



Department of Employee Relations

April 21, 2005

Tom Barrett
Mayor

Maria Monteagudo
Director

David Heard
Fire and Police Commission
Executive Director

Michael Brady
Employee Benefits Director

David Kwiatkowski
Labor Negotiator

Alderman Michael Murphy, Chair
Finance and Personnel Committee
City of Milwaukee
200 East Wells Street
Milwaukee, WI 53202

Dear Chairman Murphy:

Health care costs and health insurance cost issues are of concern to the City of Milwaukee because these costs affect not only the budget of the City, but every other public and private employer in Milwaukee. As part of the City's continuing effort to work with City of Milwaukee labor leaders, the Department of Employee Relations provided a briefing on April 14 that was attended by over 30 labor leaders.

The briefing was led by Doug Ley of Willis of Wisconsin. I would like to suggest that a time convenient, the Department of Employee Relations and Doug Ley provide a similar one-hour briefing for members of the Finance and Personnel Committee. A copy of the presentation used by Doug Ley is attached for your information.

Please let me know if this would be helpful for the Committee, or if there are related health care cost issues that need to be discussed.

Sincerely,

Michael Brady
Employee Benefits



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Employee Benefit Practice

The Monster Among Us Are We Doomed to Face Ever Increasing Medical Insurance Costs?

***Douglas J. Ley
Vice President / Director
National Actuarial Practice – Willis Benefits of North America
330 East Kilbourn Ave Suite 1400
Milwaukee, Wisconsin 53202
(414) 203-5248***



Insight into the Monster

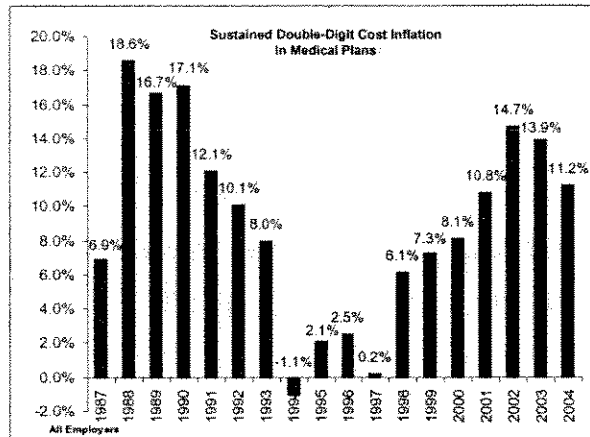
**The increase in health care costs put me over the
expenditure cap - I need to cut something.....**

Typical Municipal Budget Director

The increase in health premiums ate my raise....

Typical employee

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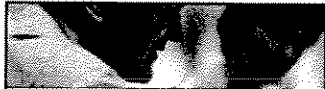
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There is no reason to be optimistic about health care costs in the future.....

- Upward pressures will continue as the population ages
- We are running out of quick fixes and takeaways
- The uninsured population is growing
- A plethora of factors drive costs none of which appear to be abating

If annual medical trend is 10% the City's medical plan cost will double every 7 years assuming no change in enrollment.


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Can the Monster be controlled?


May I have a silver bullet please!

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- **Is volume purchasing the answer?**
Put a lot of monsters together and you have... a lot of monsters, further administrative fees are low, less than 2% of the total Basic Health Plan costs, and not volume sensitive.
- **Is buying insurance the answer?**
Why bother self insuring our medical plan? Wouldn't buying insurance be easier and cheaper?
For virtually all employers with over 200 employees, self insurance is cheaper than insurance. Why? Profits, margins and contingency expenses stay with the organization sponsoring the plan. In addition, sponsors avoid premium tax, mandated benefits and have greater control over risk levels, design, funding and administration of their medical plan.
- **Are bigger discounts the answer?**
What's retail?
- **Is more "managed care" the answer?**
What more can we manage?
- **Are consumer driven health plans the answer?**
They only address one piece of the puzzle.


