Background

In the late 1980's the City of Milwaukee (City) adopted an approach called managed competition to address health care costs pioneered by Dave Riemer at the State of Wisconsin. Under this approach, all health plan vendors were invited to compete for the opportunity to provide their health coverage to employees. Competition was based on a clearly defined benefit program where each carrier competed for each employee's business by offering the lowest cost, broadest network and most value added benefits. The City fixed its contribution toward the lowest cost option and if employees wanted another option, they paid the difference in cost.

In years past, this model served the City well. However, in the two last decades the health insurance industry has seen massive consolidation and a reduction in the number of choices. Now the City offers only the Basic Health plan that is self-insured and administered by Anthem and one insured HMO plan offered by United Health Care.

Carriers have not expressed an interest in competing for employee business on a one-on-one basis and have chosen only to provide terms if they are the only insured option offered by the City. In addition, only United offered a fully insured option for 2011. The other major carriers declined based on the risk of such an insured plan and knowledge of the loss ratios experienced by United Health Care. It is very possible that for 2012 the City will not receive any insured quotes leaving offering a self -nsured HMO, which is commonly referred to as an Exclusive Provider Option or EPO, as the only alternative. Although a self-insured approach will save money over the long term when no carrier is willing to underwrite the program at a loss, it will create greater budget risk to the City stemming from the same month-to-month cost fluctuations seen for the Basic Health plan.

Over the past three and one half years, the Department of Employee Relations has worked diligently to implement a wellness program. This program includes premium incentives to get employees and spouses more involved in understanding their health status and to create programs to help them take steps to maintain health, address chronic disease, and cope with catastrophic health events.

Our world has changed dramatically over the past three years. We have seen an economic crisis that has lead to high unemployment and depressed property values. Congress passed and the President signed far-reaching health care reform legislation that will add to the cost of health benefits in the short run. The Wisconsin legislature has also been active and passed legislation that added to health plan cost by extending the age to which children are covered. Finally, municipalities continue to be challenged by a weak economy and declining tax revenues.

Against this backdrop, the cost of providing health care continues to increase for the City, leading many elected officials to state, this increase is not sustainable. What can we do about it? This document provides a summary of some of the options the City of Milwaukee must consider to address and manage the increasing cost of providing health care coverage to employees and dependents.

Key Fundamentals

Whatever design platform might be the goal for the future, certain key fundamentals must be in place. These are:

- The unions and the policy makers should agree on a way to address health care issues strategically. The best financial outcome will result if both the city and its unions agree on a uniform strategy and pursue it collectively. A uniform, collective approach allows the City to obtain the most competitive terms. A good example of this was the recent RFP process for Request for Proposal for Screening, Measurement, Health Advocacy/Coaching, Case and Disease Management where all parties worked to consensus concerning program design, administration and core values and used that consensus to garner the best possible terms.

- Health care costs stem from the following factors that are largely interrelated and more out of the control of providers than one may think. The formula for total cost is price per unit x Volume1 x Volume2 x Volume3 x Volume4 X Volume5 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

  Success in mitigating trend will involve addressing all of these factors

- Accountability is not possible in a free for all. Provider choice must be limited to foster accountability and allow the City to leverage competition between the major health care systems to its advantage. Competition should focus on not only cost per unit of service, but more importantly on the ability to partner with the City long term to reduce trend and improve health.

- The City must recognize that the current "Managed Competition" design platform is not sustainable cost wise and a new platform must be selected to replace it.

- There must be a consequence for failure to act. No one is ever comfortable with change and change will not happen unless there is a benefit to changing or a consequence to not changing. No one will agree to changes in the status quo unless there is a competing reason to do so. If the City is to be successful in bringing about change within the context of the current labor environment, there must be a clear consequence for not changing as well as an urgency to change quickly. The consequences for failing to change must be significant to be a catalyst for change and clearly communicated to all stakeholders.

- The steps the City has taken to foster employee and spousal engagement in the health screening process. Engagement must now be expanded to include participation in case and disease management and ongoing interaction with the health advocates who are there to help people.

These key fundamentals must be addressed to affect long-term impact on cost trends.

Understanding What Can Be Done to Affect Health Care Costs

There are seven ways to influence the cost of a medical benefit plan. These are:

1. Make sure that service providers cost structures are reasonable and that the service they provide is focused on measurable outcomes not process alone.
2. Increase employees share of the cost when they 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

