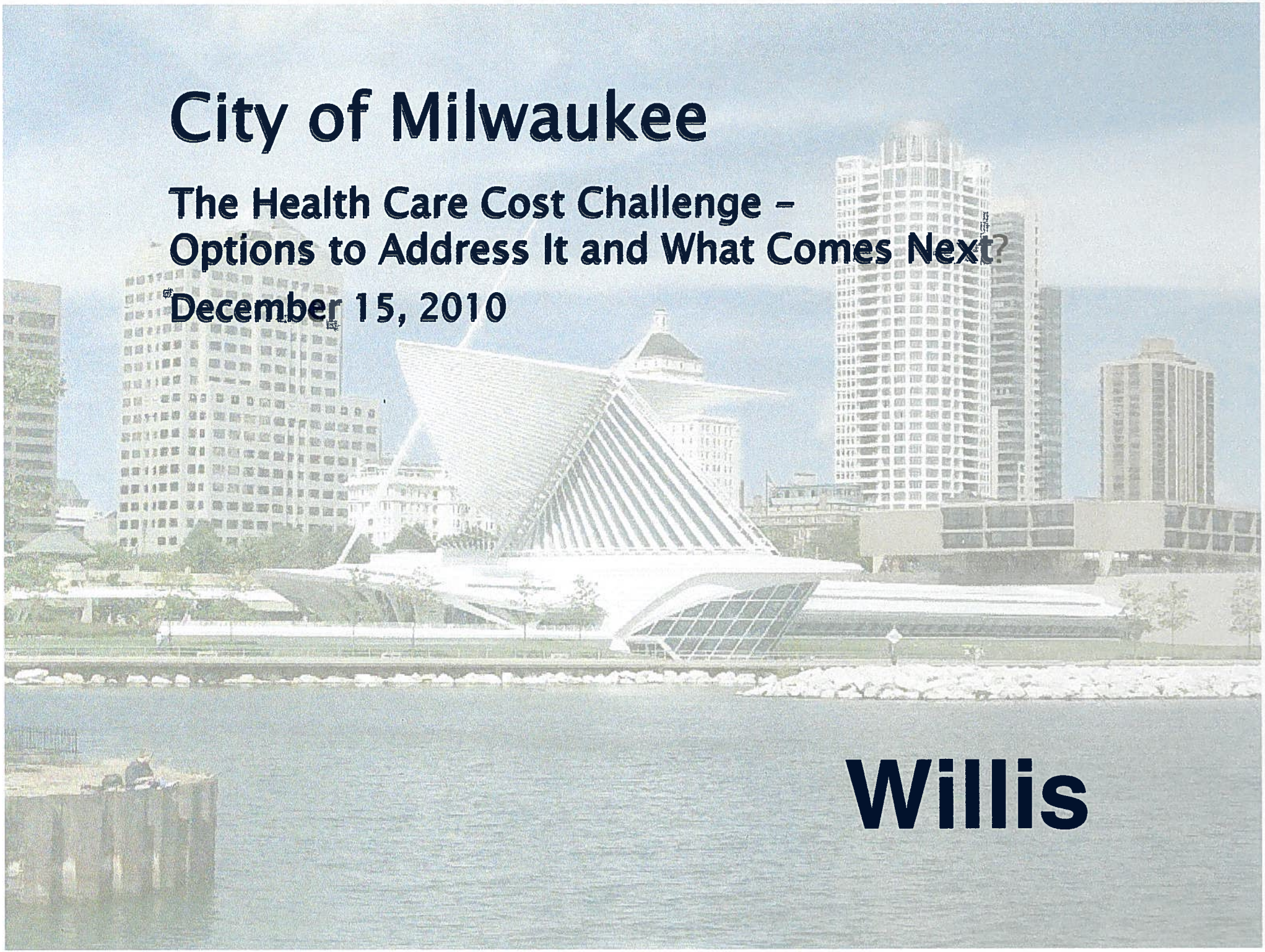


City of Milwaukee

The Health Care Cost Challenge – Options to Address It and What Comes Next?

