The Politics, Challenges, Innovations, and Opportunities of Healthcare Reform

Presented by the Public Health & Environmental Vision Section

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Moderator
Jana Hirschtick, PhD, MPH
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Jeff Smith, OD, MBA

Please silence all mobile devices and remove items from chairs so others can sit. Unauthorized recording of this session is prohibited.
Disclosure Statement:
Nothing to disclose
Community Health Counts
Sinai Community Health Survey 2.0

Jana Hirschtick, PhD, MPH
American Academy of Optometry
October 12, 2017
Sinai Urban Health Institute: Who We Are
The Need for Local-Level Health Data

• Each community has unique health needs that are masked by city-level statistics.

• Readily-available data at community level provide incomplete picture of health:
  - Clinical visit data ≠ disease prevalence or burden.
  - Lack important information on health behaviors and social factors that greatly impact health outcomes.
Sinai Community Health Survey 2.0

- Purpose is three-fold:
  1. **Document** health status of Chicago communities
  2. **Understand** social factors related to health outcomes
  3. **Translate** findings to address health inequities
Sinai Community Health Survey 2.0

• The stats
  – Follow-up to 2002 Sinai Survey
  – $1.6 million grant from The Chicago Community Trust
  – Data collected from 2015-2016 (English and Spanish)
  – Over 500 questions on 40+ health and wellness topics
  – About 1500 adult and 400 child interviews
  – Participants received $50 incentive (+$25 for child)

• Largest community-driven face-to-face health survey ever conducted in Chicago
Surveyed Communities
### Racial/Ethnic Composition

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Non-Hispanic Black (%)</th>
<th>Mexican (%)</th>
<th>Puerto Rican (%)</th>
<th>Other (%)</th>
<th>Non-Hispanic White (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Englewood</td>
<td>94%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Lawndale</td>
<td>90%</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gage Park</td>
<td>87%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Lawndale</td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>41%</td>
<td>26%</td>
<td>20%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Hermosa</td>
<td>48%</td>
<td></td>
<td></td>
<td>27%</td>
<td>16%</td>
</tr>
<tr>
<td>W. West Town*</td>
<td>11%</td>
<td>18%</td>
<td>20%</td>
<td>9%</td>
<td>42%</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>6%</td>
<td>8%</td>
<td></td>
<td></td>
<td>82%</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>Median Household Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norwood Park</td>
<td>$75,281</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W. West Town*</td>
<td>$44,108</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gage Park</td>
<td>$38,001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hermosa</td>
<td>$37,981</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>$35,935</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Chicago Lawn</td>
<td>$31,406</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Lawndale</td>
<td>$30,248</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>West Englewood</td>
<td>$25,625</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Lawndale</td>
<td>$21,763</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Chicago: $46,877  US: $51,914
Determinants of Health Framework
Sinai Community Health Survey 2.0

Health Outcomes

Health Factors

Policies & Programs

General Health Status

Quality of Life

Health Behaviors (30%)
- Diet & Exercise
- Drug, Alcohol, and Tobacco Use
- Intimate Partner Violence
- Sleep

Clinical Care (20%)
- Access to Care
- Health Care Use
- Insurance Status
- Perceptions of Care
- Vaccinations

Social & Economic Factors (40%)
- Criminal Justice Experiences
- Discrimination
- Food Insecurity
- Immigration & Acculturation
- Religion

Physical Environment (10%)
- Neighborhood Safety
- Housing & Homelessness
- Social Cohesion

Adapted County Health Rankings model

Full topic list available at www.sinaisurvey.org
Health Outcomes
Functional Limitations

In one community, over 1 in 5 were blind or had serious difficulty seeing with glasses.
West Englewood had the highest proportion of blind/vision-impaired residents.

### FIGURE 1: Percent reporting that they are blind or have serious difficulty seeing when wearing glasses

<table>
<thead>
<tr>
<th>Community</th>
<th>Prevalence (Standard Error)</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Englewood</td>
<td>22% (3.9%)</td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>14% (3.2%)</td>
</tr>
<tr>
<td>South Lawndale</td>
<td>12% (4.9%)</td>
</tr>
<tr>
<td>Gage Park</td>
<td>11% (5.3%)</td>
</tr>
<tr>
<td>West-West Town</td>
<td>10% (4.5%)</td>
</tr>
<tr>
<td>Hermosa</td>
<td>10% (4.0%)</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>7% (1.9%)</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>7% (3.4%)</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>Suppressed</td>
</tr>
</tbody>
</table>

*Sampled West Town community area west of Western Avenue only*
Post Traumatic Stress Disorder

In two communities, 1 in 4 adults had current PTSD symptoms
In two communities, 1 in 4 adults had current PTSD symptoms.
Health Behaviors
Intimate Partner Violence
In three communities, 1 in 3 women had experienced intimate partner violence
In three communities, 1 in 3 women experienced intimate partner violence.