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Is the Federal Government the answer?

- Impact of the Balanced Budget Act
- A word from our friends in the EU
- Government can't outlaw illness
- What price controls buy is the 1970s revisited


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Are employers the answer?

- They keep searching for for the silver bullet
- Want to transfer cost
- Can not or will not restrict choice
- Can't require personal responsibility
- Ranks of uninsured growing


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Are physicians the answer?

- The incidence of invasive procedures vary from place to place – why is geography destiny?
- “Treat and street” versus maintaining health.
- What is “wellness” and when should screening be done?
- The more physicians do, the greater the reward.
- What do you call the person who graduated last in their class at medical school?
- No pay for performance.


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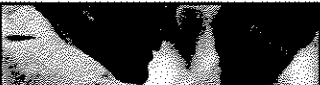
Are hospitals the answer?

- There is little evidence that patient safety has improved in the last five years
*Dr. Samantha Collier, Vice President
Health Grades*
- Some studies say 1 in 25 are harmed
- A computer in every hospital room?
- A hospital is really just an expensive hotel, and only a physician can make reservations.

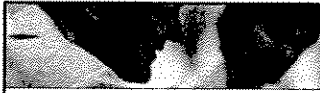
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<p>Are consumers the answer?</p> <ul style="list-style-type: none">• Why do we demand and physicians prescribe Nexium when Prilosec is available OTC?• Why prescribe an antibiotic simply because mom thinks junior should have it?• Are doctors' offices clogged with employee's needing an excuse to get paid?• Does requiring the patient to pay the bill confer to them a medical degree?• Do we really know what is best, what it costs and do we care?	<p>Willis</p>
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<p>Who is to blame for all this?</p> <ul style="list-style-type: none">• Providers (nurses, doctors & hospitals)?• Insurance Companies?• Lawyers?• Employers?• Pharmacy Companies?• You?• Fate?	<p>Willis</p>
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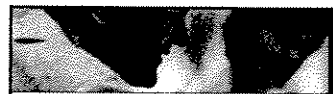
Everyone needs to take a look in the mirror

- **Federal Government**
- **Employers**
- **Physicians**
- **Hospitals**
- **Patients**
- **Everyone in the room**

We all contribute to four massive problems. First, Health care is both vast and extremely fragmented. Thousands of health care organizations can make decisions on behalf of their own interests independent of their impact on the whole. Second, there are not enterprise-wide management capabilities that allow the system to clamp down on costs of force efficiencies in ways that other industries take for granted. Third we have an extremely litigious society that exacerbates all the inherent inefficiencies and errors that result. Fourth, we don't take responsibility for ourselves.

First three courtesy of Brain Klepper Center from Practical Health Care Reform

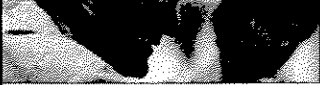
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Some of the conundrums. ...

- Patients want to be well at any cost – well!?!?
- Are physicians forced to play “pastor” for depressed individuals and mask it as Fibromyalgia or prescribe antidepressants?
- Are diseases treated the same even though different diseases have different cost structures and respond differently to prevention and treatment?
- Does our system result in uncoordinated delivery and no continuity of care


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Some of the conundrums....

- The good and bad are all paid the same
- Does our system strengthen or weaken the physician patient relationship?
- What are we managing?

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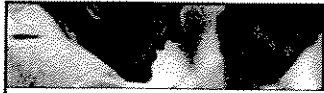
Can the Monster be controlled?

Maybe, but to succeed.....

We need to understand what drives cost, stop pointing fingers, take responsibility for what we can change, live with what we can't and participate in global processes to change those factors beyond our local control.


There is no silver bullet!

