City of Milwaukee

The Future of Health Care

What Health Plan Claims Data Tells Us
What's Next Beyond Wellness and Health Care Reform

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Issues to Address this Morning…

- What claims data tells us
- What drives medical cost
- What is being done to address cost drivers

What Claims Data Tells Us

Executive Summary

Low Cost		High Cost
Low Disease Burden	High Disease Burden	
70% of the population	25% of the population	5% of the population
10% of total medical expenses	38% of total medical expenses	52% of total medical expenses

Wellness Interventions

- Evidence based preventative services
- Health Risk Assessment (HRAs), with biometrics
- Targeted health education and communication
- Culture of health
- Tobacco-free workplace
- Incentives for engagement and health outcomes
- Engagement in lifestyle behavior change programs

Disease Management

- Identifying individuals who are likely to incur high medical costs because of chronic illness
- Communication and resources for appropriate adherence to treatment guidelines
- Incentives for compliance with disease management programs

Case Management

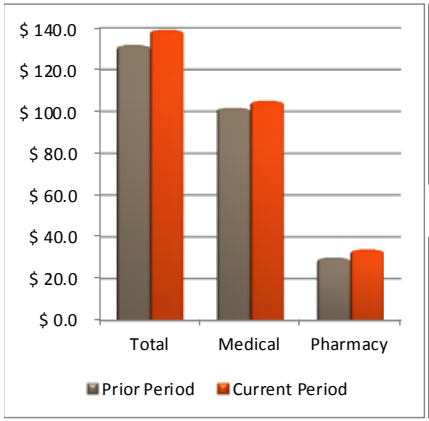
- Manage high cost
- Help members navigate system
- Quality of life measures
- Patient satisfaction
- Direct and indirect health care cost
- Morbidity / mortality data

Data covers the two year period ending June 30, 2014

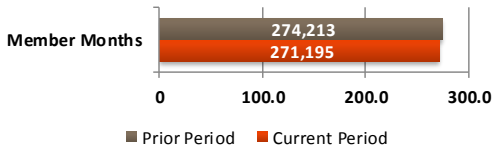
What Claims Data Tells Us

Plan Costs

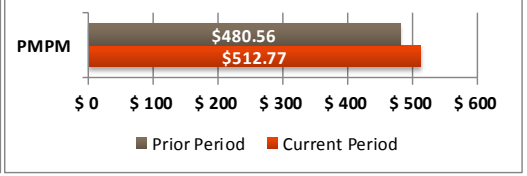
Total Expenses ($ in Millions)



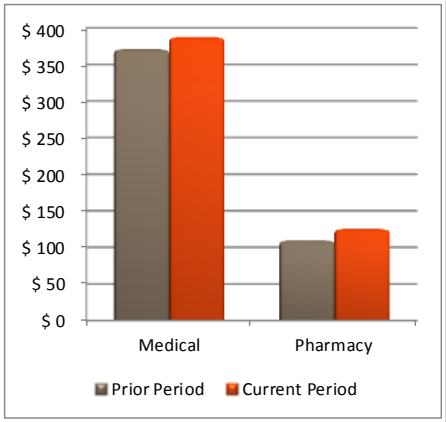
Member Change



PMPM $$ Change



PMPM $$ Change (Medical & Pharmacy)



Cost Summary	Current Period	Prior Period	% Chg PP	Adj Norm	% Chg Norm
Medical (Place of Service PMPM Spend)					
Inpatient	$123.4	$118.0	4.6%	$99.2	24.4%
Outpatient	$153.3	$141.6	8.2%	$105.0	45.9%
Office, Imaging, Etc.	$110.9	$111.4	(0.4%)	$94.5	17.4%
Pharmacy	$125.2	$109.6	14.3%	$98.0	27.8%

Cost Distribution	Members	Costs	Cst/Member	% of Cost	Norm	Δ Norm
Expense Distribution						
1%	253	$35,424,375	$140,134	25.5%	30.5%	(5.1%)
2-5%	1,011	$36,329,209	$35,928	26.1%	27.7%	(1.6%)
6-15%	2,528	$33,105,288	$13,096	23.8%	22.7%	1.1%
16-30%	3,792	$19,992,954	$5,273	14.4%	12.1%	2.2%
31-60%	7,584	$12,603,434	$1,662	9.1%	6.4%	2.7%
61-100%	10,112	$1,605,806	$159	1.2%	0.6%	0.6%
Total	**25,279**	**$139,061,066**	**$5,501**			