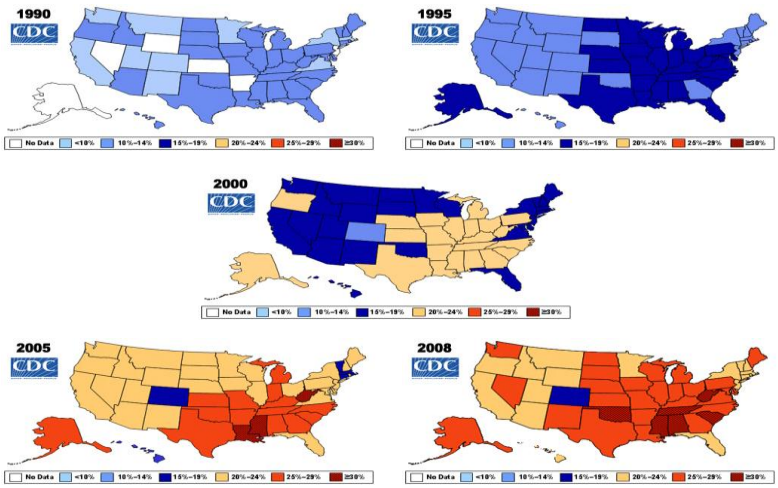
The first four are more direct and the last three are more challenging.

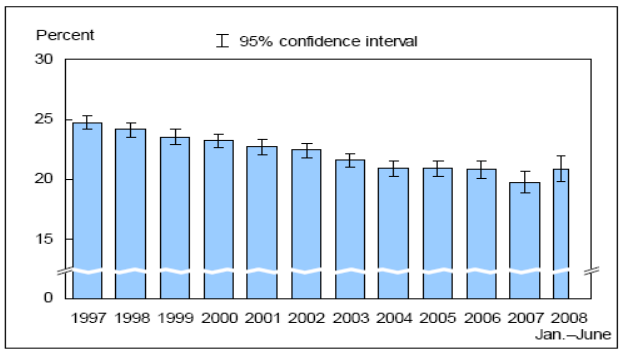
It is almost impossible to address the fifth item under the current managed competition model. With over 5,000 physicians in the networks, accountability over what happens to City employees and dependents is impossible. However, having a direct contract with a single health care system to provide health care to City members and working closely with them will create an environment where there is cost transparency, accountability to monitor where care occurs, whether care is appropriate and that excellent health outcomes are achieved. The concept of the Accountable Care Organization that is a part of health care reform supports this notion.

The last two items that influence health cost have their roots in the choice people make and what they do. We need to understand the impact these choices have on cost. The City understands the impact personal choices have on cost and has implemented several initiatives to address this. Employees obtain lower monthly cost for health coverage if they do not smoke, have health screening done and meet with a health care professional to discuss the results of the screening process. However, the foundation that exists needs to be expanded and strengthened.

For example, patient outcome is as much a function of how good of a job the provider does as well as whether the patient follows the physician's orders. Making sure employees and their families use the plans wisely is a function of knowledge, economics and engagement. People need to understand they have choices and have economic interest to care about the choices they make.

Reducing health risk and wellness is a function of good primary care, engaged people and a support process to help people stay well or address chronic disease. Sounds simple, but in practice it is not. Staying well and addressing chronic disease involves helping people change and make different choices. Unfortunately, as the following data shows, as a society, we do not do a good job in the area of obesity and smoking.





Why is changing people important? Consider the following data from the CDC that shows the percentage of people who are non-compliant with treatment recommendations, obesity rates and smoking:

- Coronary artery disease 32%
- Hypertension 35%
- Colorectal cancer 46%
- Asthma 46%
- Hyperlipidemia 51%
- Diabetes 55%

Strategic Assessment - Medical Plan Platform Options

Beyond items such as how much employees pay for coverage, their share of the cost when seeking care and selecting the vendors providing service, there are four fundamental plan design platforms that can be deployed to address rising health care costs for the City and the choices people make long term. The City is at a fundamental fork in the road with regard to health care; down which path does it go? Whatever path it goes down, is it willing to provide real assistance and incentives; does it want change driven by economics alone or by other means?

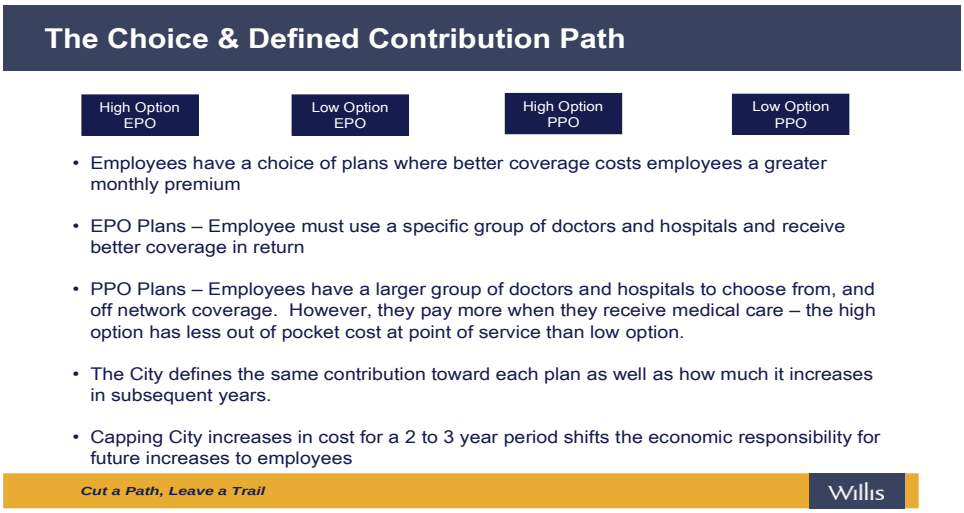
Each of these options represents a significant shift form the current benefit structure provided to employees. All options will control cost and incent employees to make wiser healthcare decisions