### Figure 3: Percent who ever experienced intimate partner violence by community area and sex

<table>
<thead>
<tr>
<th>Community</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Englewood</td>
<td>(2.9%)</td>
<td>10%</td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>(5.7%)</td>
<td>13%</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>(4.8%)</td>
<td>15%</td>
</tr>
<tr>
<td>West-West Town</td>
<td>(3.8%)</td>
<td>19%</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>Suppressed</td>
<td>24%</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>(4.7%)</td>
<td>10%</td>
</tr>
<tr>
<td>Hermosa</td>
<td>(7.2%)</td>
<td>23%</td>
</tr>
<tr>
<td>South Lawndale</td>
<td>(3.5%)</td>
<td>11%</td>
</tr>
<tr>
<td>Gage Park</td>
<td>(3.6%)</td>
<td>9%</td>
</tr>
</tbody>
</table>

Sampled West Town community area west of Western Avenue only.
Insurance Status

1 in 3 adults in South Lawndale was uninsured
High uninsured rates in predominantly Mexican communities

**FIGURE 1: Percent of adults aged 18-64 years without health insurance by community area**

- **US: 13%**
- **CHICAGO: 20%**

<table>
<thead>
<tr>
<th>Community</th>
<th>Prevalence (Standard Error)</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Lawndale</td>
<td>34% (4.5%)</td>
</tr>
<tr>
<td>Hermosa</td>
<td>30% (5.3%)</td>
</tr>
<tr>
<td>Gage Park</td>
<td>28% (4.1%)</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>21% (10.4%)</td>
</tr>
<tr>
<td>West-West Town</td>
<td>19% (3.3%)</td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>19% (5.0%)</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>17% (4.8%)</td>
</tr>
<tr>
<td>West Englewood</td>
<td>11% (5.2%)</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>Suppressed</td>
</tr>
</tbody>
</table>

*Sampled West Town community area west of Western Avenue only*
Unmet Health Care Needs

In two communities, 1 in 5 adults did not receive needed eyeglasses in the past year.
Varying unmet health care needs at community level

**Figure 3:** Percent who did not get needed prescriptions, dental care, or eyeglasses in past year due to cost by community area

<table>
<thead>
<tr>
<th>PRESCRIPTIONS</th>
<th>DENTAL CARE</th>
<th>EYEGLASSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Englewood</td>
<td>28% (8.2%)</td>
<td>22% (5.7%)</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>24% (6.5%)</td>
<td>17% (4.2%)</td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>21% (4.1%)</td>
<td>15% (3.3%)</td>
</tr>
<tr>
<td>West-West Town</td>
<td>18% (3.9%)</td>
<td>9% (2.2%)</td>
</tr>
<tr>
<td>Gage Park</td>
<td>17% (7.4%)</td>
<td>12% (2.3%)</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>15% (4.8%)</td>
<td>9% (1.7%)</td>
</tr>
<tr>
<td>Hermosa</td>
<td>10% (4.1%)</td>
<td>12% (4.1%)</td>
</tr>
<tr>
<td>South Lawndale</td>
<td>10% (3.2%)</td>
<td>22% (4.8%)</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>Suppressed</td>
<td>Suppressed</td>
</tr>
</tbody>
</table>

*Sampled West Town community area west of Western Avenue only*
Social and Economic Factors
Food Insecurity

“One out of two people?
That’s like half the people in this room!”

- Humboldt Park/West-West Town Community Forum Participant
In three communities, nearly 1 out of 2 households was food insecure.

