Moderator/Speakers:

Matthew Malinowski (moderator)
Business Manager/Board Secretary, Upper Moreland School District

Edward Kaplan
Senior Vice President, National Health Practice, Segal Co.

Bruce Judson
Vice President of Marketing, First Stop Health

Barbara Whitehorn
CFO, Director of Finance and Management Services
City of Asheville, NC
• Medical Cost Transparency and Cost Containment
  • Current state of the health benefits market
  • Challenges
  • Health benefits: future state
  • 12 strategies to manage health plan costs
  • 7 vendor contractor tips
Health Benefits
Current Environment

➢ Opioid Abuse now front and center

➢ Claim cost trends continue to move laterally
  - Annual Increase outpace overall CPI and wage increases
  - Rx plan cost trends still near double digits

➢ Continued cost shifting to plan participants in most markets

➢ Tight labor market will change plan sponsor approach to cost shifting
Gradual move towards lower plan values:

- Growing number of clients forfeiting grandfathered status (about half today are still grandfathered)
- Qualified Health Savings Accounts with High Deductible plans taking off in the corporate market but not yet in bargained group plans
- Participant out of pocket expenses increased by more than 100% in the last decade

Part-time and seasonal workers being removed from coverage:

- Notably for low margin, high turnover industries like retailers
- Some groups hanging on to these lives in pockets
Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2009 – 2016 Actual and 2017 and 2018 Projected

Source: 2018 Segal Health Plan Cost Trend Survey
1 All trends are illustrated for actives and retirees under age 65, except for MA HMOs.
2 Prescription drug trend is combined for retail and mail order delivery channels.
Major Health Benefits Trends

1. Continued cost shifting via higher copays or premium contributions
   • 108% increase in copays and deductibles since 2006 (wages increased 37%)

2. Annual per participant claim cost increase in Specialty Drugs
   (13% to 17%) and Hospital Claims (5%) driving much of plan cost increases

3. Greater emphasis on Rx prior authorization, step therapy, discharge
   coaches to lower readmission rates and other containment concepts

4. Narrow drug formularies

5. Narrow Hospital Networks

6. Increased Interest in Retail Clinics, On-Site Clinics, Telemedicine
Major Health Benefits Trends

7. Use of Health Data Mining Continues to Expand
8. Redesign of Wellness Programs
9. Reference Based Pricing
10. Redesign of Retiree Health Offering (DC approach)
Increasing Participant Out-of-Pocket Expenses

- Annual Deductibles Average $700 per individual and $1,500 per family (Kaiser Foundation)
- Annual Out-of-Pocket Maximum over $6,000 per family (Segal Large Group Multiemployer Database, 2015)
- Median Office Visit Copay to Specialists $35 (KFF)
- Median ER visit copay now $100 (Segal Multiemployer Database)
- 85% of public exchange consumers enrolled in Silver or Bronze Level Coverage with deductibles average close to $4,000 for single coverage
- 1 in 4 workers now enrolled in high deductible plans

Greater need for plan participant consumer support tools!!
Health Treatment Pricing Transparency

**Current State**

- **Providers**
  - Not consumer focused (personal experience with Urgent Care)
  - State Websites get failing grades
    - (Only 3 states get A grade for consumer pricing sites: CO, ME and NH)

- **Vendors Website**
  - Fair Health
  - HealthCare Blue Book
  - Castlight
  - Carrier Websites
  - Amino
  - Vitals—Smart Shopper
  - GoodRx, BlinkRx
Challenges

Access fees, fees typically based on regional averages and tied to a limited set of procedures (not comprehensive set of actual services performed)

- **Participants**
  - Confused
  - Overwhelmed
Health Treatment Pricing Transparency

Actual Example of Price Variation

- Hysterectomy (Maryland): 2015 commercial insurance data*

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Avg Cost Per Episode</th>
<th>Quality Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johns Hopkins</td>
<td>$20,010</td>
<td>Worse</td>
</tr>
<tr>
<td>University of Maryland – St Josephs</td>
<td>$11,691</td>
<td>Better</td>
</tr>
</tbody>
</table>

Variation in Generic Drug Pricing

<table>
<thead>
<tr>
<th>Generic Price Per Rx (30 day supply)</th>
<th>Walmart</th>
<th>CVS</th>
<th>Rite Aid</th>
<th>Stop and Shop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosuvastatin Calcium 10 MG Tab (Crestor)</td>
<td>$48.93</td>
<td>$46.07</td>
<td>$52.02</td>
<td>$40.45</td>
</tr>
</tbody>
</table>

THE PRICE IS WRONG!!!!