The four fundamental plan design approaches that the City might consider are:

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

<u>1. Choice and defined contribution approach:</u>

This is similar to the current platform used by the City, with a few important exceptions. Under this platform, employees have a choice of plans to purchase, but the choice is expanded and the City recognizes that an EPO option will be necessary when an insured HMO is not a viable choice in the future. This approach is summarized in the chart below.



There are significant differences in this approach from the current one.

1. There are more choices for people and the lower cost options are similar to what is offered by private industry.
2. The City's contribution to each option is the same, but does not have to be tied to a 100% of the lowest option.
3. The City's increase in future years is tied to a not-to-exceed-level that is bargained.

This is the simplest approach. The City can budget a flat amount for each plan monthly and knows what the City increase in this amount will be in future years. There is no budget risk to the City if more people than expected select a plan where the city contributes a greater amount toward coverage, which is the case today.

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:

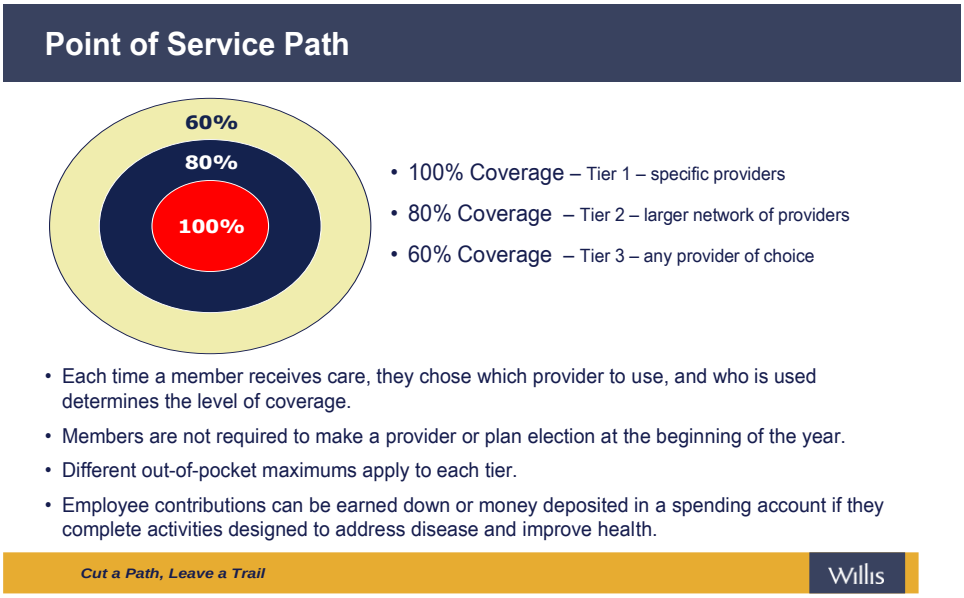
- ☞ City cost and future increases are known.
- ☞ No risk of employee selection patterns affecting cost.
- ☞ Bargaining is simplified as the focus is on dollars only, not benefits or strategies.

Cons:

- ☞ It may be difficult 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.

2. Point of Service Approach

Under this approach, a single plan is offered instead of a choice of four. The best coverage level is provided when employees obtain medical care from providers with whom the city has the most favorable partnership terms. Employees receive a lower level of benefits when they obtain care through a secondary network and the lowest level of benefits when they obtain care from non-network providers.



There are two differences in this approach from the current plan design.

1. Only one plan is offered
2. Employees contributions will be varied based on their participation in programs designed to help them maintain health and address health conditions

Value proposition:

Only one plan is offered eliminating the need for an 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 programs to maintain health and address health conditions fosters interest in, and use of these programs.

Cons:

- ☞ It will be difficult get the unions to give up choice.
- ☞ Adjustments to the plan and cost management activities need to be bargained.

