

COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION

DATE: July 19, 2010

TO: Supervisor Elizabeth Coggs, Chairwoman, Committee on Finance & Audit
Supervisor Patricia Jursik, Chairwoman, Committee on Personnel

FROM: Employee Benefits Workgroup

SUBJECT: 2009/2010 Employee Health Care and Prescription Drug Plan

Background

In 2009, the budget for employee healthcare claims realized an unexpected surplus of approximately \$12 million. To better understand if this surplus was due to a one-time event or represented a potentially on-going reduction in employee health care costs that would allow a reduction in the base budget, the Department of Administration, in conjunction with the Employee Benefits Workgroup, hired Cambridge Advisory Group Inc. to conduct a detailed evaluation of the cause and sustainability of the surplus.

Cambridge was also requested to review our underlying health plan, compare our employee and cost demographics with similar plans, and report on this comparison. In addition, Cambridge was asked to look at issues that may arise due to national Health Care Reform.

Following the analysis, Cambridge was asked to provide a report of their findings and present suggested direction for the County in health care.

Reports

Attached to this cover memo is a PowerPoint document prepared by Cambridge, which summarizes their work and conclusions, based on their review.

Findings

Cambridge has indicated that the 2009 surplus was linked to a significant and unexplained decrease in large claims (i.e. claims exceeding \$50,000). Cambridge also noted that although the costs reduction can be primarily attributed to the reduced number of large claims, a smaller portion of the savings also occurred due to the county shifting to United Health Care as the third-party provider, deeper discounts, and greater network access.

Based on analysis of both historic and year-to-date activity, Cambridge does not believe this surplus will be replicated in 2010 or future years.

Cambridge has identified other areas of concern that are explained in the attached report and summarized as follows:

- Average age of the county's active workforce is higher than the national norm for all employers
- The county's health coverage, member to employee ratio, is higher than most employers (i.e. more dependents per employee)
- The county has above national norm levels of chronic disease that causes an above national norm of large claims (i.e. claims exceeding \$50,000)
- Health risks for the county have been identified as tobacco, overweight/obesity and physical inactivity
- The county employee drug costs greatly exceed the national norm, due to higher utilization of prescription medication and higher prescription medication costs
- The county employee contribution rate is considerably lower than the national norm
- The county employee cost for co-payments, deductibles, and coinsurance is considerably lower than national levels

The Employee Benefits Work Group will continue to work with Cambridge to further analyze employee health care claims and develop strategies for managing costs.

cc: County Executive Scott Walker
Milwaukee County Board of Supervisors
Tom Nardelli, Chief of Staff County Executive's Office
Terry Cooley, Chief of Staff, County Board Chairman's Office
Jodi Mapp, Personnel Committee Clerk
Carol Mueller, Finance and Audit Committee Clerk



Milwaukee County Health Plan

Issues and Considerations

June 2010

CAMBRIDGE
advisory group inc.

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Recent History

- 2007-WPS selected on an insured basis under a multiyear contract which financially disadvantaged the County.
- 2007-Health Benefits Advisory Committee formed. Renegotiated WPS contract midyear and retrospectively saving The County tens of millions of dollars over the contract period.
- 2007-Wellness initiative as negotiated with union(s) is put into place. APS selected through RFP process.
- 2008-WPS loses access to a major provider group leading to network inadequacy. Enables release of County from contract with WPS.
- 2009-United Health selected through RFP. Deeper discounts and greater network access. First year savings exceeding \$10 million Trended Savings accrue in future years due to continued use of a superior provider network.
- 2009-Medco selected as Pharmacy Benefit Managers (PBM) on a “carve out” basis. First year savings of \$1.2 million growing to approximately \$4 million over the three year period of the contract.
- 2009-Health Plan experiences unexpected budget surplus linked to significant and unexplained decrease in claims exceeding \$50,000.
- Mid 2010- County increases needed internal resources to monitor and manage finances of the plan.

Present Situation

- Health Benefits Advisory Committee convenes to examine several key issues:
 - Understand 2009 surplus and the sustainability of related improved large claims experience.
 - Enhance necessary controls and ongoing oversight requirements to establish monitoring of budget levels and monthly costs performance of the health plan.
 - Create database and analyze underlying costs, risks and liabilities of the plan from both an actuarial and clinical perspective.
 - Quantify the potential costs and/or savings to the County due to Health Care Reform.
 - Consider possible adjustments to design and vendors to strengthen competitiveness of benefit levels, quality administrative service and address health management requirements for improved outcomes. Review Consumer Directed Health Plan options and need to redirect wellness and disease management initiatives.

Financial Considerations

- Through April plan costs are running \$2.5 million (2%) above budget on an annualized basis. This is a preliminary analysis subject to variance and volatility by year end due to:
 - Cost sharing by participants has somewhat lowered this number year to date. Later in the year and increasing number of participants will reach their out of pocket maximums thus increasing the County's cost as the year continues.
 - Offset to County's costs are claimants who exceed individual stop-loss of \$300,000 as the year goes on.
 - Number of claimants projected to incur costs above \$50,000 by year end is expected to exceed 2009s total of 200 by up to 25-30%. This increase in large claims is the reason for, and explains the present projected budget deficit.