* Wearthecost.org
Pricing Transparency

*Desired State*

- Recent data by individual providers and facilities
- Independent Source
- Easy to understand and navigate
- No fee
- Access to both price per procedure and full episode of treatment
- Side by side alternative treatments, facilities and fees
- Head to Head pricing and outcome studies
- Plan Sponsors may provide concierge services to employees
- Auction function, EBAY for medical care?
- Periodically Audited by federal agencies
Cost Containment Focus Continue to Dominate

Different Solutions for Different Industries

- **Higher Income Groups:**
  More High Deductible with Savings Accounts

- **Lower Wage Groups with High Turnover:**
  Narrow Networks more high touch Medical Management

- **Public Sector Groups:**
  Varies by Region and Fiscal Pressures
Health Benefits

Future State

- Demand for Greater Contracting and Negotiating Expertise to Increase
  - Custom Contracting
  - Custom Formulary or greater adoption of restrictive formularies
  - More focus on pay for performance guarantees and provider incentives
  - More Audits (growing distrust of health service providers)

- Greater Emphasis on Data Driven Consulting
  - SHAPE
  - Greater scrutiny of vendor reporting
Survey participants were asked to rank the top cost-management strategies implemented in 2017.

<table>
<thead>
<tr>
<th>Cost Management Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Using specialty pharmacy management</td>
</tr>
<tr>
<td>2. Intensifying pharmacy management programs</td>
</tr>
<tr>
<td>3. Contracting with value-based providers, including ACOs and PCMHs</td>
</tr>
<tr>
<td>4. Increasing financial incentives in wellness design</td>
</tr>
<tr>
<td>5. Adopting a high-deductible health plan</td>
</tr>
</tbody>
</table>
12 Strategies to Manage Health Plan Costs
Strategies to Manage Health Plan Costs

1. Perform data analytics and data mining

2. Focus on design and population strategies

3. Manage utilization of specialty drugs

4. Implement value-based purchasing strategies
Strategies to Manage Health Plan Costs

5. Consider narrow or custom provider networks

6. Consider reference-based pricing maximums

7. Implement vendor performance guarantees

8. Add remote and telemedicine services
9. Re-evaluate and update dental and vision plan offerings

10. Consider Purchasing Coalitions for better pricing terms

11. Put some teeth into your wellness and care management programs

12. Identify out-of-network providers with excessive pricing
7 Vendor Contractor Tips
1. Conduct independent assessment of any provider pricing support tools

2. Demand access to specific network provider current fees

3. Request alerts regarding highest cost providers or provider price changes

4. Make sure plan sponsor is held harmless for bills from non-participating providers when plan participants use network facilities
Vendor Contractor Tips

5. Set performance guarantees tied to vendor down time or wait times to telephonic member support services

6. Establish reasonable and defensible allowance limits for out of network provider claims

7. Negotiate communications budget with vendors to pay for customized promotions of pricing transparency tools
• Telemedicine
  • Value: Utilization and ROI
  • Realizing the promise of telemedicine
  • Principles for creating utilization and value
  • Eliminate friction which prevents use
  • Customized employee education system
  • Customized strategies for each employer
  • ROI: How savings are measured
1. The Promise and Value of Telemedicine
   • Utilization and ROI

2. Criteria for Success
   • Employee Engagement and Awareness
   • Focus on People not Technology
   • Eliminating “Friction” in Use
   • User Experience and Quality

3. Implications for Other Cost Containment Initiatives
   • Emerging Digital Cost Containment Services
   • Employee Engagement
   • Rethinking the Idea of Rationed Care
   • Assessment Criteria for Buyers
A “Win-Win” Solution

Value Creation for Employers & Employees
The doctor will see you now.
Almost all large employers plan to offer telehealth in 2018, but will employees use it?

Telehealth utilization is on the rise, employers have a long way to go to get more staffers onboard.

