Spending More for Less: What Drives Rising Health-Care Costs

MODERATOR  Linda B. Cramer  
Assistant County Manager, Chatham County, GA

SPEAKERS  Mitch W. Bramstaedt  
Senior Vice President, Segal  
Glenn E. Gustafson  
Deputy Superintendent/Chief Finance Officer  
Maria Schiff  
Director, State and Local Fiscal Health, Pew Charitable Trusts
Spending More for Less: What Drives Rising Health-Care Costs

May 24, 2017

Mitch Bramstaedt
Senior Vice President
Agenda

- PPO & Rx Trend
- What Drives Trend
- What Can you do about Trend: Direct Trend Controls (for Plan Sponsor)
- Questions
PPO & Rx Trend

Segal Health Care Trend Survey - Actual Trend History

<table>
<thead>
<tr>
<th>Year</th>
<th>PPO Trend</th>
<th>RX Trend</th>
<th>CPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>13.9%</td>
<td>17.8%</td>
<td>2.8%</td>
</tr>
<tr>
<td>2002</td>
<td>13.9%</td>
<td>18.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>2003</td>
<td>12.0%</td>
<td>14.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>2004</td>
<td>10.9%</td>
<td>13.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>2005</td>
<td>10.4%</td>
<td>10.5%</td>
<td>3.4%</td>
</tr>
<tr>
<td>2006</td>
<td>9.6%</td>
<td>9.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>2007</td>
<td>8.9%</td>
<td>7.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>2008</td>
<td>9.7%</td>
<td>7.4%</td>
<td>3.8%</td>
</tr>
<tr>
<td>2009</td>
<td>9.5%</td>
<td>7.9%</td>
<td>-0.4%</td>
</tr>
<tr>
<td>2010</td>
<td>7.6%</td>
<td>6.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>2011</td>
<td>7.5%</td>
<td>5.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>2012</td>
<td>7.3%</td>
<td>5.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>2013</td>
<td>5.7%</td>
<td>5.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>6.5%</td>
<td>10.7%</td>
<td>1.6%</td>
</tr>
<tr>
<td>2015</td>
<td>6.8%</td>
<td>11.1%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Source: 2017 Segal Health Plan Cost Trend Survey
1 All trends are illustrated for actives and retirees under age 65.
2 Prescription drug trend is combined for retail and mail order delivery channels
What Drives Trend?

- New treatments, therapies and technology
- Increased demand from increased health risks due to aging populations or rise in obesity
- Provider cost shifting from changes in CMS payments (Medicaid & Medicare)
- Provider price increase and CPI
- Leveraging effect of fixed deductibles and copayments
- Greater emphasis on detection and diagnostics
- Regulations/mandates including the Affordable Care Act (ACA)
- Other, including fraud and abuse

Trend is the forecast of annual gross per capita claims cost increases.
Top Five Cost-Management Strategies

Survey participants were asked to rank the top cost-management strategies implemented in 2016. Here are the top five strategies based on averages of these ratings:

<table>
<thead>
<tr>
<th>Cost Management Strategy</th>
<th>Rating: 5 (frequently applied) to 1 (not being applied)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using specialty pharmacy management</td>
<td>4.4</td>
</tr>
<tr>
<td>Intensifying pharmacy management programs</td>
<td>4.3</td>
</tr>
<tr>
<td>Contracting with value-based providers, including ACOs and PCMHs</td>
<td>3.8</td>
</tr>
<tr>
<td>Adding low-cost primary care access through strategies such as telemedicine, walk-in clinics and on-site clinics</td>
<td>3.5</td>
</tr>
<tr>
<td>Increasing financial incentives in wellness design</td>
<td>3.3</td>
</tr>
</tbody>
</table>
Strategies to Manage Health Care Utilization

1. Perform data analytics and data mining to evaluate the performance of health plans, to make changes to lower costs by reducing plan waste and inefficiencies, and to target disease-management programs.