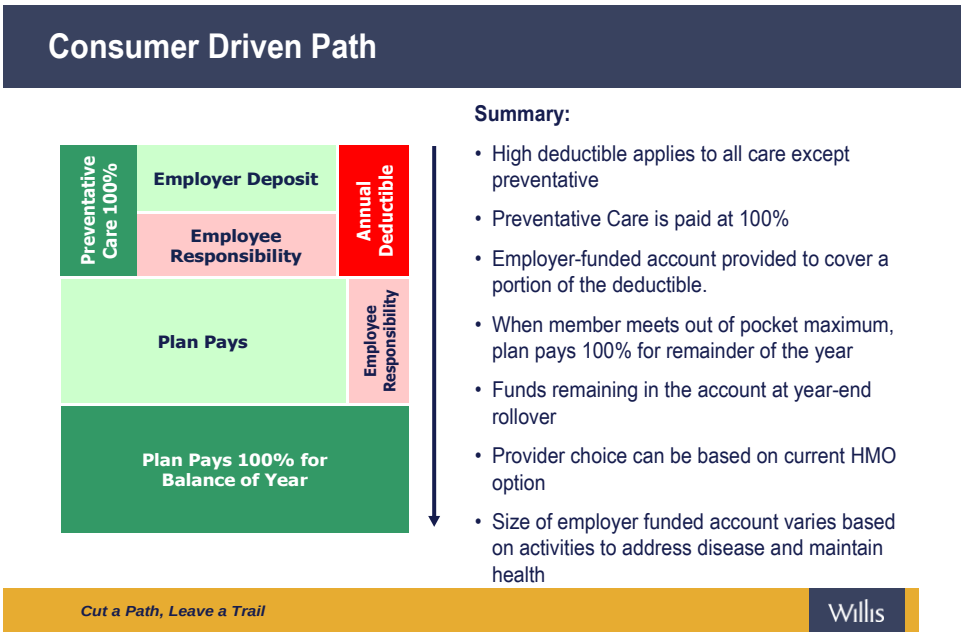
- ☞ Monitoring participation in programs to maintain health and address health issues adds an additional administration and payroll burden each year.

3. Consumer Driven Approach

These plans allow members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay routine health care expenses directly, while a high-deductible health insurance policy protects them from catastrophic medical expenses.

High-deductible policies cost less, but the user pays routine medical claims using a pre-funded spending account, often with a special debit card provided by a bank or insurance plan. If the account runs out, the user is responsible as the costs apply toward the plan deductible. Users keep any unused balance or "rollover" at the end of the year to increase future balances, or to invest for future expenses.

This system of health care is referred to as "consumer driven health care" because routine claims are paid using a consumer-controlled account versus a fixed health insurance benefit.



This path too represents a significant change from the current plans.

1. Only one plan is offered.
2. A high deductible plan is offered.
3. An employee-owned cash account funded by the City is provided from which users can withdraw money to cover discretionary expenses that are applied to the deductible

This is a more complex approach than the prior two as the City must decide upon the type of account to offer, the size of deposit and arrange for the provision of information to help employees be good consumers.

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

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.
- ☞ 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.

4. Behavioral or Engagement Approach:

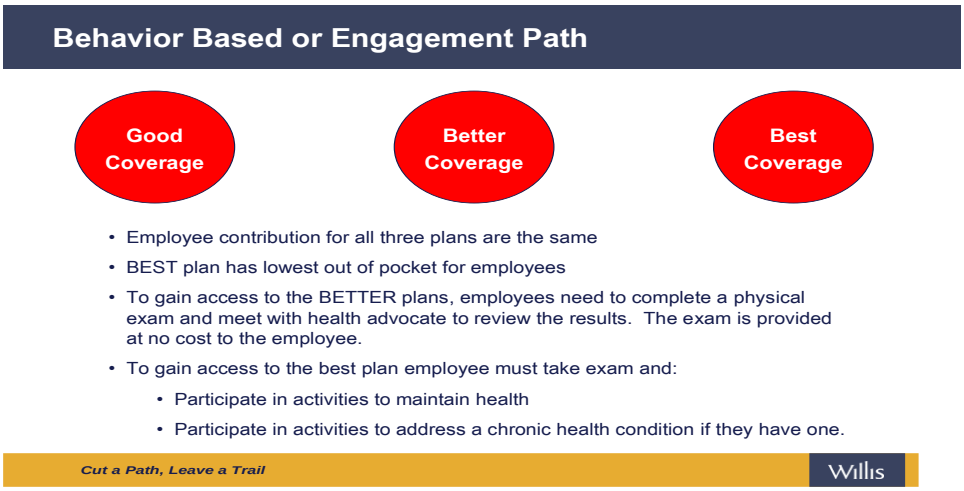
Traditionally, many employers offer several plan options that allow employees to purchase a higher level of benefit in exchange for a higher employee contribution. Employees typically make their plan selection based on receiving a higher return from the plan than it costs them to purchase the benefit. This approach, however, does not encourage preventive activity nor does it address underlying cost issues.

Under the behavior based or engagement path a paradigm shift occurs. Employees can no longer spend their way to better coverage. Rather they earn better coverage by participating in activities and programs to help raise health awareness and address chronic disease and catastrophic medical events.