December 15, 2010

Willis

National Challenges

There is no reason to be optimistic about healthcare costs…

- Health care has grown from 8% of GDP in 1990 to 16% of GDP in 2010 – expect healthcare costs to reach 20% of GDP by 2015
- Cost pressure will continue as the population ages
- We have run out of quick fixes and takeaways
- Which health plan pays our employees bills does not change a person's health destiny
- The insurance industry has failed to address increasing cost
- A plethora of factors drive cost; none of which appear to be abating or lend themselves to a quick fix

If annual medical trend is 10%, our medical plan cost will double every 7 years, if it is 6% it doubles every 12 years

Local Challenges

- Benefits are a mandatory subject of bargaining for the City – no changes can be made without agreement
- Health Plan Provider networks include almost all Southeast Wisconsin providers since employers demand all inclusive networks
- As a result competition between health systems is limited,

Active and Retiree Enrollment

- 6217 active employees enrolled with health care benefits (78% of total cost)

- 4258 retirees with health care benefits (22% of total cost)
  - 2407 Medicare retirees (3% of cost)
  - 700 additional Medicare retirees with Medicare Complete plan not sponsored by City (not part of 4258)
  - 1851 non-Medicare retirees (19% of cost)

Total Net Health Care Costs 1999-2011

Year	Net Cost	Per Member Per Year
1999	$47M	$3,838
2000	$54.5	$4,092
2001	$59.7M	$4,898
2002	$68.5M	$5,733
2003	$73.2M	$6,219
2004	$81.5M	$6,909
2005	$91.2M	$7,979
2006	$86.6M	$7,857
2007	$97.1M	$8,903
2008	$104.5M	$9,746
2009	$107.3M	$10,009
2010	$120.9M	$11,144 (not final)
2011	$135.4M	$12,822 (projected)

Past Responses to the Cost Challenge

- Managed competition model in the past
- Carved out drug benefit through Navitus
- Options for retirees outside of City sponsored Medicare plans
- Aggressive HMO RFP process in face of declining competition
- Critical Factor Analysis from Willis
- Recent changes in benefits focus on wellness

Past Responses to the Cost Challenge

- Current cost trends for the medical plan are not sustainable
- DER has worked the competitive insurance market to its advantage, however, now only UHC will provide insured quotes. Collectively Blue Cross Blue Shield, Humana and UHC have lost millions on the City over the last four years
- In spite of the significant increases, there is a good probability that UHC will pay more to providers than they receive from the City in premiums in 2010 and again in 2011.
- The self insured plan is efficient, the cost to operate it is less than three cents on the dollar – the rest is used to pay benefits for City employees and dependents
- Provider discounts approach 50% and will not get larger
- Leveraging providers or insurance carriers alone will not solve the problem.

Federal, State, County and City health benefits

- **Federal government:** requires an employee share premium of 25% of total monthly cost of health insurance, about $175-$500 per month.
- **State employee:** share of premium is $36-$188 single and $89-$471 family monthly, abut 4-6% of the total cost for most
- State retirees use sick leave balance converted to dollars to pay for retiree costs
- **Milwaukee County employee:** share of premium is $35-$110 single, EPO/PPO plans and $70-$180 family, EP/PPO plans, from 4% to 15% dependent upon group
- Milwaukee County retirees who started pre-1994 get health insurance at no cost; retirees who started after 1994 pay the full cost of their retiree health
- **City of Milwaukee employee:** share of premium is $20/$40 for HMO and $75/$150 for Basic Plan monthly, about 2% to 6% depending on plan.
- General City retirees (Milwaukee) pay $0 for HMO, $30/$60 for Basic Plan up to age 65; City pays 65-100% of pre-65 cost for Police and Fire based on sick leave balance

Who Is To Blame?

