

Helping Ohioans with
Healthcare Benefit
Choices



**Testimony of John McGough on behalf of the
Ohio Association of Health Underwriters**

S.B. 9

Before the House Insurance Committee

November 12, 2019

Chairman Brinkman, Vice-Chair Antani, Ranking Member Boggs, and members of the Committee, my name is John McGough. I am appearing today in my capacity as Legislative Agent of the Ohio Association of Health Underwriters (OAHU). OAHU's membership consists of insurance agents licensed by the Ohio Department of Insurance who specialize in the sale and servicing of health insurance benefits for both individuals and employers located throughout the state.

Background on Current Ohio Health Insurance Market

As way of background, historically claims data has only been provided to employers with 100 or more enrolled employees, however, 50-99 employer groups and 100+ employer groups are **medically underwritten in the same way**. In fact, in the **50+ market health insurers can decline to provide health insurance coverage due to medical claims**.

Ohio's small group market (1-50) is rated differently than the 50+ market through what is referred to as "community rating". Community rating spreads the actuarial risk across all small employers in each health insurer's book of business within a specific rating area. Also, **Ohio's small group market is "guarantee issue" which means that health insurers must accept all such groups regardless of health conditions**.

OAHU's supports the Senate-passed version of S.B. 9

Because Ohio's 1-50 small group market is community rated, S.B. 9 (as introduced and as passed by the Senate) only applies to groups of 50+ enrolled employees. In the past few years there have been a plethora of new health insurance products introduced into Ohio's employer group market. **Passage of S.B. 9 is very important to ensure that all 50+ size employers can**

provide their employees with reasonable health insurance options. It will empower employers to shop all funding arrangements and benefit designs available in Ohio's 50+ group market.

The problem with S.B. 9 as reported by the House Insurance Committee on May 7, 2019 is that **removal of the words "claimant health condition or diagnosis" could impede employers in the development of disease management programs.** Disease management programs have shown that, over time, they help improve the health status of employees with chronic conditions and reduce the growth of health insurance costs.

High claims data when paired with the diagnosis category provides an overview of high claim costs in comparison to premiums paid. The information is used in predictive modeling to determine if the high claims are a "one and done" or will continue. An underwriter will review the high claims against diagnosis in setting rates. For example, if there is a high claim with a diagnosis of cancer, resulting in continuing treatments, the insurer will spend more in claims than premiums collected, which will increase the premium rates accordingly for the next renewal period. If the high claim was a pregnancy or one-time surgery, the impact to premium rates will be lower.

Included with my testimony is an article in the **October 7, 2019 Modern Healthcare** magazine. Modern Healthcare describes itself as the "Only Healthcare Business News Weekly" and its circulation is to over 70,000 executives in the healthcare industry. The article is titled "**Diabetes in Depth: The Case for Comprehensive Case Management**". On the first page of the article one of the boxes has the following statement: **97% of healthcare leaders believe chronic condition management is "very important" or "important" to a successful PHM (Population Health Management) program**". Also attached with my testimony are examples of successful disease management programs.

I want to emphasize that the claims information an employer receives is **Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA) and is required to be kept private.** HIPAA has strict guidelines as to whom the protected health information can be shared, and under what circumstances this is appropriate.

HIPAA violations apply to healthcare providers, health plans, healthcare clearinghouses and all other covered entities (which includes health insurance agents and employers). **Penalties for violation of HIPAA range from \$100 to \$50,000 per violation.**

In conclusion, OAHU supports the proposed amendment to S. B. 9 which will greatly help employers, through the health insurance plans they provide to their employees, to implement successful disease management programs.



Examples of Successful Disease Management Programs

Company A

Long term experience with wellness initiatives. Review of claim reports and high claim listing revealed concerns with increased ER visits, multiple cases of diabetes and cardiac related issues. The employer contracted with MedBen Well Living program to focus on five key areas: coronary artery disease, diabetes, hypertension, cholesterol and asthma. The employer experienced a sharp increase in prescription drug utilization and outpatient visits in the first few years (reflected in the claims reports). This increase was anticipated as employees/dependents were encouraged to address chronic conditions and follow physician recommendations for medication. The high cost claims continue to decrease, and the employer has had no rate increase in the past five years.