**Figure 1: Prevalence of household food insecurity in past year by community area**

<table>
<thead>
<tr>
<th>Community</th>
<th>Prevalence (Standard Error)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humboldt Park</td>
<td>46% (5.4%)</td>
</tr>
<tr>
<td>South Lawndale</td>
<td>45% (6.5%)</td>
</tr>
<tr>
<td>Gage Park</td>
<td>44% (7.1%)</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>37% (6.8%)</td>
</tr>
<tr>
<td>West Englewood</td>
<td>33% (5.5%)</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>32% (5.0%)</td>
</tr>
<tr>
<td>West-West Town</td>
<td>30% (4.7%)</td>
</tr>
<tr>
<td>Hermosa</td>
<td>29% (4.6%)</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>7% (2.8%)</td>
</tr>
</tbody>
</table>

Sampled West Town community area west of Western Avenue only
Physical Environment
Neighborhood Safety
Many residents did not feel safe alone in their neighborhood during the day
Many residents did not feel safe alone in their neighborhood during the day.

**Figure 3: Percent who felt unsafe alone in neighborhood during daytime by community area and sex**

<table>
<thead>
<tr>
<th>Community Area</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gage Park</td>
<td>17%</td>
<td>40% (10.9%)</td>
</tr>
<tr>
<td>West Englewood</td>
<td>30%</td>
<td>39% (10.4%)</td>
</tr>
<tr>
<td>South Lawndale</td>
<td>25%</td>
<td>29% (6.6%)</td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>17%</td>
<td>20% (7.0%)</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>15%</td>
<td>16% (5.2%)</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>Suppressed</td>
<td>16% (6.7%)</td>
</tr>
<tr>
<td>Hermosa</td>
<td>3%</td>
<td>13% (2.8%)</td>
</tr>
<tr>
<td>West-West Town</td>
<td>2%</td>
<td>11% (4.0%)</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>Suppressed</td>
<td>Suppressed</td>
</tr>
</tbody>
</table>

*Sampled West Town community area west of Western Avenue only*
Takeaways
Health needs to be tackled neighborhood by neighborhood

Helping all individuals attain optimal health requires understanding of social factors that impact health
Where do we go from here?
Sinai Survey 2.0: Data to Action

Phase 1: Community Health Assessment

Phase 2: Tailored Dissemination

Phase 3: Mobilizing Toward Action
Sinai Survey 2.0: Tailored Dissemination

Community Health Counts

Obesity in nine Chicago community areas

Obesity is a clinically-defined condition characterized by a high body mass index (BMI) (30.0 kg/m^2). It is correlated with an increased risk of diseases such as type II diabetes, cardiovascular disease, and certain types of cancers. In addition, obesity is associated with increased rates of all-cause mortality and reductions in life expectancy. Furthermore, it is estimated that obesity accounts for almost 10% of all medical spending, equating to nearly $150 billion per year. Although the risks of being obese are generally well-known, individuals must also be aware of their weight status and be willing to make changes to their diet and physical activity levels in order to lose weight. This health snapshot presents obesity findings from the Sinai Community Health Survey 2.0, a community-driven, representative survey of nine communities in Chicago.

Which communities are most affected?
- In North Lawndale, West Englewood, Humboldt Park, Chicago Lawn, and Gage Park, over half of female residents were obese.
- The majority of obese adults in the nine surveyed communities tried to lose weight during the past year.

Who is most affected?
- At least 50% of non-Hispanic Black females and females of Puerto Rican origin were obese.
- One in four adults of Mexican origin who were obese considered themselves the right weight or underweight.
Sinai Survey 2.0: Tailored Dissemination
Sinai Survey 2.0: Tailored Dissemination
Sinai Survey 2.0: Mobilizing Toward Action

- **Community-Based Organizations**
  - Community health programming

- **Policy-Makers**
  - Community and city-level advocacy

- **Funders**
  - Data-driven strategic issue prioritization
  - Grantee capacity building

- **Public Health Workforce**
  - Partner, partner, partner!
  - Convening and empowering community-health advocates
Achieving Health Equity

Local-level data + Community Engagement

BROAD PARTNERSHIPS
Community Leaders, Health Systems, Funders
www.sinaisurvey.org
jana.hirschtick@sinai.org
SINAI URBAN HEALTH INSTITUTE’S (SUHI’S) STORY ABOUT USING THE COMMUNITY HEALTH WORKER MODEL

The Sinai Urban Health Institute (SUHI) team, pictured above, is comprised of a diverse group of health educators and epidemiologists.