By Bill Siwicki | September 18, 2017 | 03:33 PM
Almost all large employers plan to offer telehealth in 2018, but will employees use it?

Telehealth utilization is on the rise, employers have a long way to go to get more staffers onboard.

By Bill Sivicki | September 18, 2017 | 03:33 PM

1% to 2% Utilization
ROI: An Ongoing Issue

Telehealth: Clear use, questionable ROI
Employee telehealth tools save Cuyahoga County thousands

The center achieved a 130 percent return on investment equating to more than a $48,000 thus far – and it’s only been 90 days.

By Bill Siwicki | November 06, 2017 | 02:44 PM
<table>
<thead>
<tr>
<th>2017 Average All Clients</th>
<th>2017/18 Public Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 52.5% Utilization</td>
<td>• 74% Utilization</td>
</tr>
<tr>
<td>• 87% ROI*</td>
<td>• 186% ROI*</td>
</tr>
</tbody>
</table>

*Actual cost of diverted visits
A verifiable approach to measuring healthcare cost savings and ROI:

Actual savings for visits diverted from higher cost physical facilities

Excludes savings for:
- No change in care delivered.
- Higher cost of treating employees who postpone care.
- Avoided follow-up visits.
- Reduced absenteeism, productivity benefits.
1. The Promise and Value of Telemedicine
   • Summary: Utilization and ROI

2. Criteria for Realizing the Promise
   • Achieving Employee Engagement and Awareness
   • Focus on People not Technology
   • Eliminating “Friction” in Use
   • Maintaining Quality

3. Implications for Other Cost Containment Initiatives
   • Emerging Digital Cost Containment Services
   • Rethinking the Idea of Rationed Care
   • Assessment Criteria for Buyers
   • Principles for Employee Engagement
1% to 2% Utilization
Carrier-Embedded

7% Utilization
Non-Embedded

51.5% Utilization

Confidential
The Issue of Employee Engagement

Hurdles to the use of telemedicine:

- Inherent barrier to trying anything new
- Awareness: Must be top of mind at an unpredictable time
- Member trust
- Comparative cost to member of in-person treatment
- Pre-treatment hurdles (such as forms)
- Member experience and perceived quality
Principles for Creating Utilization and Value

- Generate Awareness
- Eliminate Friction
- Highest Quality Experience
No “one-size-fits-all” solution. Among things to consider:

- How does employer currently communicate to employees?
- Type of environment of employees?
- Are employees in same location or dispersed?
- Type of health plans offered
- Relationship of employees to HR?
- Types of conditions often faced?
- Age distribution?
- Male/Female?
- Comfort with technology?
• Welcome kit mailed home with wallet and key cards
• Printed materials for open enrollment packages

Onboarding

• 8 multi-media touches in first 60 days
• Co-branded, email communication based on user actions

Education

• Seasonal communications with
  • Health tips
  • Common uses

Reinforcement

• Periodic postcards sent to homes
• Company health fairs
• Sponsors company events

Awareness
Less than 5 Minutes Doctor Call-Back

Less than 1 Hour 24 X 7 X 365

Zero Cost to Employee
MEDICAL HISTORY: TAKEN DURING FIRST PATIENT VISIT

PATIENT CONSULTATION: RECORDING AVAILABLE ON PATIENT PORTAL
A Quality experience builds patient trust and word-of-mouth

• Requires doctor training on “Webside manner”
Why do so many of us avoid going to the doctor? Even doctors.

Not seeking medical help can be dangerous and ultimately expensive. So why do so many of us skip the doctor?
1. The Promise and Value of Telemedicine
   • **Summary: Utilization and ROI**

2. Criteria for Realizing the Promise
   • Achieving Employee Engagement and Awareness
   • Focus on People not Technology
   • Eliminating “Friction” in Use
   • Maintaining Quality

3. Implications for Other Cost Containment Initiatives
   • Assessment Criteria for Buyers
   • Emerging Digital Cost Containment Services
   • Rethinking the Idea of Rationed Care
   • Principles for Employee Engagement
Confidential

Telemedicine Purchasing Criteria

Built-In Employee Education System

High Utilization (first year)

Contractual Refund Guarantee

No Black-Box Savings Calculation
Are Healthcare Systems About to be Amazoned? Telemedicine and Lessons from Internet Services