Company B

Receives regular claims reports with high claim listings. They acquire a new plant and saw an immediate and significant spike in asthma, diabetes and hypertension conditions. The employer hired MedBen Well Living to meet with employees of the new plant and develop targeted education and activity-based programs to address the three conditions. Employee absenteeism at the plant has shown dramatic improvement and the high claim costs are decreasing.

Company C

Significant conditions in high claims listings (including coronary artery disease, diabetes and depression). The employer selected Bravo Wellness to run an educational campaign, onsite health screenings and incentive programs for participation. The employer has experienced an increase in employee morale and a decrease in total claim costs.

Diabetes in Depth: The Case for Comprehensive Diabetes Management

Diabetes has reached an epidemic level in the United States, affecting over 30 million people. Over 84 million U.S. adults—more than a third—are estimated by the CDC to have prediabetes, meaning they're at an increased risk of developing type 2 diabetes, heart disease and stroke. The diagnosis and management of diabetes has become a significant priority for all payers and providers in their efforts to manage population health.



\$327 billion

the total direct and indirect estimated cost of diagnosed diabetes in the U.S. in 2017

SOURCE: American Diabetes Association

"Diabetes impacts not just individual patients, but also their families and their communities," said Kate Berry, senior vice president of clinical affairs and strategic partnerships for America's Health Insurance Plans (AHIP). "The cost of treating diabetes and complications over time can get very serious. We can't understate the impact it's having on the American health system."

Experts say payers and providers looking to minimize the disease's impact on outcomes must consider the importance of targeted, personalized interventions and the promise of real-time data.

CONNECTING PROVIDER, PAYER AND INDIVIDUAL

In a survey conducted by Modern Healthcare Custom Media on behalf of Envolve Health, nearly all respondents (97%) believe that care coordinators who help manage chronic conditions such as diabetes are "very important" or "important" to a successful Population Health Management (PHM) program. Respondents also said that chronic condition management is one of their top three most significant challenges in managing population health.

Prevention is crucial in managing diabetes, and payer-provider collaboration is key in working directly with individuals to accomplish that. "Insurers and providers are working together to implement new programs to really get ahead of the disease," Berry said.

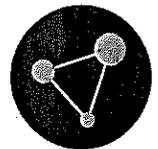
Innovation is occurring in the efforts to bring together payers, providers and individuals in an attempt to coordinate care and influence health behaviors.

Successful coordination of diabetes care requires much more than a well-staffed call center. Healthcare leaders must cultivate a comprehensive care coordination program that incorporates evidence-based protocols, individualized attention and targeted solutions toward barriers that prevent success. Care coordinators play a key role in helping individuals with diabetes overcome social barriers that make it difficult to manage the disease.

"Health insurance providers are meeting patients where they are, deploying wellness coaches and dietitians through telehealth, at their own clinics, and even at community locations like the YMCA or grocery stores," Berry said.

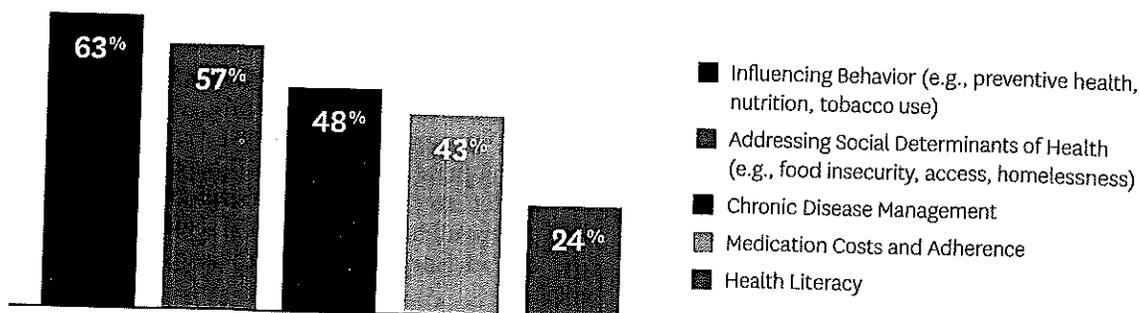
97%

of healthcare leaders believe chronic condition management is "very important" or "important" to a successful PHM program