Comments

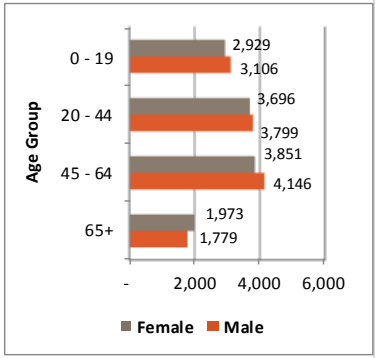
- Total expenses increased by 5.5% over the prior period driven by a 6.7% increase in PMPM cost, offset by a (1.1%) decrease in member months
- PMPM Medical cost increased by 4.5%, while PMPM Pharmacy cost increased by 14.3%
- Inpatient and Outpatient services represent 71.4% and all other services comprise 28.6%
- Total spend is skewed slightly more toward the low cost end of the distribution compared to the norm

What Claims Data Tells Us

Plan Utilization

Plan Demography and Risk Review	Current Period	Prior Period	% Chg PP	Norm	% Chg Norm
Current Employees	9,897	10,047	(1.5%)		
Current Members	22,486	22,736	(1.1%)		
Dependent Ratio	2.3	2.3	0.4%		
Average Age	41.0	42.2	(2.8%)	35.7	14.8%
Utilization	**Current Period**	**Prior Period**	**% Chg PP**	**Adj Norm**	**% Chg Norm**
Emergency Room Metrics					
ER Visits (per 1000)	297.2	289.7	2.6%	276.5	7.5%
% ER Visits Resulting in Admission	45.9%	45.3%	1.2%	45.5%	0.8%
Paid per ER Visit	$1,014	$1,013	0.0%	$894	13.4%
Inpatient Metrics					
Inpatient Days (per 1000)	541.8	544.1	(0.4%)	523.3	3.5%
Average Length of Stay (Days)	5.2	5.2	(0.6%)	5.7	(9.0%)
Total Admissions (per 1000)	104.5	104.4	0.1%	93.2	12.1%
Medical	44.2	46.4	(4.6%)	40.2	10.1%
Surgical	32.1	34.0	(5.5%)	33.0	(2.7%)
Perinatal	19.2	15.8	21.6%	14.8	29.5%
Behavioral	9.0	8.2	9.2%	5.1	76.1%
Drug Utilization					
Pharmacy Scripts (per 1000)	16,256.4	16,562.2	(1.8%)	13,158.2	23.5%
Pharmacy Scripts - % Generic Drugs	83.9%	82.3%	1.9%	80.4%	4.4%
Office Visit Utilization					
Total Office Visits (per 1000)	**5,365.8**	**5,465.7**	**(1.8%)**	**4,371.1**	**22.8%**
Regular Office Visits	3,847.4	3,893.3	(1.2%)	3,356.4	**14.6%**
Preventative Office Visits	501.2	493.9	1.5%	428.1	**17.1%**
Behavioral Health Office Visits	766.3	830.1	(7.7%)	408.1	**87.8%**
CT Scan	126.8	136.9	(7.4%)	95.1	**33.4%**
MRI Scan	96.2	103.1	(6.7%)	78.8	**22.0%**
On-Site Clinic Visits	-	-		-	-
Urgent Care Visits	**22.8**	**22.0**	**3.5%**	-	-

Member Profile



Comments

- 50.8% of the members are male and 49.2% of the members are female
- 'ER visits', 'admission rates' and 'paid amounts for ER visits' were all more than the norm.
- Medical, Perinatal, Behavioral are higher than the norm, while Surgical is lower than the norm
- Generic drug utilization is more than 'norm' and 'prior period'
- Preventative office visits accounted for 9.3% of total office visits

What Claims Data Tells Us

Members are grouped by RRS and then by CGI. This allows us to see the cost impact of those members with gaps in compliance with evidence-based care guidelines, either through member non-compliance or peer provider quality.

