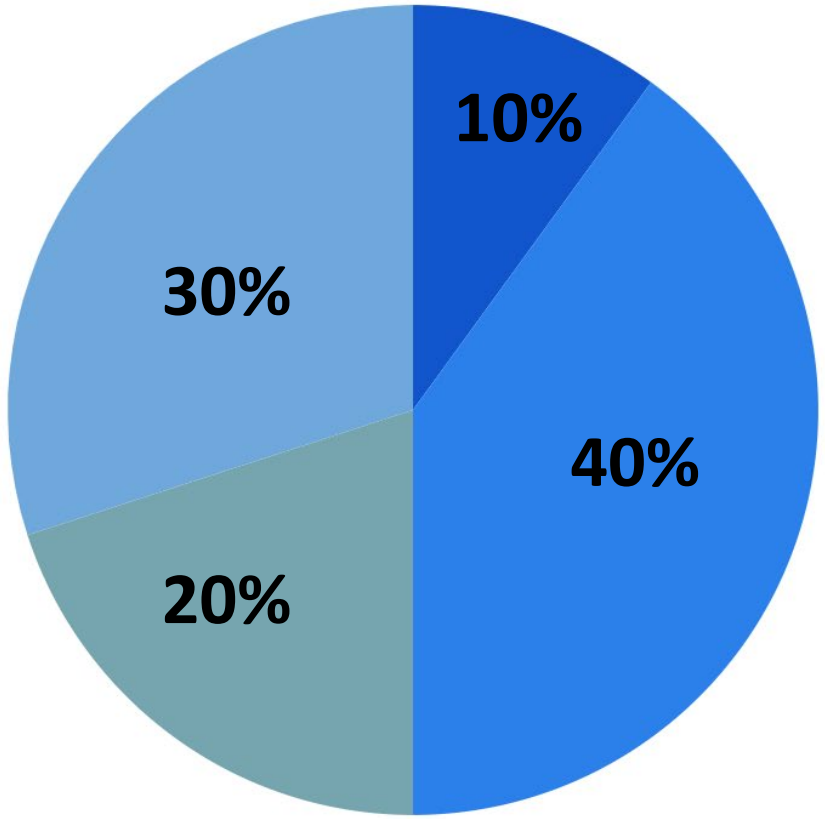
Social Determinants of Health and Population Health

Health Behavior

Tobacco Use
Diet & Exercise
Alcohol Use
Unsafe Sex

Physical Environments

Environmental Quality
Built Environment



Health Care

Access to Care
Quality of Care

Socio-Economic Factors

Education
Employment
Income
Family/Social Support
Community Safety

Source: University of Wisconsin Population Health Institute

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SDOH Benefit Landscape

Health Related Supplemental Benefits

2016

Medicare Advantage plans can offer additional primarily health-related medical services, i.e., dental, vision, and hearing.

Supplemental Non-Medical Benefit Expansion

2019

Broader MA and Part D benefits are considered primarily health related, i.e., transport, meals, adult day care.

Flexibility in Uniformity Requirements

2020

MA plans can offer disease-tailored benefit designs, including lower cost sharing for certain services or supplemental benefits not available to all enrollees.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

2020

Plans can offer disease-tailored benefits design, including lower cost sharing for certain services or supplemental benefits not available to all members.

SDOH Benefit Landscape

Guiding Principles

Supplemental Benefits Must Be

- Clear and easy to understand
- Equitable and targeted to those with greatest need
- Designed to be manageable and sustainable
- Evolve with experience and data supporting their effectiveness

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Evidence for Improved Outcomes