Sinai Health System is located on the West and Southwest sides of Chicago, IL.
SUHI’S STORY ABOUT USING THE COMMUNITY HEALTH WORKER MODEL

Chicago asthma by the numbers

25%
Percentage of African American children in Chicago who have asthma, roughly 1 in 4.1

9x
The number of visits to the ED by African American children as compared to white children in Chicago.2

35%
The number of Chicago’s children who had missed at least 1 day of school due to asthma in the past two weeks, when surveyed.4

2x
The prevalence of asthma in Chicago’s African American children as compared to the rest of the US. This is double the national average.1, 2

6x
The number of hospitalizations of African American children compared to their white counterparts.3

8x
The rate at which African American people in Chicago with asthma die as compared to their white counterparts.4

3 in 4
The number of students with asthma who do not have documentation on file with their schools, and that means they cannot receive formal support to manage asthma attacks at school.5

80%
Percentage of African American children on the West side who had no controller medication in the home.1, 2

48%
Percentage of African American children living in Westside Chicago communities who live with a smoker.1, 2

60%
Percentage of African American children on the West side who had been to the ED due to asthma in the past year.1, 2
Asthma is a serious lung disease, yet with proper long-term management it can be controlled and people can have fulfilling and productive lives.

Goals:
1. Decrease asthma-related morbidity and mortality;
2. Improve quality of life;
3. Decrease costs

Utilizing Community Health Workers (CHWs) making home visits

APHA defines a Community Health Worker as:
"...a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served."
SHS service area residents are more likely to have asthma that’s poorly controlled
  - Hospitalization, ED, mortality and morbidity rates higher in inner-city, minority Chicago communities
  - In some instances, prevalence exceeds 1 in 4
    • *Sinai’s Community Health Survey*
    - Asthma rates among federally-assisted housing residents are approximately twice the national rate
• All of our projects are a collaboration between various community organizations
SUHI’S STORY ABOUT USING THE COMMUNITY HEALTH WORKER MODEL

- Community Health Workers
  - Effective hiring/training processes, appropriate supervision
  - Reimbursement and sustainability on-going challenge
- Participants
  - Economic hardship and competing priorities
- Collaboration is key
  - Need for legal, housing and social service referrals is vast. Need to have right partners in place
- Partner with the community

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*a Gutierrez Kapheim M, Campbell J. Best practice guidelines for implementing and evaluating community health worker programs in health care settings. Chicago, IL: Sinai Urban Health Institute; 2014.*
## SUHI’S STORY ABOUT USING THE COMMUNITY HEALTH WORKER MODEL

### Table 1. Sinai Asthma Program Outcomes**

<table>
<thead>
<tr>
<th></th>
<th>PAI-1&lt;sup&gt;1&lt;/sup&gt;</th>
<th>PAI-2&lt;sup&gt;2&lt;/sup&gt;</th>
<th>CPATCE (Sinai)</th>
<th>HHHC&lt;sup&gt;3&lt;/sup&gt;</th>
<th>HCBT</th>
<th>ACP&lt;sup&gt;***&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>56</td>
<td>50</td>
<td>160</td>
<td>151</td>
<td>59</td>
<td>68</td>
</tr>
<tr>
<td><strong>Asthma Emergency Dept. Visits</strong></td>
<td>74.3% decline</td>
<td>73.5% decline*</td>
<td>47.6% decline*</td>
<td>69.0% decline*</td>
<td>83.3% decline*</td>
<td>73.5% decline*</td>
</tr>
<tr>
<td><strong>Asthma Hospitalizations</strong></td>
<td>86.2% decline</td>
<td>71.4% decline*</td>
<td>50.0% decline*</td>
<td>62.7% decline*</td>
<td>50.0% decline*</td>
<td>95.9% decline*</td>
</tr>
<tr>
<td><strong>Urgent Health Care Resource Utilization&lt;sup&gt;^&lt;/sup&gt;</strong></td>
<td>79.6% decline*</td>
<td>69.3% decline*</td>
<td>50.0% decline*</td>
<td>54.7% decline*</td>
<td>75.8% decline*</td>
<td>73.6% decline*</td>
</tr>
<tr>
<td><strong>Nighttime Asthma Symptoms</strong></td>
<td>–</td>
<td>51.6% decline*</td>
<td>63.6% decline*</td>
<td>43.8% decline*</td>
<td>73.3% decline*</td>
<td>61.5% decline*</td>
</tr>
<tr>
<td><strong>Pediatric Asthma Caregiver’s Quality of Life</strong></td>
<td>–</td>
<td>Increased by 0.8&lt;sup&gt;†&lt;/sup&gt;</td>
<td>Increased by 0.4&lt;sup&gt;†&lt;/sup&gt;</td>
<td>Increased by 1.2&lt;sup&gt;†&lt;/sup&gt;</td>
<td>Increased by 0.7&lt;sup&gt;††&lt;/sup&gt;</td>
<td>Increased by 1.0&lt;sup&gt;††&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Cost-savings per Participant&lt;sup&gt;</strong>&lt;/sup&gt;**</td>
<td>$4,503.44</td>
<td>$2,561.60</td>
<td>$1,402.87</td>
<td>$2,119.81</td>
<td>$813.03</td>
<td>$3,200.05</td>
</tr>
<tr>
<td><strong>Cost-savings /$ spent on the program&lt;sup&gt;€&lt;/sup&gt;</strong></td>
<td>$7.79</td>
<td>$5.58</td>
<td>$3.38</td>
<td>$4.54</td>
<td>$2.33</td>
<td>$5.79</td>
</tr>
</tbody>
</table>