64.3% of the population is classified with a 'Low Care Gap Index' and the 'Average Care Gap Index' of 2.47 is higher than the norm of 1.14.

	Members	Percent of Members	Average PMPY	Spend ($ in millions)	Percent of Spend	Average Age
Low Relative Risk Score (< = 1.13)						
Low Care Gap Index (0 -2)	11,389	50.9%	$1,540	$46.8	15.0%	
Medium Care Gap Index (3 -4)	1,558	7.0%	$2,560	$11.6	3.7%	28.9
High Care Gap Index (+5)	452	2.0%	$3,430	$4.5	1.4%	
Subtotal Low RRS	**13,399**	**59.9%**	**$1,722**	**$63.0**	**20.2%**	
Medium Relative Risk Score (> 1.13 and < = 2.69)						
Low Care Gap Index (0 -2)	2,370	10.6%	$5,670	$36.8	11.8%	
Medium Care Gap Index (3 -4)	1,477	6.6%	$5,990	$25.8	8.3%	53.1
High Care Gap Index (+5)	1,405	6.3%	$5,520	$22.8	7.3%	
Subtotal Medium RRS	**5,252**	**23.5%**	**$5,720**	**$85.3**	**27.4%**	
High Relative Risk Score(> 2.69)						
Low Care Gap Index (0 -2)	636	2.8%	$17,470	$29.6	9.5%	
Medium Care Gap Index (3 -4)	780	3.5%	$18,550	$41.5	13.3%	65.0
High Care Gap Index (+5)	2,312	10.3%	$13,700	$92.6	29.7%	
Subtotal High RRS	**3,728**	**16.7%**	**$15,358**	**$163.7**	**52.5%**	
Total	**22,379**		**$4,932**	**$312.0**		

What Claims Data Tells Us

Preventative Measures

Evaluation of your populations compliance with evidence-based preventative services is critical and should be a key starting point. The U.S. spends billions on healthcare services of questionable value, while basic, evidence-based preventative services are not being performed as often as recommended.

The following details screening and preventative tests - and the associated compliance with these tests - for the entire population. This data is based on Verisk definitions and may differ from the Carrier/ASO standards.

Description	Members with Gap	Members	Actual	Norm
All individuals without any claim in the last 12 months	2,006	21,221	9.4%	14.1%
All individuals without flu vaccination in the last 12 months	15,974	21,221	75.3%	82.9%
All individuals between 6 months and 5 years old without flu vaccination in the last 12 months	278	760	36.6%	48.3%
All individuals > 50 years old without flu vaccination in the last 12 months	6,032	8,058	74.9%	81.1%
All individuals > = 51 years old without long office visit in the last 24 months	632	7,853	8.0%	15.9%
All individuals without a follow-up office visit within 2 weeks of a Chest pain-related ER visit	260	750	34.7%	43.4%
All individuals > = 50 years old without any colorectal cancer screening in the last 24 months	6,248	8,168	**76.5%**	72.4%
Men > 50 years old without PSA level in the last 24 months (controversial test)	2,355	3,767	**62.5%**	51.1%
Women > 20 years old without pap smear in the last 24 months	4,343	7,205	**60.3%**	49.9%
Women between 21 and 65 years old without pap smear in the last 24 months	2,994	5,770	**51.9%**	47.6%
Women between 40 and 49 years old without mammogram in the last 24 months	408	1,405	29.0%	47.3%
Women > = 49 years old without mammogram in last 12 months	2,369	4,309	55.0%	57.2%

What Claims Data Tells Us

Top Chronic Conditions

The following chart contains the top chronic conditions / diseases based on total paid. This chart also presents utilization patterns of members with chronic conditions, for total office visits, emergency room visits and hospital admissions.