Cost Containment Examples

- Transparency Services
- Chronic Care Mgmt.
- Care Navigation
- Second Opinions
Employee Engagement: People Not Technology
Rethinking Rationed Care and Incentives
The Employers Role in Promoting Health
The Asheville Project
- Asheville’s workforce
- The Asheville Project foundation principles

Employee Health Clinic

Tying It All Together
- Value-based benefit design
- Partnering with providers to reduce health-care costs
The Asheville Project®
City of Asheville, North Carolina
Asheville’s Workforce

- 1,126 full-time employees and 195 retirees
- Self-insured health program
- 2,370 covered lives
- The Asheville Project® (1997 inception)
The Asheville Project: 
The Foundation Principles

• We want you to empower you to manage your health;
• We will give you the tools to improve your disease outcomes;
• We will remove barriers to get you the treatment you need
History

- 1997 - Program begins at the City of Asheville with 47 participants (employees, retirees and their insured dependents).

- 1998 - Asthma module added.

- 2000 - High blood pressure and high cholesterol (CV Health) added.

- 2005: A depression pilot is launched.

- 2006: Replication of The Asheville Project model expands with the launch of the Diabetes Ten City Challenge.
### The Asheville Project: Four Areas

<table>
<thead>
<tr>
<th>Area</th>
<th>Year</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>1997</td>
<td>106</td>
</tr>
<tr>
<td>Asthma</td>
<td>1998</td>
<td>51</td>
</tr>
<tr>
<td>CV Health</td>
<td>1999</td>
<td>229</td>
</tr>
<tr>
<td>Depression</td>
<td>2006</td>
<td>55</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2016</td>
<td>94</td>
</tr>
<tr>
<td>Asthma</td>
<td>2016</td>
<td>64</td>
</tr>
<tr>
<td>CV Health</td>
<td>2016</td>
<td>218</td>
</tr>
<tr>
<td>Depression</td>
<td>2016</td>
<td>77</td>
</tr>
</tbody>
</table>

**Total participants:** 297

156 participants enrolled in 2+ co-morbidities
13% of covered lives on the city’s plan
The Asheville Project: 2013

<table>
<thead>
<tr>
<th>Condition</th>
<th>Patients enrolled in 1 Program</th>
<th>Patients enrolled in 2+ (Co-morbidities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>18</td>
<td>99</td>
</tr>
<tr>
<td>Asthma</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>124</td>
<td>116</td>
</tr>
<tr>
<td>Depression</td>
<td>19</td>
<td>46</td>
</tr>
</tbody>
</table>

Total participants: 310
15% of the covered lives on the City’s plan
Incentives

Removing the barriers to patient compliance:

- Patient Education
- Ongoing counseling with pharmacist care managers
- Disease-specific lab tests
- Disease-specific medication and supplies
- Receive a point towards wellness credit

ALL ARE PAID AT 100% by the City of Asheville
Direct Medical Costs Over Time*


*Mean Cost / Patient / Year*

- Baseline
- Follow-up Year 1
- Follow-up Year 2
- Follow-up Year 3
- Follow-up Year 4
- Follow-up Year 5

- Other Rx
- Diabetes Rx
- Claims $
# Cardiovascular Events Covered By Study Period

<table>
<thead>
<tr>
<th>Diseases</th>
<th>3 years prior to program</th>
<th>3 years after start of program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All cardiovascular events</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart attacks/ strokes/ mini-strokes/ acute angina</td>
<td>93</td>
<td>50</td>
</tr>
<tr>
<td><strong>Heart attacks</strong></td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td><strong>ER visits / hospital admissions</strong></td>
<td>175</td>
<td>81</td>
</tr>
<tr>
<td><strong># of patients w/ 2 or more events per year</strong></td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td><strong>In compliance</strong></td>
<td>-</td>
<td>300</td>
</tr>
<tr>
<td><strong>Cardiovascular as a % of total client claims</strong></td>
<td>30.6%</td>
<td>19.0%</td>
</tr>
<tr>
<td><strong>Total cost of all events</strong></td>
<td>$1,345,000</td>
<td>$497,000</td>
</tr>
</tbody>
</table>
Asthma Program Patients with ER Visits

*Acordia data 2.2 million lives
Depression

PHQ-9 Score Summary*

- Changes from baseline
  - 80% of participants have had improvements
  - 8% had no change
  - 12% had worsening

* for 104 participants (average duration = 12.0 months)
Replications

- American Pharmacists Association (APhA) developed HealthMapRx, based on the success of The Asheville Project® model.
- Implemented by over 80 employer groups around the United States.
- Buncombe County has implemented this program for its employees and dependents.
- Biltmore Estates has a similar program.
Asheville Project ....What’s Next?