<sup>*Statistically significant p<0.05</sup>

<sup>^ Sum of ED visits, hospitalizations, and urgent clinic visits</sup>

<sup>† An increase of 0.5 is clinically significant</sup>

<sup>‡ Ns vary because parent is unit of analysis not child. HCBT N=42, ACP N=50</sup>

<sup>**Cost-savings after accounting for program costs</sup>

<sup>†† Cost Savings per $ spent = Healthcare Cost Savings/Cost of Program</sup>

**Table is pending publication

***This data is representative of the children who have completed 6 months in the ACP program

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SUHI’S STORY ABOUT USING THE COMMUNITY HEALTH WORKER MODEL

- As SUHI’s overall mission states, we envision “for all communities to thrive in health.”
- The CHW model is proven to improve health outcomes, decrease costs, and improve quality of life.
SUHI’S STORY ABOUT USING THE COMMUNITY HEALTH WORKER MODEL

• SUHI has amassed wealth of information on how best to:
  – Hire, train, and supervise CHWs
  – Integrate CHWs into health care systems
• CHW Best Practice Guidelines 1report
• Nationally recognized expert in implementation and evaluation of the CHW Model
• CROWD - CHW consulting and training center
Innovation and Opportunity in the Private Health Insurance Market

ANTHONY T. LO SASSO, PHD
UNIVERSITY OF ILLINOIS AT CHICAGO
Big picture: Overall trends in insurance coverage

- We have witnessed a decline in uninsured from 13% in 2013 to 9% in 2016
- A combination of non-group (individual Marketplace) & Medicaid
Two broad categories of recent developments: demand and supply side

- Demand side interventions attempt to alter patient behavior through cost-sharing

- Supply side interventions attempt to alter behavior by affecting the provider’s behavior or by “steering” patients towards different providers
What’s happening to Employer Health Insurance Premiums?

- Premiums continue their upward march
  - Family coverage: $18,764 in 2017 up from $5,791 in 1999
  - Single coverage: $6,690 in 2017 up from $2,196 in 1999

Figure 1.10
Average Annual Premiums for Single and Family Coverage, 1999-2017

* Estimate is statistically different from estimate for the previous year shown (p < .05).
However, some evidence that the rate of growth is slowing

- The most recent 5-year period featured slowest premium increases (19%) in the last 15 years

- Why are we seeing this?

---

Figure 1.13
Cumulative Premium Increases for Covered Workers with Family Coverage, 2002-2017

- Premium Increases
- Overall Inflation
- Workers’ Earnings

<table>
<thead>
<tr>
<th>Period</th>
<th>Premium Increases</th>
<th>Overall Inflation</th>
<th>Workers’ Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002 to 2007</td>
<td>19%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>2007 to 2012*</td>
<td>11%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>2012 to 2017*</td>
<td>0%</td>
<td>12%</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Percentage change in family premium is statistically different from previous five year period (p < .05).

What is driving the changes?

- There is strident growth in cost-sharing—deductibles

Figure 7.18
Among Covered Workers With a General Annual Health Plan Deductible for Single Coverage, Distribution of Deductibles, 2007-2017

*Distribution is statistically different from distribution for the previous year shown (p < .05).

NOTE: Average general annual health plan deductibles for POS, PPO plans, and HMO/SCCs are for in network services.

What is driving the changes?

- And copayment for office visits are increasing...
What is driving the changes?

- As are copayments for specialist visits...