Everyone shares in the blame

- Federal and State Governments
- Employers
- Physicians
- Hospitals
- Patients
- Everyone in the room

Keep in mind…

If there was a proven solution, we could buy the book and follow the recipe. All parties need to work together locally to innovate and solve the problem and this needs to be done within the context of consensus on an overall strategic plan design platform to replace the current model

Where Do We Go Next?

What can we do to control the cost of providing medical benefits to our employees?

What has been done was good within the context of the local challenges that we faced.

We need to take things to a new level and move from good to great with when it comes to addressing the health care cost challenge.

There are numerous tactical considerations that must be considered.

However, to be effective they must be implemented within the context of City consensus on an overall strategic direction.

What are the Options?

There are many tactics to address rising costs, all of which fall into once of the following seven areas:

1. Make sure that service providers cost structures are reasonable and that the service provided is focused on measurable outcomes not process alone.
2. Increase employees share of the cost when the receive medical care (currently most care results in no cost to the employee)
3. Limit the size of population that is covered
4. Increase what people pay each paycheck
5. Look at where care is provided, appropriateness of care and outcomes
6. Make sure people use the plans wisely
7. Reduce or manage health risks in the population

The first four are more direct and the last three are more challenging but will have a bigger impact

What Causes Medical Cost Increases

Health care cost is determined by interaction of multiple factors

Price per unit x $Volume_1$ x $Volume_2$ x $Volume_3$ x $Volume_4$ X $Volume_5$ adjusted for Outcome = Cost

Volume 1 = Determined by physician practice and billing patterns

Volume 2 = Determined by patient preferences and expectations

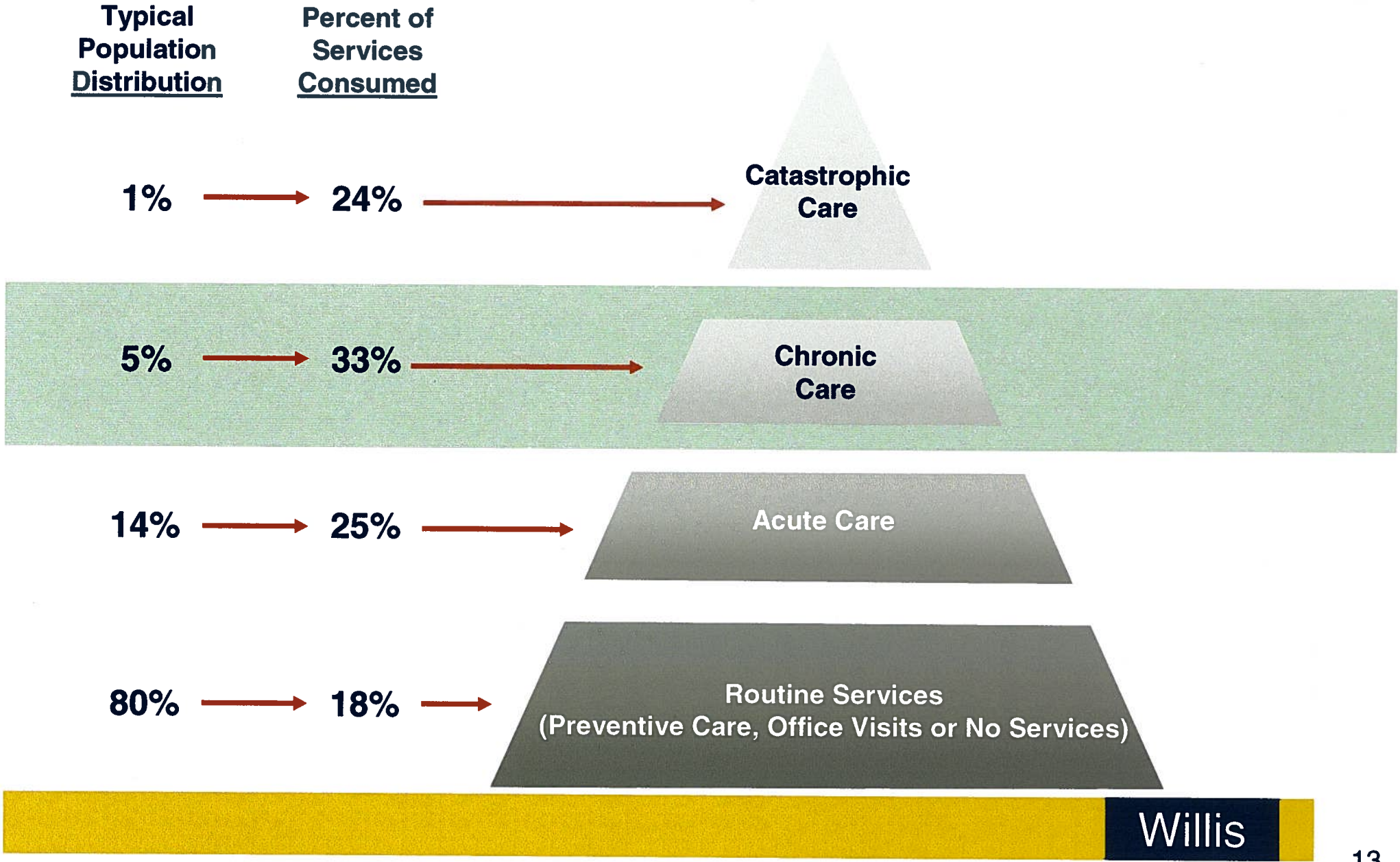
Volume 3 = Determined by patient health status and lifestyle