- Modification of prescription drug formulary
  - Remove brand-name from copay waiver program and educate participants about generics
- Evaluating a possible weight management module
- Increasing participation of dependents participation in the Asheville Project.
- Adding DME co-pay waivers for Asthma and Hypertension to provide home nebulizers and Blood Pressure measurement abilities to decrease Emergency Room Visits (✓ Done – 2017)
- Adding Nutrition Counselor to assist with goals relating to weight loss and disease management (✓ Done – 2017)
Asheville Wellness Program

• Wellness program with financial incentives.
• Tobacco-free affidavit – or cessation program.
• Health risk assessment and biometric screening (employee and covered spouses).
• Participation/completion of a minimum of 6 wellness activities during the year to retain benefits.
• BCBS of NC & UNC Asheville’s Health & Wellness program to create an internship program specifically tied to wellness.
• Specific wellness opportunities onsite.
• Provide linkage to physical, emotional and financial wellness.
Employee Health Clinic

- Fully staffed (MD, PA, RNs) and open to all employees, covered retirees and dependents.
- No fee for visit
- Acute and minor visits, primary care visits for employees and dependents. Referrals to specialists.
- Onsite management and treatment of workman’s comp injuries and urgent care treatment for personal injuries.
- Occupational services: work-related injuries, vaccinations, drug testing, hearing testing, CDL physicals.
- Pre-employment screenings (new-hire police and fire physicals new CDL)
- One-on-one consultation as needed for high risks identified through wellness screening.
Tying It All Together
The Asheville Project®, Onsite Medical Clinic, and Wellness Program

- How can we use all the information available to keep costs down?
  - Utilize medical claim data to identify early warning diagnosis.
  - Meeting with patients in onsite medical clinic to enroll in disease management program and helping maintain compliance.
  - Working with patients one-on-one when changes are made to covered programs.
  - Ongoing review of covered medications to identify changes that have the potential for a negative outcome.
Value-Based Benefit Design – a fundamental change to the way health benefits are structured

• VBBD is a strategy that minimizes or eliminates out-of-pocket costs for high-value services in defined patient populations
  • High-value services are identified through scientific evidence
  • The more **clinically beneficial** and **cost-effective** the therapy is for a patient group, the lower the out-of-pocket costs

• **Lowering out-of-pocket costs for high-value services** has been found to improve access to and use of those services

PARTNERING WITH PROVIDERS
To Reduce Health-Care Costs

- Partnering with Park Ridge Hospital to perform required annual physicals for all fire fighters at negotiated price.
- Partnering with Open MRI to provide discount with all City employees for service.
- Providing onsite Tobacco Cessation Program utilizing specially trained staff.
- Partnering with Solstas Lab to provide services at lower negotiated prices for health clinic patients without running through insurance with the goal of lowering costs to the City.
Summary

• Value-based design is fundamentally NOT creating barriers to care (i.e., higher co-pays, increased deductibles, higher pharmacy tiers, higher out-of-pocket)

• Key steps: analyze, design to outcome desired, implement, measure results / outcomes

• Use your employee health clinic to enhance your employee benefits without breaking the bank

• Design wellness programs to reward healthy members and achieve financial goals
Questions:
Speakers will take questions and comments. This session is being recorded, please utilize the microphone in the aisle to ask all questions.

Provide Feedback:
Please take a few minutes to provide your feedback at www.gfoa.org/conf-eval

Discuss/Comment:
Join the discussion at #GFOA2018

Contact GFOA:
To contact GFOA about session topics please email research@gfoa.org

Speaker Contact Information:
Edward Kaplan
Email: ekaplan@segalco.com

Bruce Judson
Email: bjudson@fshealth.com

Barbara Whitehorn
Email: bwhitehorn@ashevillenc.gov