Digital tools are empowering patients with better access to expertise by extending the reach of care coordinators. A wide variety of apps allow individuals to more easily track glucose levels, submit clinical data, and learn best practices for managing the disease. These apps are supplemented by voice assistants like Amazon Alexa and Google Home, which now have skills that allow members to call a coach or receive care

Top 5 population health challenges cited by healthcare leaders

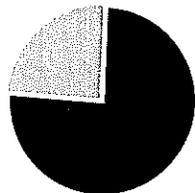


alerts. For example, Envolve Health's On.Demand Diabetes Management program allows patients to use Amazon's Alexa to call a coach or case manager, receive care alerts or healthcare reminders, and contribute to clinical and well-being data to enhance care coordinators' data analysis.

BUILDING TRUST TO INFLUENCE BEHAVIOR

While education is crucial in ensuring individuals with diabetes understand how to manage their condition, most U.S. adults with diabetes understand the nature of their condition. What they need is comprehensive support in managing it, enabled by tools that make it easier—such as automated testing strip refills—and coaching that offers personalized strategies and counseling on how to stay on track.

"Impacting behavior change is more than an educational issue. Individuals who know they have diabetes understand their disease. They know they need to check their blood pressure. They know A1C is important, and they know diet and exercise are important," said Jeremy Corbett, MD, divisional chief health officer of Envolve Health. "They're just having trouble. Our ability to help them lies in what we can do to remove barriers and make it easier to be healthy."



76%
of healthcare executives reported that their organization currently has a care coordination program for chronic illnesses like diabetes

The gold standard in diabetes care management is a one-on-one relationship with a specific coach that works directly with the individual to accomplish key goals. When care coordinators know members well, they can appeal to a particular personality and motive to steer them in a healthy direction and get ahead of potential problems.

"This is not coach by committee," Corbett said. "If you don't have a relationship, you don't have trust. If you don't have trust, the conversation isn't going to move in a productive direction."

Any number of barriers may prevent members from seeing their physician regularly. If patients can be coached on an hour-long conversation by someone who knows their story and has a relationship with them, significant improvements can take place between in-person visits.

"Any time you can tailor an intervention to how a specific patient is presenting, you're more likely to inspire change," Berry said.

REAL-TIME SUPPORT REQUIRES REAL-TIME DATA

Payers traditionally use claims data to determine how best to coordinate care and coach individuals. That can be a challenge for people with diabetes, whose conditions may change rapidly from one day to the next and whose claims are likely to be months old.

"The effectiveness of diabetes management is multiplied when we're able to coach members using real-time data."

Jeremy Corbett, MD, Divisional Chief Health Officer, Envolve Health

"Claims data is typically outdated given the time it takes for them to process and be paid out by today's systems. It's the same as saying that you shouldn't dress today based on last week's weather," Corbett said. "The effectiveness of diabetes management is multiplied when we're able to coach members using real-time data."

Even if individuals aren't testing glucose levels as regularly as they should be, their data is indispensable to care coordinators who can use it to better understand possible interventions for condition management. Problematic data may prompt a care coordinator to reach out, rather than wait for a patient to call.

Noncompliance with glucose monitoring can also signal to care coordinators that an individual may be struggling with medication and treatment adherence. "If we have a real-time data stream, it can give us a reason to connect with the patient about a number of related issues," Corbett said.

TAKE THE NEXT STEP IN MANAGING YOUR POPULATION

When technology, proven techniques and early intervention are utilized to combat diabetes, everyone wins. Health plans actively using Envolve Health's On.Demand have achieved a 22% reduction in Emergency Room (ER) spend per member per month and a 15% reduction in ER use per member per month. On.Demand users also show a 46% increase in engagement through telephonic interventions and a 4.9% decrease in average glucose measurement.

Start realizing cost savings and population health benefits by incorporating On.Demand into your health plans. Contact Envolve Health at 1-844-234-0810, or visit envolvehealth.com.

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