Volume 4 = Determined by payer

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

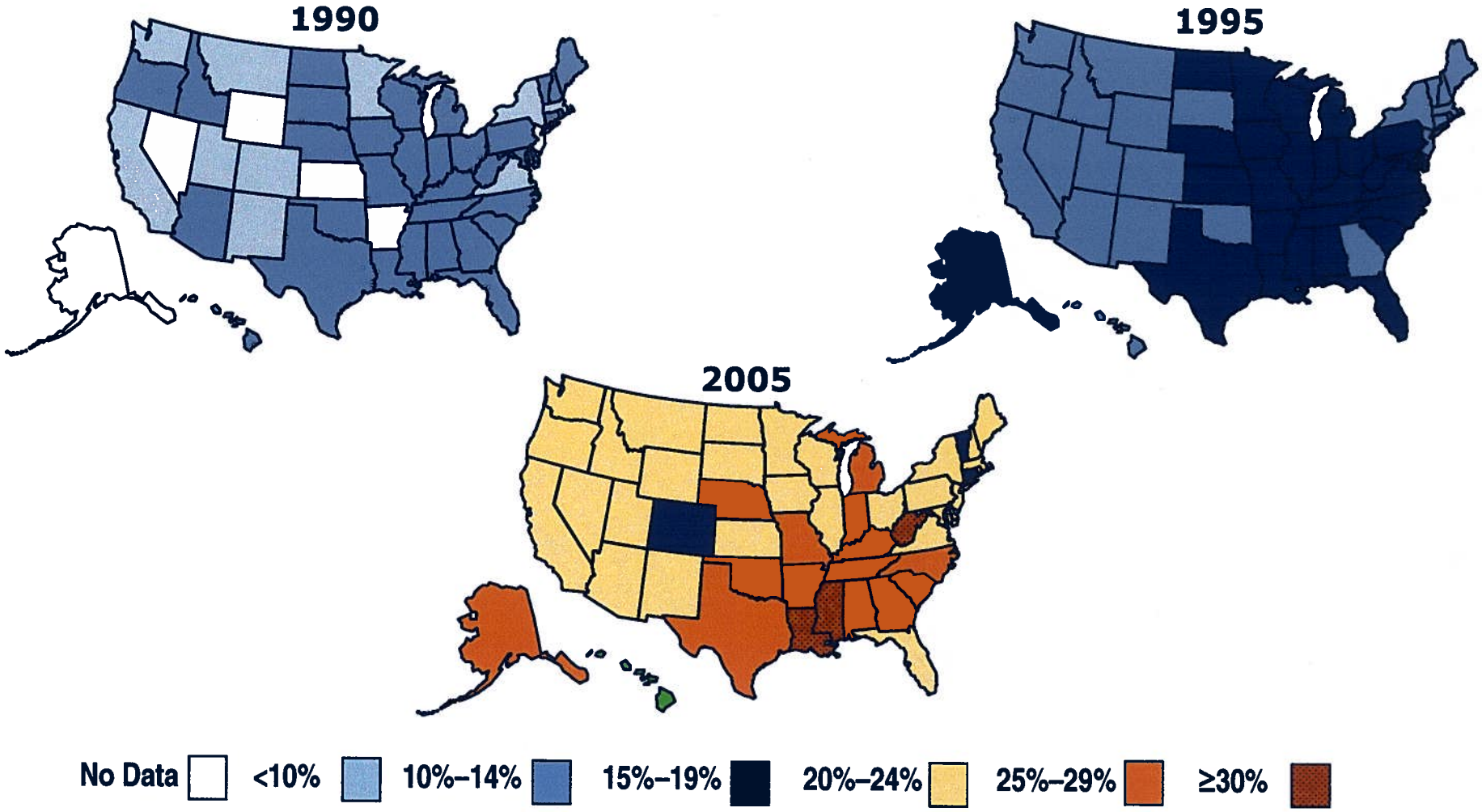
Outcome = the benefit of the treatment or encounter to the patient