---

**Figure 7.41**
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, 2006-2017

*Distribution is statistically different from distribution for the previous year shown (p < .05).*

What is driving the changes?

- And pharmacy copays reflect:
  - Increasing use of 4-tier copay regimes
  - And Rx copays are increasing
High deductible health insurance is now the new normal

- Most large firms offer them now
- Still many small firms offer them
What do we know about the effects of HSA enrollment? Some recent evidence

- Health care spending drops sharply & suddenly
- 12-14% spending reduction

From: What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*
Q J Econ | © The Author(s) 2017. Published by Oxford University Press on behalf of the President and Fellows of Harvard College. All rights reserved. For Permissions, please email: journals.permissions@oup.com
What did enrollees cut back on?

<table>
<thead>
<tr>
<th>Service</th>
<th>Change in quantity</th>
<th>Service</th>
<th>Change in quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially High Value Care</td>
<td>-7.5%</td>
<td>Imaging</td>
<td>-17.7%</td>
</tr>
<tr>
<td>Preventive care</td>
<td>-5.4%</td>
<td>CT scans for sinuses</td>
<td>-26.0%</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>-29.7%</td>
<td>Back imaging</td>
<td>-21.3%</td>
</tr>
<tr>
<td>Diabetes drugs</td>
<td>-48.0%</td>
<td>Antibiotics for respiratory infection</td>
<td>-44.4%</td>
</tr>
<tr>
<td>Statins</td>
<td>-19.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension drugs</td>
<td>-24.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

=> In short, they cut back on everything, regardless of apparent value
What remains to be known about HSAs?

- How do we “activate” patients to become consumers?
  - Patients rarely use price transparency tools when they are made available. Why?
- Can “smarter” enrollee-side benefit design improve decision-making and outcomes?
  - E.g., so-called value-based designs that charge lower or no cost-sharing for highly effective, recommended treatments
  - Evidence is mixed
- Ultimately how much can we expect patients to do?
Leveraging the supply side of health care

- Increasingly firms are looking more closely at provider networks.

**Figure 14.4**

Among Firms Offering Health Benefits, Percentage of Firms That Eliminated Hospitals From Their Network or Offer a Narrow Network Plan, by Firm Size, 2017

- Eliminated Hospitals or Health Systems from Network in Past Year to Reduce Cost
- Offers Plan: Considered Narrow Network

*Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).*

**SOURCE:** Kaiser-HRET Survey of Employer-Sponsored Health Benefits, 2017
Narrow network plans have high penetration in the Marketplaces

2015 consumers are being offered a wide range of network types

<table>
<thead>
<tr>
<th>Distribution of 2015 individual exchange networks by network breadth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Across the U.S. % of networks across all tiers (n = 2,864)</td>
</tr>
<tr>
<td>In the largest city of each U.S. state % of networks across all tiers (n = 372)</td>
</tr>
</tbody>
</table>

- **Ultra-narrow**: 17% / 21%
- **Narrow**: 22% / 34%
- **Tiered**: 6% / 7%
- **Broad**: 55% / 38%

**SOURCE**: McKinsey Center for U.S. Health System Reform analysis of publicly available network information. **Data as of**: 12/31/2015

1. Of the 2,930 networks in the U.S., 66 are in rating areas that contain no hospitals and thus cannot be assigned a network breadth (breadth is defined by the percentage of hospitals in a rating area that participate in a network). For this reason, the 66 networks are not included in Exhibits 1 and 2.
Why think more about who’s in-network?

- Because prices vary *a lot* for healthcare in the US
- Removing expensive providers from the network can potentially achieve savings

Prices for CT scans

<table>
<thead>
<tr>
<th>Percentile</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>25th Percentile</td>
<td>$138</td>
</tr>
<tr>
<td>Average</td>
<td>$566</td>
</tr>
<tr>
<td>95th Percentile</td>
<td>$1,672</td>
</tr>
</tbody>
</table>
What do we know about narrow networks? Some recent evidence

- Office visits and specialist visits, lab & radiology all fall
- So do preventive care services
- There is an increase in out-of-network use
- Spending falls
- But where are the effects coming from?