2. Manage utilization of specialty drugs by requiring prior authorization, implementing preferred step therapy, mandating use of a limited network of specialty pharmacies and identifying preferred treatments within disease categories.

3. Implement value-based purchasing strategies such as holding providers accountable for the quality of care, managing the use of health care to reduce inappropriate care, rewarding the best-performing providers and encouraging participants to be knowledgeable health care purchasers.

4. Consider narrow or custom provider networks. Network evaluations should be performed using “total cost of care”. This uses risk-adjustment to capture differences in patient-population characteristics to effectively evaluate impact of medical management.

5. Implement vendor performance guarantees that cap average network provider increases to overall CPI plus a margin, such as 1% or 2%.
Strategies to Manage Health Care Utilization

5. Add remote and telemedicine services based on current needs, demographics and marketplace options.

6. Offer a high deductible health plan (HDHP).

7. Introduce innovative employee participant contribution strategies such as incentives to influence enrollment decisions regarding coverage for spouses or other dependents who may have coverage options elsewhere.

8. Evaluate PPO network pricing discounts, which could potentially yield significant savings without increasing plan costs.

9. Take advantage of additional discounts for brand-only maintenance medications by providing incentives to use mail-order pharmacies (through mandates and/or lower copayments) or by requiring use of a “retail90” pharmacy network.

10. Adopt a cafeteria-style approach to health benefit coverage options with a fixed defined contribution strategy.
Questions
Colorado Springs School District 11

Health Plan Design

Glenn Gustafson
Deputy Supt/CFO
glenn.gustafson@d11.org
Trump: 'Nobody knew health care could be so complicated'
• The District is self-funded (Self-Insured)

• The District contracted with the “BEST Trust” in July 2004
  – Provides oversight and management of the District’s medical and prescription plans and supports our wellness efforts

• The District partnered with Colorado Choice Health Plan in 2013
  – Third party claims administrator
  – Manages our network of physicians

• The District partnered with Penrose-St. Francis (Centura) in 2013 as our hospital partner
Key Plan Components

- Employee Benefits Insurance Committee
- Self-Funded Plan
- Exclusive Contract w/ Local Hospital (Centura)
- School District Pool for Purchasing Power (BEST)
- Wellness Component
- District Employee Clinic
- VEBA Trust Organization
- Trust Owned Life Insurance (TOLI)
- District Staff and 3rd Party Benefits Consultant
Benefits Insurance Committee

Composition

- 6 Teachers
- 4 Classified (non-exempt)
- 2 Administrators
- 1 Retiree
- 4 Ex-Officio Staff
Challenges

• Rising health-care and plan administration costs
• Managing our surplus
• Aging workforce
• Encouraging employees to participate in managing their health
FY 17/18
Recommendations for Medical Plan Design

• **Deductible**
  – Should remain $1150 single and $2300 family

• **Out of Pocket Maximum**
  – Should remain $3000 single/$6000 family for Tier 1
  – Should remain $4000 single/$8000 family for Tier 2

• **Office Visit Co-pays**
  – Should remain $30/$55 for Tier 1
  – Should remain $35/$60 for Tier 2
# D-11 Wellness
## Health Promotion Program (participation optional)

- **Cash Incentive**
  - Up to $200 cash available to the plan subscriber
  - Up to $100 cash incentive available for enrolled spouse

- **How to earn the cash incentive for FY17/18**
  - Employee submission of the completed Health Provider Screening Form and employee completion of Personal Health Assessment (worth $200)
  - Enrolled spouse’s submission of the completed Health Provider Screening Form (worth $100)
  - Enrolled spouse’s completion of Personal Health Assessment (optional)

**NOTE:** Incentive available for plan subscriber and spouse ONLY if enrolled in the D11 Health Plan

---

**Health Provider Screening Form**

***ALL INFORMATION IS REQUIRED TO PROCESS YOUR SCREENING FORM***

INCOMPLETE OR ILLEGIBLE FORMS ARE AT RISK FOR NOT BEING PROCESSED FOR INCENTIVES

**FORM DEADLINE:** xx/xx/20xx BY 5:00 PM MST

### Section 1: Participants Information

- **First Name:**
- **Last Name:**
- **Member ID:**
- **Gender:**
- **Birth Date:**
- **Email:**