Where is the Money Going?



Obesity Trends* Among U.S. Adults

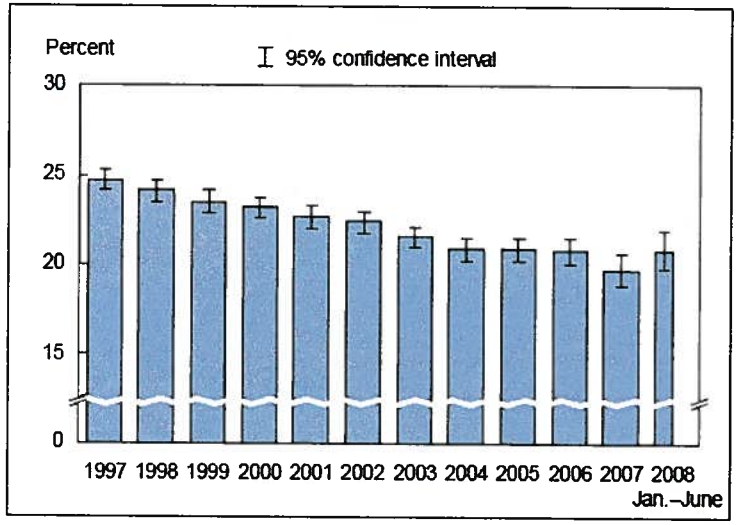
(*BMI ≥30, or about 30 lbs overweight for 5'4" person)



Following Doctors Orders

The following percentages of patients are non compliance with recommended care

- Coronary artery disease 32%
- Hypertension 35%
- Colorectal cancer 46%
- Asthma 46%
- Hyperlipidemia 51%
- Diabetes 55%
- Smoking **see chart at right**



Resources for Employees to engage in quality and cost comparison

- Examples of Pricepoint and Checkpoint for hospitals in Milwaukee

- Wisconsin Hospital Association: Price Point, http://www.wipricepoint.org/
- Wisconsin Hospital Association: Check Point: http://www.wicheckpoint.org/Report_Topic_Index.aspx
- UHC: www.myuhc.com

- Leapfrog Group for Quality Measures: national measurement, Milwaukee hospitals are not participating as of 2010 , http://www.leapfroggroup.org/

Where Do We Go Next?

There are four fundamental strategic benefit platforms that the City can chose to replace managed competition and address the many factors that drive the cost of health care. Each if properly implemented can address the multiple factors that drive medical cost. Each will cover preventive in full and allow for emergency service.