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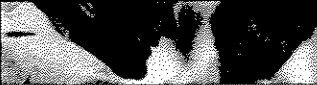
	City Can Control	City Can't Control
• Inflation in Fees
• Use of Services (Utilization)		
- Aging Population
- Employee Demand
- Physician Practice Patterns
• Litigation
• Fraud
• New Technologies		
- Machines
- Drugs
- Therapies
• Cost Transfer		
- Federal Government
- Bad Debt
- Charity Care (uninsured)
• Duplication of Service
• Life Style
• Consumer Insulation From Cost
• Administrative Complexity
• Outcome
• Lack of Information		
- Provider
- Patient
• Lack of accountability

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“Grant me the serenity to accept what I cannot change, the courage to change what I can and the wisdom to know the difference.”


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Knowledge is power....

- Understanding the facts (coming to grip with what we just discussed)
- Understanding the past (what is driving our costs)
- Predicting the future (where are we headed)
- Doing something about it (beyond repeating the failures of the past)


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The tools and discipline to understanding the past

- Trend analysis
- Historical rate sufficiency
- IBNR
- Am I different and why
- Where is the money going

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Trend analysis – what does this tell me?

- How are my costs changing over time?
- How volatile are my costs?
- How do I compare to national trends?

You can drown in a lake with an average depth of 2 inches


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Historical rate sufficiency – what does this tell me?

- Do I have a bias of under or over projecting?
- Who is “making” or “losing” money?
- Are there seasonal fluctuations?
- What is the impact of catastrophic claims?


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What is IBNR and why is it important?

- A measure of what's out there that hasn't been paid
- A measure of claims service
- It's more than just a liability –it affects the rates/cost forecast
- Timing of claims payment affects stop loss reimbursement

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Am I different and why?

- What are my principal cost drivers
 - What can I change and what can't I change*
- The big claimant wild card
 - Population segmentation*
- Demographics
 - Unlike wine...old is not better*

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What are the principal cost drivers?

A small number of “things” drives a significant portion of the cost

- 25 drugs equal 30%-40% of total drug cost
- 25 diagnosis drive 35%-45% of total hospital cost
- 25 procedures drive 30%-35% of total professional costs

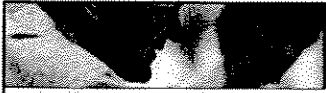
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Where is the money going – what are the principal cost drivers?

- Top 25 drugs – generally statins, PPIs, non-sedating antihistamines and antidepressants
- Top 25 diagnoses – generally heart related, digestive, cancer, joint and renal
- Top 25 procedures – generally office visits, pap test, psychotherapy, chiropractic and therapeutic procedures

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What determines total health care cost?

Price per unit x Volume₁ x Volume₂ x Volume₃ x Volume₄
adjusted for Outcome = Cost

Volume 1 = Determined by physician practice and billing patterns
Volume 2 = Determined by patient preferences and expectations
Volume 3 = Determined by patient health status and lifestyle
Volume 4 = Determined by payer

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What defines cost in the health care environment?

Outcome = Benefit to the patient as determined by:

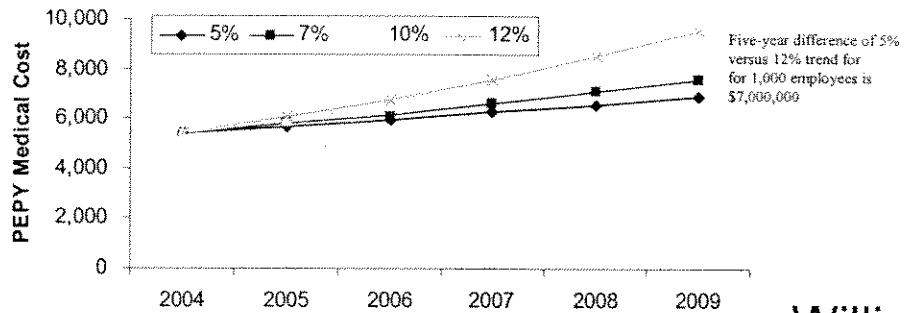
- a. Efficacy: Which treatment produces the best result for the patient?
- b. Effectiveness: Does the treatment result in superior outcomes when applied in the delivery system?
- c. Appropriateness: Is the treatment used appropriately at the right time in the right place?
- d. Execution: How well does the provider perform the procedure?
- e. Patient Compliance: Does the patient understand and comply with the treatment plan?