### Section 2: Biometric Screening Results

Exam and lab test must have occurred on or after 5/1/2016

- **Blood Pressure:** __________ / __________
- **Height:** __________ ft. __________ in.
- **Weight:** __________
- **Total Cholesterol (TC):** __________
- **HDL (High Density Lipoprotein):** __________ mg/dL
- **TC/ HDL RATIO:** __________
- **Glucose:** __________ mg/dL
- **LDL (Low Density Lipoprotein):** __________ mg/dL
- **Triglycerides:**

**Office Address stamp (if available):**

**Office City, State, Zip Code:**

**Office Area Code and Phone Number:**

### Section 3: Patient Signature (Required) Form Deadline: xx/xx/20xx

By signing below, I give my physician listed above permission to send this form to Penrose – St. Francis Health Services.

By signing this form, I authorize my physician to disclose my biometric screening results to Penrose-St. Francis Health Services for the purpose of administering my wellness benefits and incentives awards, as applicable. To the extent I am covered under an employer group policy which provides incentives awards related to a biometric screening program, I authorize Penrose St. Francis Health Services to disclose information regarding my participation in this screening event and eligibility for various incentive awards to the plan sponsor of my employer group health plan for the purpose of administering any incentive awards.

I understand that I am not obligated to participate in this screening program and that this authorization is voluntary. However, I understand that there may be certain wellness benefits (including incentive awards) under my health plan that I will not be eligible for as a result of not participating in this program or not providing my biometric screening results to the plan sponsor.

I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation. Unless revoked earlier, this authorization will expire one year from the date of my signature.

**Patient Signature Required**

**Please Print Your Name**

**Date**
TOLI Concept
Pension Reform Act of 2006, IRS Code Regulation 101 J

- A life insurance policy is taken out on employees
- The life insurance premium is financed (non-recourse)
- The cash value of the policy “day one” equals the premium paid and grows over the year(s)
- The “Rate of Return” on the cash value is guaranteed to be greater than the loan interest rate (spread 2 to 2.5%)
  - The Trust receives the excess Cash Value from the policy
- The Trust receives the Net Death Benefit which equals {Death benefit (-) bank loan (-) the interest loan}
- The money received by the Trust is used to enhance reserves, pay for healthcare costs, wellness programs, and pay the free death benefit to the employees

Note: The Trust, school district and the employees are at NO FINANCIAL RISK.
TOLI Balance

- Balance 05/31/13 - $5,938,261
- Balance 12/31/16 - $6,906,719
- Increase in Balance - $968,458
- % Increase – 16.3%
- Avg Annual Increase – 4.5%
### Financials: 2011-12 through 2016-17