1. *Choice and defined contribution approach*
2. *Point of service approach*
3. *Consumer driven approach*
4. *Behavioral or engagement based approach*

The Choice & Defined Contribution Path

High Option EPO	Low Option EPO	High Option PPO	Low Option PPO

- Employees have a choice of plans where better coverage costs employees a greater monthly premium
- EPO Plans – Employee must use a specific group of doctors and hospitals and receive better coverage in return
- PPO Plans – Employees have a larger group of doctors and hospitals to choose from, and off network coverage. However, they pay more when they receive medical care – the high option has less out of pocket cost at point of service than low option.
- The City defines the same contribution toward each plan as well as how much it increases in subsequent years.
- Capping City increases in cost for a 2 to 3 year period shifts the economic responsibility for future increases to employees

The Choice & Defined Contribution Path

Value proposition

Since increases beyond the budgeted amount is the responsibly of employees, the City is out of the business of driving change or arguing about what should be done. The only issue to bargain is the contribution and caps on future increases to the City. The City with its unions can work together to develop strategies to address health benefit cost and influence people to do the right things to be good consumers and manage their health.

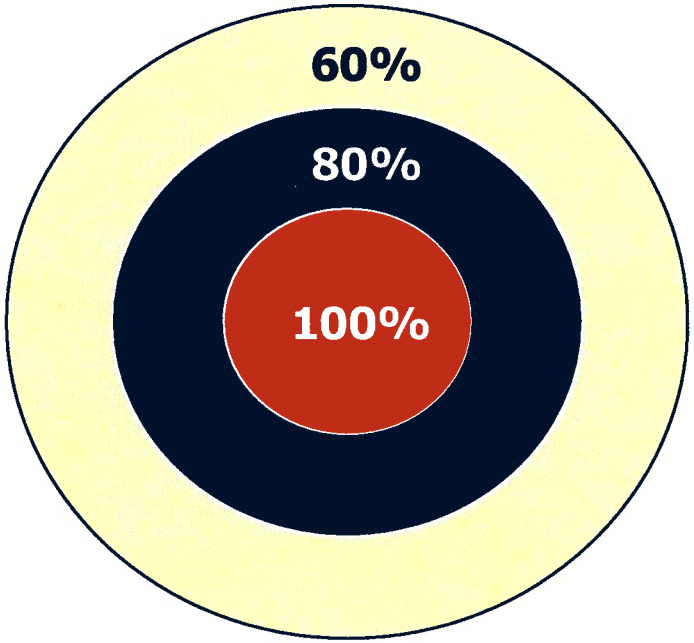
Pros:

- City cost and future increases are known.
- No risk of employee selection patterns affecting cost.
- Bargaining is simplified as the focus is on dollars only not benefits or strategies.

Cons:

- It may be difficult to get the unions to agree, to accept the risk of future increases.
- Employees will perceive that that they have been forced to accept financial responsibility for something they believe they have little control over.
- This strategy is not common and is generally used with retiree medical populations.

Point of Service Path



- 100% Coverage – Tier 1 – specific providers
- 80% Coverage – Tier 2 – larger network of providers
- 60% Coverage – Tier 3 – any provider of choice

- Each time a member receives care, they chose which provider to use, and who is used determines the level of coverage.
- Members are not required to make a provider or plan election at the beginning of the year.
- Different out-of-pocket maximums apply to each tier.
- Employee contributions can be earned down or money deposited in a spending account if they complete activities designed to address disease and improve health.

Point of Service Path

Value proposition

Only one plan is offered eliminating the need for a open enrollment. Employee engagement is a function of participation in programs designed to promote good health and assist people with chronic health conditions or catastrophic health events. Cost sharing features that incorporate employee engagement in cost can also be part of the program. For example, pharmacy benefits can be based on a percentage of the cost versus flat dollar copayments.