Underlying Costs, Risks and Liabilities

- Claims are being incurred in a health care market place which is one of the five most costly in the country from a unit cost standpoint and by providers with no discernable superior clinical quality or outcomes
- County's demographics are above national norm.
 - Average age of 46 of active workforce verses norm of 42. This number worsens when includes early retirees (a disproportionate number of claimants exceeding \$50,000) who receive benefit levels equal to active employees.
 - Member to employee ration of 2.45 to 1 verses norm of 2.1 to 1. The County provides coverage to a greater number of lives (e.g. family size) than most employers.
 - A historic level of 250-300 claims exceeding \$50,000 each year versus an expected norm of 175-225. The 2009 plan year was the only one over the last four years to fall within the normal range. This is the apparent reason for the unexpected budget surplus. 2010 appears to project a number exceeding 225.

Underlying Costs, Risks and Liabilities

- Per Employee Per Month drug costs of \$266 versus an expected norm of \$141-167. This has been driven by below norm use of lower cost generic equivalents and mail order service as well as above norm use of high cost specialty drugs. In addition, the use of specialty drugs has been above norm at physician offices and retail pharmacies as compared to the lower cost mail order option.
- An active employee contribution rate of approximately 5-7% versus national norm of 20-25% and an employee cost charge (e.g. copayments, deductibles, coinsurance) of 7% on the HMO and 20% on the PPO versus national norms of 12-15% on HMOs and 20-25% on PPOs. Participants paying less than national norms for plan designs richer than national norm.
- A retiree population which pays no contribution if hired before 1994. Existing individual lifetime maximums may be nullified under Health Care Reform. No overall cap of the plan (still allowable under Reform) exists. Also, all retirees hired after 1994 are allowed to “buy in” on a fully contributory basis. This results in significant adverse selection. Reform will offer these participants additional options.

Underlying Costs, Risks and Liabilities

- Above norm levels of chronic disease states including, hypertension, hyperlipidemia, diabetes, asthma, depression and heart disease linked directly to County risk factors of obesity, tobacco and physical inactivity. These factors drive the continuous above norm large claim activity which are not currently addressed by the wellness program which incents enrollment rather than adherence.
- The County faces continuous annual double digit health care increases due to the outlined casualties.

Health Care Reform

- The County faces potential substantial exposure, requiring ongoing analysis around Health Care Reform. Proper calculation of costs and liabilities must consider:
 - Increased administrative expenses, effect of Medicare/Medicaid cost shift, elimination of lifetime limits, per participant fee for comparative effectiveness research, inclusion of preventive care at 100% and individual mandate provisions.
 - Waiting to calculate additional effects on taxes to insurers which are expected to be passed on to plan sponsors and cost of excise tax on “Cadillac plans” which projects to apply to the County, based on its costs and historic healthcare trend.
 - Need to gain regulatory clarification around Health Care Reform potential offsets and/or revenue streams for Behavioral Health and Jailhouse covered populations.

Considered Changes

- Prepare for the administrative, costs and challenges of Health Care Reform.
- Bring participant contribution and cost share levels to market levels.
- Redesign pharmacy benefit levels to increase generic and mail order utilization as well as to close potential gaps in care linked to possible adherence shortfalls.
- Change clinical management model
 - Alter existing wellness design to incent adherence over enrollment. Prepare RFP based on redesign, pay for performance and health improvement matrices.
 - Develop appropriate risk reduction strategies and programs.
 - Implement an integrated health management model which leverages the resources of UHC, Medco and selected wellness vendor to engage members through effective risk stratification, coordinate outreach and communication to effect participant behavior.

Considered Changes

- Significantly delay considered implementation of Consumer Directed Health Plan (CDHP) option.
 - CDHP designs often create an unintended consequence whereby participants delay or avoid needed services for chronic care in order to maintain account balances.
 - The covered population needs support, resources and time to grow into educated consumers who historically have had access to established needed clinical arrangement resources.
 - The local health care delivery system needs to alter its behavior and cost levels for CDHP to be appropriate for the County's covered population.
 - Health Care Reform will cause the need to focus existing limited administrative resources which would be unreasonably burdened by a CDHP's required administration and communication responsibilities of CDHP.

Conclusion

- Need to maintain focus and work of Health Benefit Advisory Committee based to understand the non-sustainability of present cost escalation levels.
- Focus development of appropriate integrated health management strategies and programs which leverage resources among County's vendors.
- Continued negotiations with UHC and Medco to improve their accountability to the County and their performance regarding unit cost for medical and pharmacy services.
- Consideration of alternative plan provisions, management strategies and vendors to positively affect escalating.
- Actively recognize and work on the costs, needed resources and possible revenue streams tied to Health Care Reform.