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Full controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Office Visits</td>
<td>0.637</td>
<td>-0.035**</td>
</tr>
<tr>
<td>Any Emergency Room</td>
<td>0.118</td>
<td>0.015</td>
</tr>
<tr>
<td>Any Specialist Visit</td>
<td>0.348</td>
<td>-0.035***</td>
</tr>
<tr>
<td>Total Spending</td>
<td>$3,951</td>
<td>-25.6%**</td>
</tr>
<tr>
<td>Insurer Paid</td>
<td>$2,960</td>
<td>-32.8%**</td>
</tr>
</tbody>
</table>

Robust standard errors in parentheses. * p < 0.10, ** p < 0.05, *** p < 0.01
Results control for other person-level and plan characteristics.
Decomposition of spending effects: what aspect of the network drives the results?

1. **Selection on Price**: are providers in the narrow network cheaper than those not in the narrow network?
2. **Bargaining**: is the insurer able to obtain lower reimbursement rates for providers to join the narrow network?
3. **Selection on Quantity**: are the providers in the narrow network more efficient than those not in the narrow network?
4. **Utilization Management**: do narrow network providers actively manage the care for narrow network enrollees?
Decomposition of spending effects: what aspect of the network drives the results?

1. **Selection on Price**: are providers in the narrow network cheaper than those not in the narrow network? **Answer: YES, 90% of the effect is from this**
2. **Bargaining**: is the insurer able to obtain lower reimbursement rates for providers to join the narrow network? **Answer: No**
3. **Selection on Quantity**: are the providers in the narrow network more efficient than those not in the narrow network? **Answer: A little**
4. **Utilization Management**: do narrow network providers actively manage the care for narrow network enrollees? **Answer: No**
So where do we go from here?

- In addition to narrow networks and high deductibles, multiple innovations are being tried in the United States
  - Bundled payments
  - ACOs
  - Patient-centered medical homes
  - Reference pricing
- Some of this is driven by the federal government, some is driven by insurers, and some is driven by payers
The elusive triple aim remains the goal

- Improved experience of care
- Improved population health
- Reduced healthcare costs per person

- There IS innovation going on
  - Does not seem wise to stop it
- But there is a long way to go...
EVERYONE AGREES TO HELP REDUCE HEALTH CARE COSTS!

I CAN'T AFFORD THAT DIAGNOSIS. DO YOU HAVE A CHEAPER ONE?
Affordability Care Act and Optometry

Jeff Smith, OD, MBA
2017

Please silence all mobile devices and remove items from chairs so others can sit. Unauthorized recording of the session is prohibited.
Disclosure Statement

• I do not accepted consultation fees or anything to disclose

• Employed as Medical Director and Executive Vice President for HVHC, Inc.
AS OF JULY 31st 2017
Agenda of Topics

• Understand a brief history of ACA
• Understand if there is a “real” need for healthcare reform out there?
• Understand what is the basics of ACA
  – Objectives of ACA?
  – Where do the revenues for ACA come from?
  – What are the 10 Essential Benefits?
  – What is ACA population?
  – Future of ACA, reformed programs, “skinny ACA”?
• Some fun Stories
  – Misunderstandings that still continue today
  – Nothing is really new or is it?
Brief History

• With much discussion and media coverage ACA passed both the House and Senate
• Signed into Law by President Obama
  – March 23, 2010
  – Became a heighten “conflict point” between Democrats and Republicans
• Challenge brought to Supreme Court
  – June 28, 2012
  – Court agreed to review ACA
  – Court found ACA “constitutional”..or confirmed it
Brief History

• Confusion spreads!
  – Late night TV comedy material

• Implementation.............rocky!
  – After Implementation, controversy continues
    • “good” and “bad” press

• Becomes Major Issues in the 2016 Presidential Election
  – “Appeal and Replace It” of “Appeal It”

• Appeal attempts by the Trump Administration starting with campaigning promises
  – Appeal passed the House, but not the Senate....yet?
Brief History

• As of July 31, 2017......”It is the Law.....It is for Real”
  – As of end of 2016, about 11.1 million Americans have medical insurance through the ACA’s Exchanges or Marketplaces
  – Expansion of Medicaid, another 15.9 million are covered
  – Confusion and complexity continues
Brief History

• So in conclusion on the history of ACA
  – Confusing and no consensus
    • Before, During and After
    • Ironically, many say template for National ACA is Massachusetts Healthcare reform championed by Mitt Romney
Was Health Care Reform Needed?

• So Basic Question.......  

Do we have great healthcare here in the USA?”
Was Health Care Reform Needed?