Researchers and Publication	Year	Type	Method	Results	Link to Study	
Feinberg, Passaretti, Coolbaugh, Lee, & Hess NEJM Catalyst	2018	Medically Tailored Meals	In 2016, Geisinger Health System sought to combat diabetes in Pennsylvania. Their partner, Fresh Food Farmacy, delivered 175,000 meals and provided each patient with 15 hours of nutrition education.	Over 18 months, Geisinger recorded a >40% decrease risk of and an 80% reduction in cost for patients, from an average of $240,000 pmpy to $48,000 pmpy.		80% MedEx Savings
Pruitt, Emechebe, Quast, Taylor, & Bryant Population Health Management	2018	Peer Support	A national Medicaid and Medicare Advantage health plan coordinated social supports for their members through an internal peer-based call center.	Members with their social needs met experienced a $2,443 PMPY savings in health care expense.		$2,443 PMPY Savings
Nichols & Taylor Health Affairs	2018	NEMT	Applied the Vickney-Clarke-Groves mechanism to evaluate the economic value of addressing transportation.	Researchers found $4B in annual savings with traditional NEMT in Medicaid and an incremental $537M in annual savings when scaled nationally.		$4B/Y Medicaid Savings
Christiansen & Morning University of Nevada, Nevada Health & Human Services Report	2017	CHW	Researchers evaluated a community health worker (CHW) operated by a managed care organization for a Medicaid super-user population in Las Vegas, NV between 2015 and 2017 using a pre-/post-intervention evaluation.	Researchers found a 1.8:1 overall ROI on the adoption of a CHW program resulting in an average 8% overall cost.		1.8x ROI
National Institute of Diabetes and Digestive and Kidney Diseases	2002	Behavioral Health	The NIDDKD studies the impact of lifestyle changes and medication adherence on preventing type 2 diabetes.	Researchers found lifestyle changes reduced participant risk of developing Type 2 diabetes by 58% and medication by 31%.	NIH	58% Reduced Risk

Funding SDOH Programs and SSBCI

1. Analyze
2. Scan
3. Design
4. Capitalize
5. Launch

Benefit Financing

On-Benefit	• Paid by plan and included in bid.
Mid-Year Benefit Enhancement	• Paid by plan and/or external financing.
Off-Benefit	• Administrative benefit. Paid by plan and/or external financing.
SSBCI	• Paid by plan and/or external financing and included in bid.

External Financing Sources

Federal Government	• e.g. COVID relief bill
State Government	• State program funded.
Private	• Funded by local stakeholders, foundations, philanthropy, and/or private investors.

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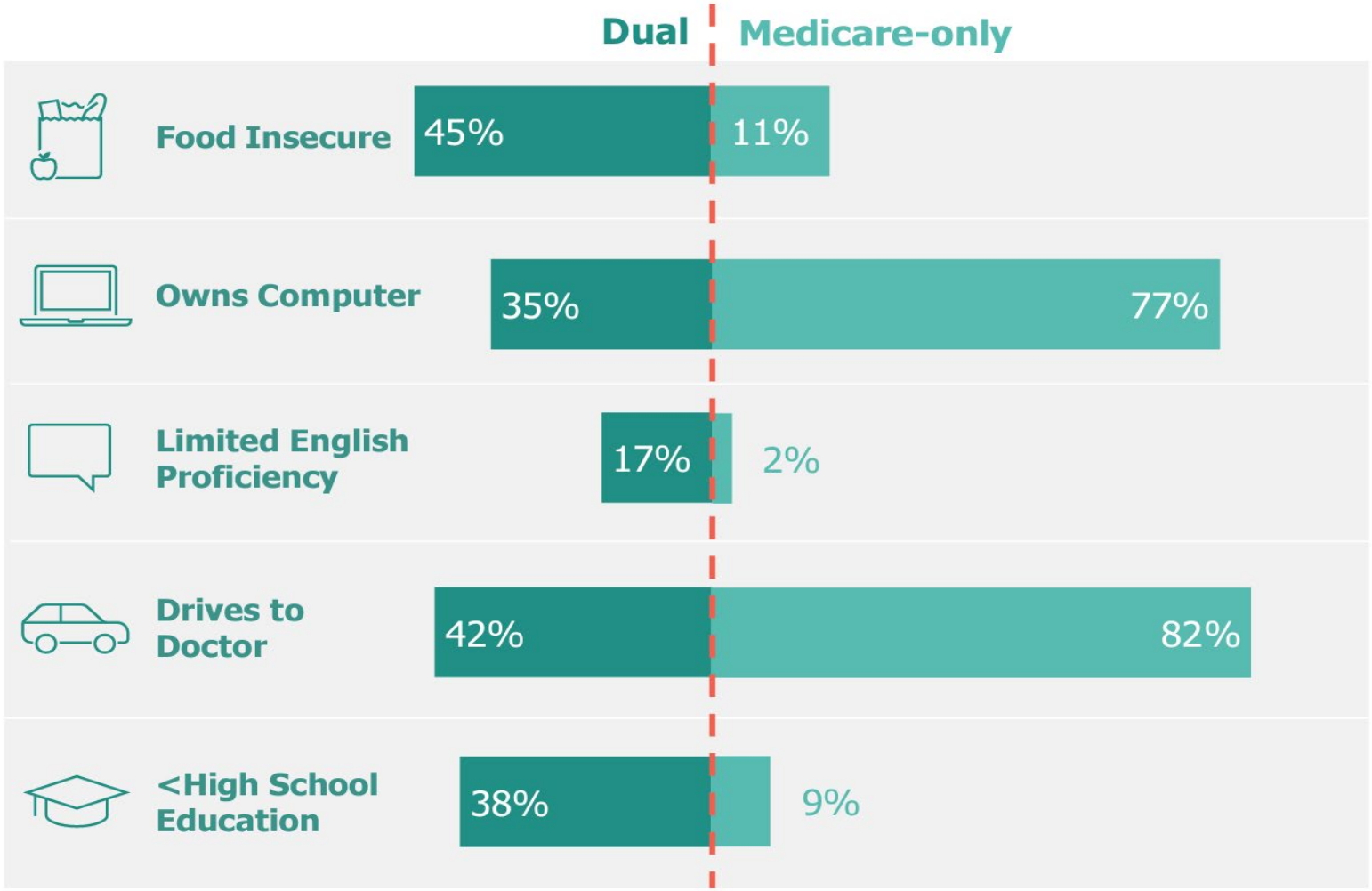
Duals Have Far Greater Social Needs