Under this path there are three plans offered which consist of a basic high deductible plan; a better plan with higher co-pays; and a best plan that has the richest level of benefit. However, the difference lies in the fact that unlike traditional options, each plan costs the same. Employees are enrolled in the Better or Best plans based upon their participation in certain wellness related activities or "qualifiers".

These qualifiers include the completion of a wellness assessment; the gathering of weight, height and waist measurements; a complete blood analysis; age and gender based screenings; and participation in diabetes management and smoking cessation programs. The program utilizes the services of third party medical professionals or "advocates" who provide individual support to covered members.

Employees who do not choose to participate in these programs are enrolled in the "Good Coverage" option. "Good Coverage" is a high deductible health plan that protects against catastrophic health care expenses but requires a significant out of pocket cost to the employee if they need medical services.



As with the consumer driven path, there are significant changes from the current approach.

1. Choice as it is known today goes away.
2. People earn their way to better coverage by participation in activities designed to maintain health and address disease.
3. The City leverages its relationship with Workforce Health to provide local health advocacy services that fill a care gap.
4. The City continues to invest in screening the entire population in a consistent fashion.

This complex approach requires investment in additional capabilities to track participation in screening, case management, disease management and interactions with the health advocates. However, this approach has been shown to drive meaningful reductions in trend, reduction of health risks in the population and better management of large claimants.

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 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.

Summary

Each of these paths is designed to focus on reducing health risk and improving the overall health of the population while controlling cost.

Any of these paths or a hybrid combining portions of each can be used to begin to address the complex issues raised earlier in this report that address the personal choice aspect of health care cost.

Over the last 6 years, the City has collected and analyzed utilization data to understand where its medical plan dollars were going. It is clear that the focus needs to be on employee wellness and engagement as well as provider costs and practice patterns. This is why more organizations have begun to put a greater emphasis on "wellness." These activities have occurred across a continuum ranging from simple education about wellness to global processes that include health screenings, health advocates (coaches) and requirements that people use screening and the tools to help improve their health.
Since the introduction of wellness programs there has been much discussion regarding the benefit these programs generate and measuring return on investment. Largely the benefits tie back to the goals the organization sets and where on the wellness continuum it wants to be.

For example, if an organization seeks to position itself on the educational side of the continuum it might do the following. ABC Company offers an education process where via the Internet and printed media employees are made aware of the availability of services to help people with chronic conditions and endeavor to increase awareness of health issues. Information about the services of organizations such as the American Lung Association, the American Diabetes Association, Weight Watchers, a wellness newsletter and access to an on site fitness center all can help build a wellness culture and awareness.

On the other end of the spectrum are organizations that seek transformational change with respect to employee health. These organizations change the culture and benefit paradigm on multiple levels. For example, the cafeteria and vending machines might only feature healthy food. Processes to systematically screen and measure over 90% of the population are put in place.

Based on the results of screening, programs are developed to help people stay well, address chronic disease and help in the event of a catastrophic illness. Finally, the culture of the organization evolves so the use of these tools is expected, not an option. There are significant consequences for those who do not engage. People can no longer spend or negotiate their way to better benefits. They need to earn better coverage or deposits to savings accounts by actively participating in the programs offered to help them. Finally, steps are taken to measure both the financial savings and health improvement over time.

Currently, the City falls somewhere near the middle of the continuum. It has a wellness committee in place and is in the process of conducting health risk screenings City-wide with lower monthly cost as the incentive.

This continuum from education to engagement exists because the definition of wellness is somewhat elusive and means different things to different people. When asked in focus groups what wellness is, participants generally reply it is getting a yearly physical, going to the gym, eating right, taking care of yourself, etc. Given where the City is today, how would its employees and the committee answer this question? How would you like them to answer this question?

If an organization seeks to generate measurable improvements in the health of the population and lower trend year over year, it must focus on the engagement side of the continuum. Engagement on this continuum contains a clear

definition of wellness, integrates all programs, requires engagement and has clearly articulated outcome measurements on which success will be judged.

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.

Beyond personal choice, difficult decisions may 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 outlined on page two this white paper.

Tactical Consideration Assessment

Independent of what medical plan model is chosen there are numerous tactical considerations. Along with making a decision on overall strategy, specific tactics and how they apply to the City's unique circumstances needs to be continually assessed. There are many opportunities. Following is a comprehensive list of these tactics and:

- Whether, they can be implemented without being bargained,
- The expected relative ability of each tactic to constrain costs,
- When the tactic should be deployed, and
- Specific comments unique to each strategy and issues that affect them.