Diseases	Members per 1000		Total paid	PMPY		Office Visits per 1000		ER Visits per 1000		Admission per 1000	
	Actual	Adj Norm		Actual	Adj Norm	Actual	Norm	Actual	Norm	Actual	Norm
Hypertension	216	126	$ 52,715,628	$ 11,379	$ 9,442	8,538.5	7,826.5	487.2	422.9	248.7	166.8
Hyperlipidemia	179	72	$ 37,761,842	$ 9,713	$ 8,035	8,265.9	7,600.5	386.1	276.2	177.0	98.6
Osteoarthritis	98	46	$ 29,618,635	$ 14,088	$ 13,796	11,124.8	11,425.1	548.4	540.6	300.6	265.1
Diabetes	95	58	$ 28,166,596	$ 14,017	$ 11,670	9,289.3	8,634.4	524.5	483.0	272.7	206.2
Coronary Artery Disease (incl. MI)	57	35	$ 17,385,321	$ 14,328	$ 15,931	10,557.0	10,358.4	762.3	784.5	473.9	450.0
Congestive Heart Failure	17	11	$ 11,344,848	$ 31,506	$ 28,345	12,583.2	13,677.8	1,349.7	1,569.8	999.8	1,117.0
Cerebrovascular Disease	29	16	$ 10,363,550	$ 17,342	$ 19,984	11,441.1	11,620.1	1,005.7	1,150.0	644.3	643.8
Congenital Anomalies	21	9	$ 9,931,274	$ 22,813	$ 22,329	10,598.8	10,197.1	535.2	570.3	303.2	327.3
Asthma	41	19	$ 9,524,302	$ 10,768	$ 9,595	9,652.9	9,189.1	651.2	694.1	184.3	156.5
Chronic Renal Failure	21	11	$ 9,427,633	$ 21,764	$ 27,410	11,464.4	13,007.5	1,073.5	1,023.8	748.0	678.7

What the Data Tells Us

- Per member per month cost was up 6.6%
- Utilization patterns are generally headed in the right direction but still higher than adjusted norms
- Use of generic medications is better than comparable populations
- Adherence to preventive screening guidelines is better than the norms in most areas
- The City's population is older than a typical population creating cost and utilization headwinds along with a greater incidence of chronic disease than a comparable population
- Data is somewhat skewed as Medicare eligible retires are included – this will be addressed in future reports

Where Health Care Costs are Headed

Although trend is down and the City's health plan costs have been relatively flat, there is no reason to be optimistic about healthcare costs in the future…

- Health care has grown from 8% to 17.9% of GDP in 2011 – healthcare costs are expected to reach 20% of GDP by 2021 and cost pressures will increase as the population ages and advancements in technology – *Bloomberg*
- Although the increase in health care premiums in the US was only 3.0% in 2013, much of this was due to cost transfer to employees who saw out of pocket costs increase 12.9% in 2013 – *Kaiser Family Foundation* The City implemented a 12% premium and deductible/co-insurance increase in 2012. Employee premiums and cost share have remained flat for subsequent years and 2015 premiums are still at 2012 level, although changes have been in the cost sharing provisions
- Employers are placing increased focus on "population health management," but challenges is to get people to act on what is learned via three step processes such as the City's.
- Treatment costs and outcomes still are not very transparent although progress is being made
- What physicians historically have been paid to do and the personal choices people make has created a "care gap" that contributes to the decline in health of the American population, success long term will be predicated on addressing this gap

Understanding Cost Drivers

Health care cost is determined by multiple sources

Price per unit x $Source_1$ x $Source_2$ x $Source_3$ x $Source_4$ X $Source_5$ adjusted for Outcome = Cost

Source 1 = Determined by physician practice, billing patterns and technology

Source 2 = Determined by patient preferences and expectations

Source 3 = Determined by patient health status and lifestyle

Source 4 = Determined by payer

Source 5 = Does the patient understand and comply with proposed treatment

Outcome = The benefit of the treatment or encounter to the patient

Our Strategy to Address the Cost and Health

- Joint assessment of alternatives to UHC and ESI with County, MPS and Transit
- Make sure that our population is *aware* of their health status and *acts* on that knowledge
- Continually assess the programs that exist help people and how they can be improved
- Monitor and evolve how our Workplace Clinic can help address the care gap
- Get our population engaged in using programs to help them and follow doctors orders
- Focus on a partnership and leveraging to tools UHC, Work Force Health, and others
- Monitor results with data(claims and biometrics) and take corrective action as necessary
- Share results and progress

The Importance of Innovation

- The City seeks to innovate versus imitate, especially if what was done by others does not generate the intended result
- A book outlining the solution is not yet complete - our strategy and process is a journey not a destination
- The City's goal is to be community leader in addressing cost and health