<table>
<thead>
<tr>
<th>Month</th>
<th>Net Claims</th>
<th>Stop/Loss Recoveries</th>
<th>Rx</th>
<th>Stop/Loss Insurance</th>
<th>TPA</th>
<th>BEST</th>
<th>Wellness</th>
<th>Other</th>
<th>Total</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 11/12</td>
<td>18,076,820</td>
<td>(1,037,779)</td>
<td>4,499,735</td>
<td>777,336</td>
<td>675,899</td>
<td>287,633</td>
<td>465,946</td>
<td>65,555</td>
<td>23,811,145</td>
<td>N/A</td>
</tr>
<tr>
<td>FY 12/13</td>
<td>17,995,666</td>
<td>(584,952)</td>
<td>3,966,613</td>
<td>890,970</td>
<td>737,029</td>
<td>275,276</td>
<td>263,015</td>
<td>119,271</td>
<td>23,662,888</td>
<td>-0.62%</td>
</tr>
<tr>
<td>FY 13/14</td>
<td>17,376,306</td>
<td>(712,327)</td>
<td>4,001,832</td>
<td>1,007,869</td>
<td>661,441</td>
<td>269,132</td>
<td>88,008</td>
<td>193,496</td>
<td>22,885,757</td>
<td>-3.28%</td>
</tr>
<tr>
<td>FY 14/15</td>
<td>13,752,597</td>
<td>(356,083)</td>
<td>4,316,837</td>
<td>1,494,348</td>
<td>654,534</td>
<td>232,777</td>
<td>528,906</td>
<td>191,392</td>
<td>20,815,308</td>
<td>-9.05%</td>
</tr>
<tr>
<td>FY 15/16</td>
<td>13,368,649</td>
<td>(193,527)</td>
<td>4,858,083</td>
<td>1,385,500</td>
<td>651,064</td>
<td>230,684</td>
<td>664,531</td>
<td>245,551</td>
<td>21,210,535</td>
<td>1.90%</td>
</tr>
<tr>
<td>FY 16/17 Thru 12/31</td>
<td>7,698,082</td>
<td>(40,564)</td>
<td>2,470,623</td>
<td>698,234</td>
<td>333,082</td>
<td>131,691</td>
<td>189,115</td>
<td>140,170</td>
<td>11,620,433</td>
<td>-45.21%</td>
</tr>
</tbody>
</table>

**Colorado Springs School District 11**

**Total Costs by Month**
Health Plan History Since Conversion

Health Plan Expenses

- FY11/12: $23,811
- FY12/13: $23,662
- FY13/14: $22,885
- FY14/15: $20,815
- FY15/16: $21,210
- FY16/17: $23,240

FY11/12, FY12/13, FY13/14, FY14/15, FY15/16, FY16/17
Questions?

glenn.gustafson@d11.org
719-520-2042
The Controllable & the Uncontrollable

Controllable by state

- Medicaid expansion, y/n?
- Breadth of benefits and income eligibility levels above floor (Medicaid, BH)
- Criminal justice code
- Provider reimbursement rates
- Incentives (tobacco tax, bike lanes)
- County, state taxes

Uncontrollable

- Population demographics
- Underlying cost of services (i.e., RN salary)
- Offering of employer sponsored health insurance
- Epidemics (Zika, opioid)
- Federal Medicaid match
- Must provide services to inmates
- Countercyclical
Overlaps (and Underlaps)

• States and counties fund and provide similar health services through many agencies: clinics, prisons, schools, courts, public health departments
• Some individuals are served by many agencies that usually don’t/can’t share information: Medicaid, courts, jails/prisons, mental health and SUD providers, housing agencies
• Many individuals are dually BH diagnosed, physically ill
• Mentally ill and addicted individuals often cycle between community (EDs) and incarceration w/o care handoffs
• Wide state variation in menu of services offered to individuals
MH/SUD Conditions Affect Cost of Treatment

Medicaid spending per member per month (2012)

- MH/SUD
- No MH/SUD
BH Diagnoses Among High Costing Medicaid Populations, 2013, New Jersey

- **1986**
  - Out-of-Pocket: 18%
  - Private Insurance: 20%
  - Other Private: 6%
  - Medicare: 17%
  - Medicaid: 27%
  - Other Federal: 5%
  - Other State and Local: 5%
  - MH Spending: $32 Billion

- **2009**
  - Out-of-Pocket: 11%
  - Private Insurance: 26%
  - Other Private: 13%
  - Medicare: 27%
  - Medicaid: 5%
  - Other Federal: 5%
  - Other State and Local: 5%
  - MH Spending: $147 Billion

- **2014**
  - Out-of-Pocket: 10%
  - Private Insurance: 26%
  - Other Private: 14%
  - Medicare: 29%
  - Medicaid: 5%
  - Other Federal: 5%
  - Other State and Local: 5%
  - MH Spending: $179 Billion

- **2020**
  - Out-of-Pocket: 10%
  - Private Insurance: 25%
  - Other Private: 15%
  - Medicare: 30%
  - Medicaid: 5%
  - Other Federal: 5%
  - Other State and Local: 5%
  - MH Spending: $238 Billion

*Note: Bar segments less than 5 percent are not labeled.*

Source: SAMHSA Spending Estimates.