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Explosion in SSBCI, Much More to Come

Benefit	2020 Number of Plans Offering Benefit(s) (Percentage of Total Plans in 2020)	2021 Number of Plans Offering Benefit(s) (Percentage of Total Plans in 2021)	2022 Number of Plans Offering Benefit(s) (Percentage of Total Plans in 2022)
Non-Primarily Health-Related Benefits through Special Supplemental Benefits for the Chronically Ill (SSBCI)			
Food and Produce	101 (2%)	345 (7%)	763 (14%)
Meals (beyond limited basis)	71 (2%)	371 (8%)	403 (7%)
Pest Control	118 (3%)	208 (4%)	326 (6%)
Transportation for Non-Medical Needs	88 (2%)	177 (4%)	375 (7%)
Indoor Air Quality Equipment & Services	52 (1%)	140 (3%)	166 (3%)
Social Needs Benefit	34 (1%)	211 (4%)	244 (5%)
Complementary Therapies	1 (<1%)	0 (0%)	123 (2%)
Services Supporting Self-Direction	20 (<1%)	96 (2%)	151 (3%)
Structural Home Modifications	44 (1%)	42 (1%)	57 (1%)
General Supports for Living	67 (2%)	150 (3%)	328 (6%)
"Other Non-Primarily Health-Related" Benefit	51 (1%)	191 (4%)	359 (7%)