Audit Effectiveness of Current Cost Controls (does not require bargaining)

Perceived Impact (1 little 7 large cost impact) 7
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- Requires regular attention audit of case management particularly important
- Audit claims and ensure payments are correct, timely and properly recorded

Leading-Edge PPO/HMO Contracting/Pricing (most labor agreements allow for this)

Perceived Impact (1 little 7 large cost impact) 5
Urgency (2011, 2012, 2013, 2014) 2011 for 2012 implementation
Comments:

- Although HMO costs have risen, it is projected that UHC will take a loss
- If the plan were a self HMO this would have resulted in a loss to the City
- This strategy will not be implemented until the insured rates offered are considered to be excessive or carriers refuse to offer an insured quote.

Proactively Control Retiree Costs/GASB Liability (requires bargaining)

Perceived Impact (1 little 7 large cost impact) 1
Urgency (2011, 2012, 2013, 2014) 2014
Comments:

- Unless coverage is terminated for current retirees, little short term impact on cost
- Stopping coverage for future retirees will have huge impact on City GASB 45 obligation
- It would be very difficult to get unions to agree to eliminating pre 65 coverage
- Private insurance market place and Medicare provide suitable coverage to post 65 retirees making terminating coverage at 65 palatable.

Assessment of Participant Satisfaction (does not require bargaining)

Perceived Impact (1 little 7 large cost impact) 1
Urgency (2011, 2012, 2013, 2014) 2014
Comments:

- Current service levels are good however, make employees more aware of value
- No impact on cost – City will include performance guarantees in all contracts

Vendor Accountability, Performance Guarantees (does not require bargaining)

Perceived Impact (1 little 7 large cost impact) 1
Urgency (2011, 2012, 2013, 2014) 2012
Comments:

- Note above, current service levels good financial guarantees in future agreements
- Current service levels are good however, make employees more aware of value
- No impact on cost – City will include performance guarantees in all contracts

Improved Rx Efficacy (in many instances must be bargained)

Perceived Impact (1 little 7 large cost impact) 4
Urgency (2011, 2012, 2013, 2014) 2012
Comments:

- City has grown generic use from 46% in 2006 to 67% in 2010
- P4P in place with Navitus
- Current agreement returns all rebates to City
- Consider unit pricing RFP in 2012

Insure Diagnostic Accuracy (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 3
Urgency (2011, 2012, 2013, 2014) 2013
Comments:

- Carriers currently look at code accuracy, upcoming, fraud, etc.
- Medicare will no longer pay for mistakes consider urging carriers to do the same
- An issue that is difficult for the City of address

Joint Purchasing (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 3
Urgency (2011, 2012, 2013, 2014) 2014
Comments:

- Carriers (UHC, Anthem, Navitus, Medco, etc.) have larger groups and hence more clout
- Makes sense from a shared services perspective, i.e., public sector clinics
- For administrative costs, technology has eliminated much of the cost and volume sensitivity
- See collaboration presentation dated 1-22-2009

On-Site Biometric Screening (must be bargained)

- In progress

Access to Retail or On-Site Medical Clinic (does not need to be bargained if use not mandatory)

Perceived Impact (1 little 7 large cost impact) 4
Urgency (2011, 2012, 2013, 2014) 2013
Comments:

- Very difficult to convince unions to go along with this as people need to agree to give up current relationships with primary care and other physicians
- Investments in on site resources better focused on disease management and wellness that attempting to building a competing health care delivery system that will require a large capital investment

Fraud Audit (does not require bargaining)

Perceived Impact (1 little 7 large cost impact) 2
Urgency (2011, 2012, 2013, 2014) 2012
Comments:

- Audit carriers – past audits have not produced huge returns on investment
- Investigate employee bill audit program where employees get a portion of savings of corrected errors

Advocate for Real Health System Reform (does not require bargaining)

Perceived Impact (1 little 7 large cost impact) 2
Urgency (2011, 2012, 2013, 2014) 2014
Comments:

- As evidenced by health care reform efforts very difficult
- One promising area is a RHIOs they are expected to enable health information exchanges (HIE). Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care.

Educate Employees, Retirees and Spouses (education alone does not require bargaining – incentives do)

Perceived Impact (1 little 7 large cost impact) 4
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- This must be an ongoing process. However, there must be incentives for people to act on what they learn

Offer Benefit Plan Incentives (must be bargained)

Perceived Impact (1 little 7 large cost impact) 7
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- Use stick approach and align City programs and employee costs with private industry

Use Data to Identify Primary Care Delivered by Specialists (does not require bargaining doing something with that information would)

Perceived Impact (1 little 7 large cost impact) 4

Urgency (2011, 2012, 2013, 2014) 2012
Comments:

- In many instances, specialists are paid at the same rate as primary care physicians. If this is the case with UHC and Anthem the financial impact of doing this is lessened

Pay for Preventive Services (Not Physicals) (does not need to be bargained but should be as it is an enhancement)

Perceived Impact (1 little 7 large cost impact) 5
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- What truly constitutes preventive services is not well defined and subject to debate – the key issue is filling a care cap by helping people with chronic disease and member engagement in programs designed to help them. History and data shows people will not use programs designed to help them
- A good part of this is addressed by the screening process and the disease management programs that Workforce Health will develop for the City