- **1986**
  - SUD Spending = $9 Billion
  - Out-of-Pocket: 13%
  - Private Insurance: 32%
  - Other Private: 3%
  - Medicare: 9%
  - Medicaid: 4%
  - Other Federal: 11%
  - Other State and Local: 27%

- **2009**
  - SUD Spending = $24 Billion
  - Out-of-Pocket: 11%
  - Private Insurance: 16%
  - Other Private: 5%
  - Medicare: 16%
  - Medicaid: 5%
  - Other Federal: 11%
  - Other State and Local: 31%

- **2014**
  - SUD Spending = $31 Billion
  - Out-of-Pocket: 9%
  - Private Insurance: 16%
  - Other Private: 4%
  - Medicare: 16%
  - Medicaid: 5%
  - Other Federal: 11%
  - Other State and Local: 28%

- **2020**
  - SUD Spending = $42 Billion
  - Out-of-Pocket: 9%
  - Private Insurance: 16%
  - Other Private: 4%
  - Medicare: 16%
  - Medicaid: 5%
  - Other Federal: 10%
  - Other State and Local: 28%

Note: Percentages may not add to 100 due to rounding.

Source: SAMHSA Spending Estimates.
Jails

• During 2015, 10.9 million Americans were booked into a jail but each week, more than half turned over (short stays)
• These individuals more likely than general population to have diabetes, infectious diseases and especially, mental illness/SUD
• Many get care in jail for first time in a long time
The high rate of disease and lack of a source of usual care among justice-involved individuals make jails a potentially important site for healthcare intervention, despite the fact that their central purpose is to detain people who engage in criminal behavior and pose a threat to public safety, not to improve public health or their health.
• Introduction of screening and treatment of STIs in San Francisco county jail lowered their prevalence at a nearby community clinic.

• Discontinuation of screening for chlamydia and gonorrhea in males in 2003 at Cook County jail resulted in underreporting of cases citywide and observed increased prevalence in female infections in community.
Virginia Jails Show Wide Variation in Share of Funds Dedicated to Healthcare
What Can Data Sharing Facilitate?

Camden County, NJ
San Diego County, CA
Cross-Sector High Utilizers

# of ED Visits

# of Police Encounters

[Graph showing data distribution]
Prevalence of Substance Abuse, Mental Health, and Homelessness*

Substance Abuse: 39% (Entire Police Population), 78% (Police Only High Utilizers (6+ Arrests)), 24% (Police & Hospital High Utilizers (6+ Arrests & 10+ ED Visits; n=205))

Mental Health: 54% (Entire Police Population), 22% (Police Only High Utilizers (6+ Arrests)), 16% (Police & Hospital High Utilizers (6+ Arrests & 10+ ED Visits; n=205))

Homelessness: 41% (Entire Police Population), 19% (Police Only High Utilizers (6+ Arrests)), 19% (Police & Hospital High Utilizers (6+ Arrests & 10+ ED Visits; n=205))

*Substance abuse and mental health were identified through diagnosis codes from hospital encounters. Homelessness was identified through address data from both hospital and police records. All three are likely to be underreported in the data.
San Diego County Health & Human Services Agency

• *Live Well San Diego* uses Knowledge Integration program that relies on electronic information exchange for county health, social service, behavioral health, physical health, and probation data

• Integrates services from public health, benefits, alcohol and drug services, aging and independence services, mental health, child welfare, probation, housing and community development
Upcoming Publications

• Jails: Inadvertent Healthcare Providers

• Evaluating State Prison Health Care: cost, quality monitoring, reentry care continuity
  – State Prisons and Pharmaceuticals
  – State Prisons and Hospitalization
For further information

Maria Schiff
mschiff@pewtrusts.org
202 540-6822
pewtrusts.org/CorrectionalHealth