• Answer.......Yes and No
  – Yes
    • We have fantastic institutions and highly trained practitioners
  – No
    • Too many do not have access and too many cannot afford it
    • Too expensive collectively, especially when compared to other countries

• Hence, a trick question that is politically loaded
Was Health Care Reform Needed?

- What are the best indexes or ways to look at a large population quality of healthcare?
  - E.g. compare to other large Industrial countries

- Three major areas:
  - 1) Clinical point of view
  - 2) Economic (affordability) point of view
  - 3) Access point of view
Was Health Care Reform Needed?

- Clinical point of view
  - 2 major indexes
    - Average Life Expectancy:
      - US is below the average on longevity
    - Infant Mortality Rate:
      - US is below average
Was Health Care Reform Needed?

• Economic point of view
  – Cost of top 100 most utilized medical procedure
    • Micro point of view......
    • Higher than the average in the US than other industrialized nations
    • Hence, why "travel medicine" is growing
  – Healthcare cost as a % of total GNP
    • Marco point of view......
    • US doesn’t score well with this index
    • US % of total GNP that is for Healthcare is higher than any other industrialized country.
Was Health Care Reform Needed?

• Access point of view
  – Actually a function of affordability and geography in the US
    • Rural issues
    • Remote areas e.g. Alaska
Was Health Care Reform Needed?

• Probably..........a “yes” and a “no” is the best answer
• Issues:
  – our cost here in the USA
  – our uncovered folks
Understand the Objectives of ACA

• Lofty to say the least
  – Multi facetted and one can see how it lends to confusion
• Official List:
Understand the objectives of ACA

• What is it that ACA is going to do for us?
  – Improving healthcare nationwide
  – Providing better and more effective healthcare
  – Offer more affordable choices for with or without insurances
Understand the objectives of ACA

• What is it that ACA is going to do for us?
  – Reforming the way that Insurers and providers offer their services
  – Putting regulations unto place
  – Reducing the amount of costs in healthcare
  – Provide incentives, like tax breaks to small businesses
Understand the Finances/Revenues of ACA

• So how do you pay for this
  – Revenue streams from many sources

• Official list:
  – Personal income tax
    • Personal Mandates if one’s health insurance is not “proved” on income taxes
  – A tax on Medicare of 0.9% personal
Understand the Finances/Revenues of ACA

• Unearned income tax on people who earn >$200K
• Spending cuts in other Govt. departments
  – Verbiage with many governmental programs, hardly ever happens
• A tax levied against insurance companies
• Taxes levied against business that have 50 or more FT workers that didn’t comply
Understand the Finances/Revenues of ACA

- Do the revenues cover the cost?

- No, not so far. Big issue.
Understand the “10 Essential Benefits”

• The essentials that are “designed” to keep people healthier
• The ACA 10 essentials
  – Prescription medication*
  – Emergency services
  – Hospitalization and surgery
  – Laboratory services
  – Mental health service, such as behavioral therapy, counseling, substance abuse treatment and psychotherapy
Understand the “10 Essential Benefits”

• The ACA 10 Essentials cont.’
  – Outpatient care
  – Pediatric care, including dental and vision*
  – Prenatal and postnatal care
  – Preventive care in the form of general wellness checkups and chronic disease management
  – Rehabilitative care
Understand the “10 Essential Benefits”

• ACA 10 Essentials
  – All designed to create effectiveness in plans
  – Attempt to standardize plans
  – Attempt to move to preventive care
  – All designed to promote growth of all disciplines, including optometry
Understand the ACA population

• Were are the “Millions” of ACA Members are coming from:
  – 1) Covered by an ACA Plan obtain through the ACA marketplace (exchanges)
    • State Market (exchanges)
  – 2) Dramatic Expansion of Medicaid
  – 3) Standard or existing insurance, but an ACA Essential benefit
Understanding ACA

• Some learning from ACA at this point:
  – Growth in people covered with insurances
    • 10s and 10s of million
    • Uninsured in USA has dramatically decreased
  – Funding for ACA
    • Various revenue streams, but not financially sound yet
    • Healthcare cost are not going down
    • Finances unknown
Understanding ACA

• ACA and Optometry
  – Overall has increased more access to patients for optometry
  – Specifics:
    • Pediatric care for vision
    • Prescription medications
    • Increases in Medicaid populations
Understanding ACA

• Some Basic Conclusions
  – Still politicized
  – Still confusing
  – Still not resolved
Thank you

Please remember to complete your session evaluations online.