Encourage Use of Health Coaching Services (does not need to be bargained of not required)

Perceived Impact (1 little 7 large cost impact) 7
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- There must be incentives to use

Pay for Efficiencies (e.g. e-visits, Phone Consults) (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 2
Urgency (2011, 2012, 2013, 2014) 2014
Comments:

- These have not been shown to be cost effective or have widespread acceptance

Promote Patient-Centered Medical Homes (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 2
Urgency (2011, 2012, 2013, 2014) 2014
Comments:

- If well executed and incentives to use are in place this would be very effective this touches on the Accountable Care Organization concept that is part of health care reform. The ACO concept involves providers being paid a fixed fee to manage a population over an episode or care or a continuum of care

Close Maternity Oversight (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 3
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- All plans currently have programs to foster a healthy and term delivery – the key is use and the City should consider and incentives for members to use these programs as federal law precludes them being a requirement

Leverage Health/Productivity Connection (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 4
Urgency (2011, 2012, 2013, 2014) 2013
Comments:

- This is more of a proof of concept and part of ROI in wellness and screening.
- Measures need to be developed and integration with Workers Compensation considered

Disease Management Assessment/Improvements (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 6
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- Part or process with Workforce Health
- Need to put in place ROI measures and outcome measures

P4P (Provider Pay-4-Performance) (does not need to be bargained)
Perceived Impact (1 little 7 large cost impact) 6
Urgency (2011, 2012, 2013, 2014) 2013
Comments:

- Requires a narrow network focused on City
- Carrier programs to broad and not targeted
- Requires access to medical records to judge effectiveness claims data is a measure of activity not outcome for the patient

Narrow Network

Perceived Impact (1 little 7 large cost impact) 7
Urgency (2011, 2012, 2013, 2014) 2013
Comments:

- Some disruption to employees
- A true avenue to cost accountability and partnership with a provider

Dependent Audit (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 4
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- Best practices in place for the future
- High employee noise as process requites marriage and birth certificates on all dependents
- Do we need to audit more tenured employees
- The City currently does this

Medical tourism

Perceived Impact (1 little 7 large cost impact) 2
Urgency (2011, 2012, 2013, 2014) 2013
Comments:

- This is paying for medical procedures that can be performed cheaper overseas
- There are concerns over quality – but more are guaranteeing outcome
- Concerns over shipping dollars outside of the community and US

Centers of Excellence (if mandatory needs to be bargained)

Perceived Impact (1 little 7 large cost impact) 6
Urgency (2011, 2012, 2013, 2014) 2012
Comments:

- Require or encourage that high cost procedures be performed at centers with the best outcomes
- In some cases will require out of state travel
- Currently have been indentified by several carriers such as UHC, Sun Life and others

Selective Contracting by Procedure (needs to be bargained)

Perceived Impact (1 little 7 large cost impact) 4
Urgency (2011, 2012, 2013, 2014) 2011
Comments:

- Bargaining with providers occurs at the procedure level
- Requires access to outcome data which is difficult to obtain and interpret
- Concerns over liability issues to the City as the selection can be construed as a warranty

Integrated Medical Record (does not need to be bargained)

Perceived Impact (1 little 7 large cost impact) 3
Urgency (2011, 2012, 2013, 2014) 2014
Comments:

- Allows for housing of employee health and expense data in one place that is owned by the employee and can be shared with providers
- Only effective if people use it
- May be considered redundant to RHIOs

Glossary of terms

Co-pay: Health insurance plans generally require covered members to pay a portion of the cost of health services. A co-pay represents the fixed dollar amount a covered participant pays when they receive a defined medical service. For example, a covered participant may need to pay $20 for an office visit or $10 for a visit to the chiropractor. The fixed dollar amount is the co-pay

Coinsurance: Health insurance plans cover a defined percentage of the cost of health services. This is referred to as coinsurance. For example the current HMO plan offered to City employees covers most services at 100%. Therefore, the coinsurance is zero for the covered member. The basic health plan pays 80% of certain medical services such as physical therapy and office visits. In this case the coinsurance is 20%.

Consumer Driven Health Plans: Consumer driven health plans (CDHPs) are a somewhat recent development. They involve the use of a high deductible health plan coupled with an account that contains money used at the discretion of the covered participant to pay for defined medical expenses. There are two different kinds of accounts used for these plans. The Health Savings Account was created under the Medicare Modernization Act. This program operates in a fashion similar to a 401K plan. Both the employeer and the employee can place money in the account on a pre tax basis and funds withdrawn are not subject to income tax. The health savings account programs are somewhat inflexible since the federal regulations require very specific plan design requirements. Another account used for a CDHP plan is called a Health Reimbursement Account. Such accounts are made possible by IRS code section 105. These accounts allow more flexibility in their design, but do not allow employee contributions on a pretax basis.