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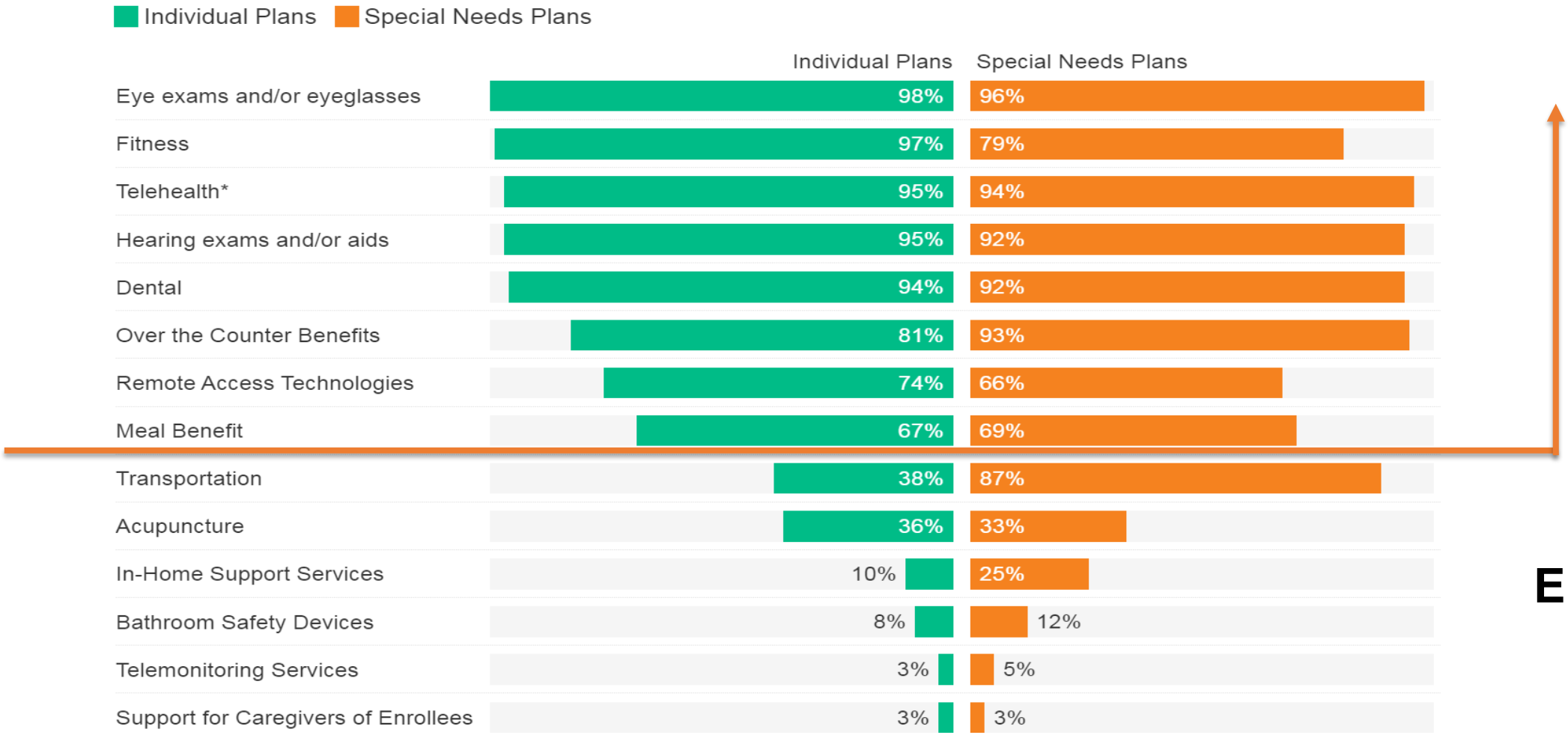
More than 90% of individual Medicare Advantage plans provide access to vision, fitness, telehealth, hearing, or dental benefits

Share of Individual and SNP Medicare Advantage Plans with extra benefits by benefit and plan type, 2022



"Table Stakes"

Emerging

Example: Non-Emergency Medical Transportation

- 5-10% of the US population are transportation disadvantaged. Elderly: 20-30%. Duals: 40-50%.
- $37.5 billion in health care expenses are caused by patient no-shows in the US, with seniors and the low-income most likely to miss appointments and to use the emergency department as a source of primary care.
- $2200-6000 PMPY savings consistently found for NEMT
- $4.5-18 billion could be saved by widely-available NEMT benefits

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SDOH Market Summary

	Market Opp (MA Population)	% MA Population	Net PMPM* value (total membership)
Benefit Enrollment	$15B	Up to 40%	$11-40B+
Food Security	$17.34B	15%	$8-21B
Housing/ Home Safety	$11.6B	25%	$1-2.6B
Loneliness Outreach	$2.1B	43%	$5-10B
Community Health Workers	$30B+	30%	$12-50B
Transportation	**$9.68B**	**20%**	**$4.5-18B**
Palliative/ Complex Care	$30B+	2-5%	$7-26B
Opioid MAT	$1.9B	0.5%	$1-4B