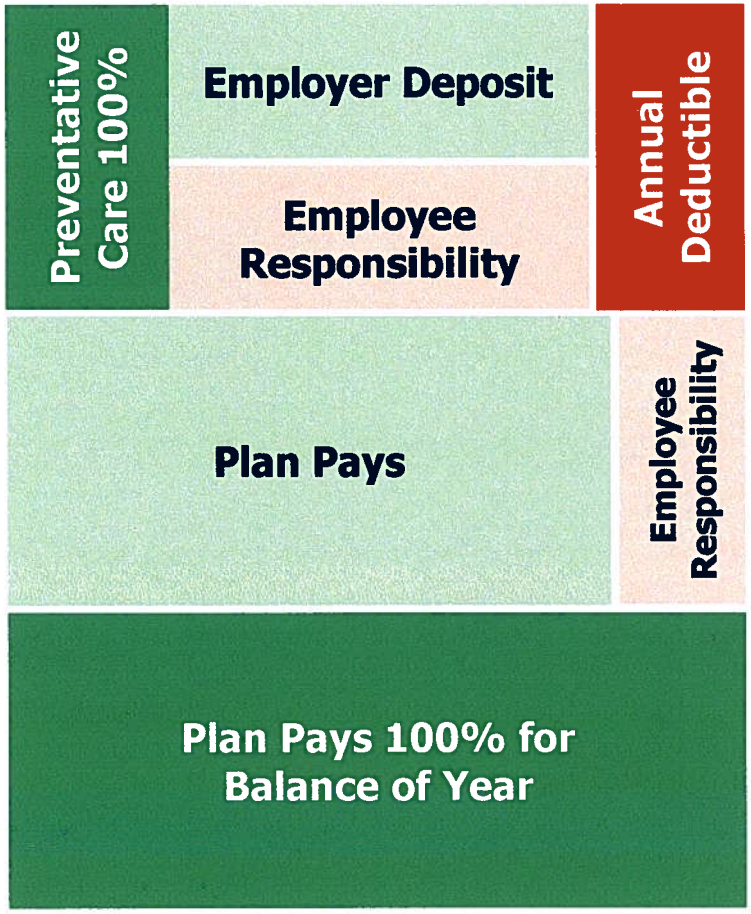
Pros:

- Simple, only one plan is offered, no open enrollment.
- No risk of employee selection patterns affecting cost.
- Design features can foster economic engagement in cost and varying employee premium copays based on participation in health conditions fosters interest in, and use of, these programs.

Cons:

- It will be difficult to get the unions to give up choice.
- Adjustments to the plan and cost management activities need to be bargained.
- Monitoring participation in programs to maintain health and address health issues adds an additional administration and payroll burden each year.

Consumer Driven Path



Summary:

- High deductible applies to all care except preventative
- Preventative Care is paid at 100%
- Employer-funded account provided to cover a portion of the deductible.
- When member meets out of pocket maximum, plan pays 100% for remainder of the year
- Funds remaining in the account at year-end rollover
- Provider choice can be based on current PPO option
- Size of employer funded account varies based on activities to address disease and maintain health

Consumer Driven Path

Value proposition

The argument is that such plans give patients greater control over their own health budgets. According to economist John C. Goodman, "In the consumer-driven model, consumers occupy the primary decision-making role regarding the health care they receive."

Goodman points to a McKinsey study which found that CDHP patients were twice as likely as patients in traditional plans to ask about cost and three times as likely to choose a less expensive treatment option, and chronic patients were 20 percent more likely to follow treatment regimes carefully. (Goodman, John (2006), "Consumer Driven Health Care", Networks Financial Institute Policy Brief, Indiana State University, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=985572#PaperDownload