Deductible: Health insurance plans generally require covered members to pay a portion of the cost of health services. A deductible is a defined dollar amount for all medical services in total received by a participant. No services are reimbursed under the plan until that predetermined dollar deductible amount is reached. This is similar to the deductible for auto insurance. For example, if the deductible is $200 the first $200 in covered services would not reimbursed.

EPO: An EPO or Exclusive Provider Option may look identical HMO from the employee's viewpoint. . The difference is that an EPO is self-insured and an HMO is fully insured.

HMO: An HMO or Health Maintenance Organization can be either insurers or a group of healthcare providers. They accept responsibility for a specific set of healthcare benefits offered to customers and provide those benefits through a network of physicians and hospitals. In the past, it was generally accepted that HMOs would be less costly than other health plans due to their focus on health maintenance and limiting the provision of healthcare services to a limited number of providers. Now industry professionals question the ability of HMOs to do a superior job of controlling cost. Today the principal distinctions of an HMO is the requirement that covered participant sees a set group of providers and the benefits provided are typically more generous to the covered participant than the benefits offered under other plans.

In network: Health insurance plans seek to contract with healthcare providers for preferential reimbursement terms. These preferential reimbursement terms result in discounts off of what the provider would normally charge for service. Providers that agree to these preferential reimbursement terms become members of the health insurance plan's "network." Hence, those providers are designated as in network.

Insured: Many health plans may be fully insured. Under a fully insured arrangement a health plan or health insurance company charges a plan sponsor a fixed monthly premium guaranteed for a year in return for providing coverage for a defined group of medical services. If the total value of the services paid on behalf of plan members exceeds the premium the carrier is at risk for funding the difference. If the total value of services paid is less than the

premium the carrier experiences a profit or surplus. Proponents of this approach argue since the carrier or health plan is at risk that they will strive to control costs in order to generate an underwriting surplus. Opponents of this approach argue that carriers have the incentive not to pay for necessary services or if the cost of medical services paid is higher than the premium simply recoup the loss in higher future premiums.

Out-of-pocket costs: Most health insurance plans have coinsurance provisions. Out-of-pocket cost refers to the portion of *covered* medical expenses not reimbursed by the plan that are the responsibility of the covered member. For example if the employee coinsurance is 20% and total charges are $100 the plan will pay $80. The employee employee's out-of-pocket in this example is $20.

Out-of-pocket maximum: Most health insurance plans have coinsurance provisions. These require that employees pay a portion of the *covered* cost of medical services. An out-of-pocket maximum refers to the maximum amount of covered services that a participant must pay before the plan pays 100% of covered services for the balance of the year. For example if the out-of-pocket maximum is $2,000 and the employee coinsurance is 20% once covered expenses under the plan reach $10,000, the 20% share paid by the employee reaches $2,000 and the plan will pay 100% of covered charges for the remainder of the year. Out-of-pocket maximums generally include only employee coinsurance but can also include co-pays and deductibles.

Out of network: Health insurance plans seek to contract with healthcare Providers for preferential reimbursement terms. Providers who decide not to agree to the preferential reimbursement terms for services are not in the health insurance plan network. Hence those providers are referred to as out of network.

PPO: A Preferred Provider Organization (PPO) is established either by a health insurance plan or insurance carrier to obtain preferential pricing terms (discounts) from a group of providers. Providers who agree to these terms are referred to as in network. Those who do not agree to the preferential pricing terms are considered out of network. The design of a PPO plan generally provides more generous benefits to plan participants who seek services from network providers then if they received care from non-network providers. For example, most PPO plans will provide 80% coverage for services received in network and 60% coverage for services received out of network.

Premiums: Under an insured plan, premiums represent the fixed cost the City will pay to the health plan or insurer for each employee covered under the plan. Many times premiums also refer to a portion of the total premium that employees have deducted from their paycheck each pay period for the health plan option they select. Under a self-insured plan an actuary generally determines premiums so that the expenses and the established rates align over time. When setting the premiums for a self-insured plan the actuary will use the same approach that an insurance carrier or health plan would use in setting the rates for an insured program. However, the actuary generally will not add additional charges for profits and other contingencies to the rates.

Self-insured: Today many employers with over 500 employees self-insure their medical insurance plans. Under a self-insured plan the plan sponsor hires an insurance company or an organization that specializes in administering health plans to perform services such as making payments, tracking eligibility and other services necessary to maintain a health insurance plan. The plan sponsor is responsible for providing funding for claims. The plan sponsor no longer has a fixed cost for a predetermined length of time and is responsible for paying whatever the cost of claims are. Proponents of this approach touted the flexibility that the plan sponsor has in the design of the program and can immediately realize the benefit of loss control processes. Opponents of self-insurance argue it exposes the employer to an unnecessary risk.