Key SDOH Savings

Non-Emergency Transportation

$570 pmpm

Healthy Meals Delivery

$570 pmpm

Community Health Workers

$210 pmpm

Affordable Housing

$1,300 pmpm

Benefit Enrollment

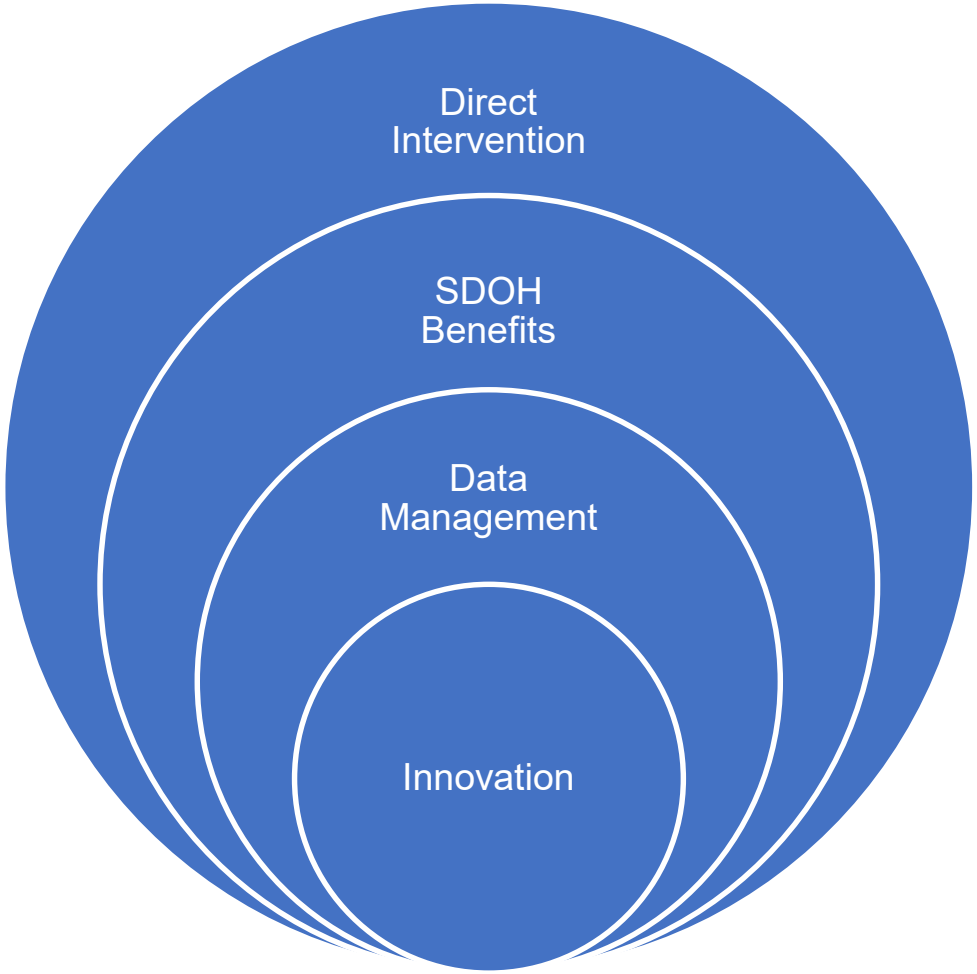
$338 pmpm

Companionship

$134 pmpm

*PMPM value accounts for the cost of the service and totals net value across risk adjustment (where relevant), medical expense reduction and stars

The Role of Private Capital in Member Engagement



Conclusions

- Precision engagement is key to improving insurance enrollment and benefit utilization
- Lower-income populations require emphasis on texting, mobile events, and in-person intervention (navigators, community health workers/promotores)
- End of PHE presents greatest threat to Medicaid coverage
- Medicare Advantage is biggest laboratory on member engagement and poverty-related benefits
- Private capital has distinct role in financing innovations and interventions in member engagement and social welfare benefits

A final thought: SDOH benefits and interventions should be counted under the Medical Loss Ratio as quality improvement expenses. CMS has existing authority to do so and NAIC should support.

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Thank you!

Chairman and Founder, Nightingale Partners

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