Consumer Driven Path

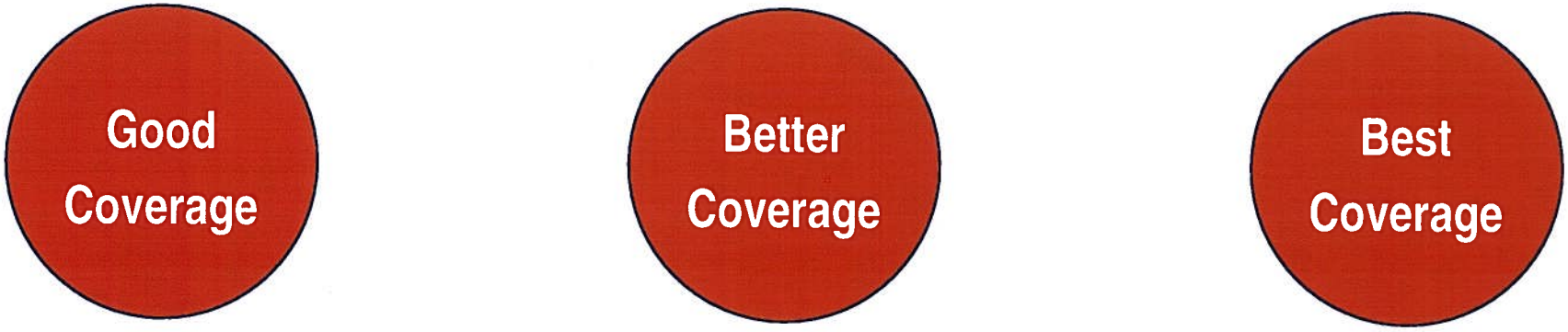
Pros:

- Fosters a high level of employee engagement in cost
- This path offloads decisions regarding what discretionary care is paid for by the plan to the employee level. Employees can use or not use the account to pay for certain expenses.

Cons:

- Administration of spending accounts and the selection of the best vehicle (HSA or HRA) adds additional complexity and cost It may be difficult to get the unions to agree, to accept the risk of future increases.
- Medical care cost is not as transparent as needed to foster good economic decision making.
- Size of the City deposit to the account will subject to collective bargaining.
- High deductible plans are subject to trend leveraging. This occurs when the amount of claims that exceed the deductible increase at a rate greater than medical cost trend.

Behavior Based or Engagement Path



- Employee monthly premium for all three plans are the same
- BEST plan has lowest out of pocket for employees
- To gain access to the BETTER plans, employees need to complete a physical exam and meet with health advocate to review the results. The exam is provided at no cost to the employee.
- To gain access to the best plan employee must take exam and:
  - Participate in activities to maintain health
  - Participate in activities to address a chronic health condition if they have one.

Behavior Based or Engagement Path

Value proposition

This path seeks to identify and treat disease in the insured population and engage employees in the improvement of their health. It will also effectively focus healthcare resources toward early detection and prevention, reduce the number of catastrophic cases, improve the quality of life of covered employees and dependents, promote employee productivity and to continue to provide a market competitive health insurance program.

Pros:

- Such plans have shown measurable reductions in trend and risk factors.
- The focus is on health and avoiding illness that resonates well in negotiations versus arguments on cost and reductions in benefits.

Cons:

- Employees will be concerned over privacy issues.
- The City will make short-term investments in screening and support services to impact trend over the long term.
- The program is complex and requires new programs.

Next Steps

Insurance is a method to finance health care, not provide it. We need to focus on the behavioral aspects, gaps in care delivery and quality to reduce trend long term.

To ignore this is to repeat the mistakes of the past and the fail in addressing the challenge of the future

To make any model work requires changes in the culture that go beyond the design of the medical benefit program offered. Any model will fail if the underlying culture of the organization and its impact on people is not taken into account. Addressing cultural issues within the City and the historical distrust between labor and management is tantamount to the success of the effort.

Next Steps

Beyond the personal choices people make, difficult decisions will need to be made regarding who will provide health care services to City employees and dependents. There is no way to get accountability under the current system where covered employees and spouses have unfettered access to over 5,000 health care providers.

Any of the options outlined can reach similar financial and health goals. However, the success will be contingent on addressing all parts of the health care equation.

Questions

- Questions and Comments