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Small incremental savings can generate significant results

Sample Medical Cost Projections

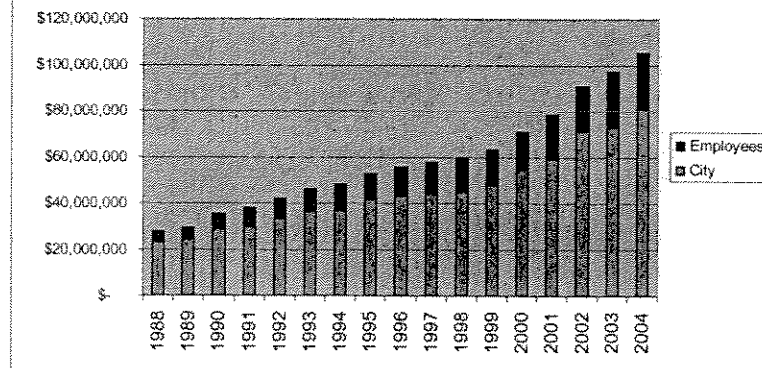
Base Year 2004 with various trend assumptions



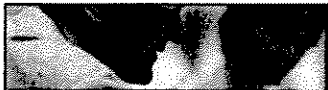
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Bringing it Closer to Home

Actual City and Employee Health Plans Cost Increases



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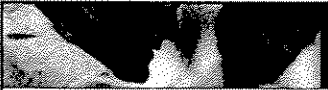


Bringing it Closer to Home

From 2000 through 2004, the cost of the medical coverage increase a little over 10% per year.

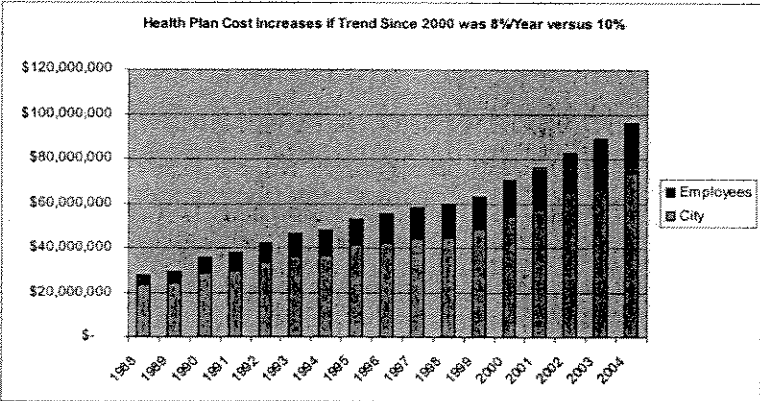
What would have happened had the City been able to reduce the rate of increase to 8% a year from 2000 through 2004 instead of 10%?

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Bringing it Closer to Home

Health Plan Cost Increases if Trend Since 2000 was 8%/Year versus 10%



Year	City Cost (\$)	Employees Cost (\$)	Total Cost (\$)
1989	20,000,000	5,000,000	25,000,000
1990	22,000,000	5,500,000	27,500,000
1991	24,000,000	6,000,000	30,000,000
1992	26,000,000	6,500,000	32,500,000
1993	28,000,000	7,000,000	35,000,000
1994	30,000,000	7,500,000	37,500,000
1995	32,000,000	8,000,000	40,000,000
1996	34,000,000	8,500,000	42,500,000
1997	36,000,000	9,000,000	45,000,000
1998	38,000,000	9,500,000	47,500,000
1999	40,000,000	10,000,000	50,000,000
2000	42,000,000	10,500,000	52,500,000
2001	44,000,000	11,000,000	55,000,000
2002	46,000,000	11,500,000	57,500,000
2003	48,000,000	12,000,000	60,000,000
2004	50,000,000	12,500,000	62,500,000

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The savings had the rate of increase been 8% versus 10% would be significant to both the City and employees.

Year	City	Employees	Total
2000-2001	\$1,647,402	\$532,774	\$2,180,176
2001-2002	\$6,480,804	\$1,742,465	\$8,223,269
2002-2003	\$6,229,407	\$2,098,979	\$8,328,386
2003-2004	\$6,867,534	\$2,074,337	\$8,941,871
Total	\$21,225,147	\$6,448,555	\$27,673,702

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Can you really reduce trend?

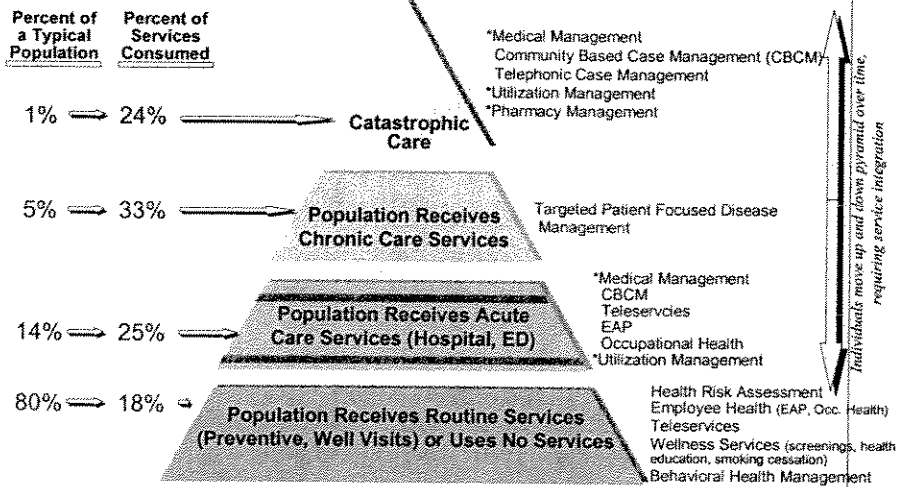
Yes – provided you are willing to understand what factors drive cost and take active collaborative steps to address them.

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*It doesn't need to be cost transfer –
we need to get smart - can we afford
not to do the right things?*

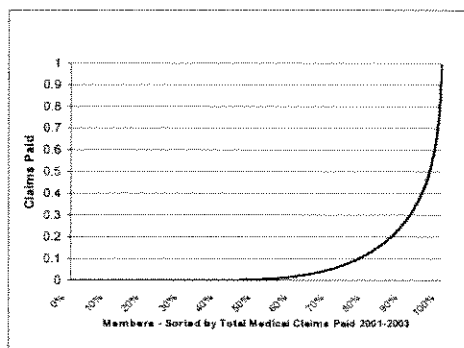
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What strategies do I need? A successful strategy must focus on managing all population segments



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Population Segmentation – look who's spending the money



No matter how big we make deductibles it doesn't offset the big spenders

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Keys to Success

To truly succeed in managing the cost of medical benefits, the focus needs to be on integrated global approaches not just the solution du jour. The focus must be on:

- Know what is driving your costs
- Keeping people well,
- Effectively treating episodic illnesses,
- Effectively treating chronic disease,
- Selecting appropriate providers, and
- Managing peoples movement up and down the pyramid

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Keys to Success

- Remove barriers to communication
- Partner with providers
- Partner with vendors
- Restrict choice – you can't have accountability with a free for all
- Foster knowledge and accountability
- Monitor progress and results
- Labor and Management must partner – not fight

Can we afford the cost of inaction and the status quo? - the nations health care bill is 14% of GDP and increasing can we afford 14% of pay? There is no silver bullet just many small opportunities that add up to big dollars

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