Controlling Health Care Costs
Results of Oakland Schools Four-Year Plan

October 23, 2009
MASB Presentation
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Today’s Agenda

I. Background
II. Affect of Health Plan Cost Increases On District
III. Oakland Schools Study Process
IV. Oakland Schools New Four-Year Plan
V. Outcome
VI. Board Take Away

Background

- Health care is fastest rising cost component of most developed economies
- Today, health care consumes 16.3% of U.S. GDP and projected to rise to 19.5% by 2017
- U.S. health care system offers access to incredibly sophisticated health care services
- But U.S. spends $650 billion more on health care than expected - about 33% of total – when compared to other countries in Organization for Economic Cooperation and Development (OECD)
Health Care Spending Per Capita


Countries spend more on health care as their wealth increases. Health care spending in the United States is far above the expected level, even after adjusting for relative wealth.

Background

- U.S. employers pay health care cost for employees
- Health plan costs increasing much faster than other prices and state payments to MI K-12 Public Schools
- Everyone wants best health care possible, but rising cost squeezing tight Public School budgets
- Many plans taking action to control cost without changing benefits, but most “low hanging fruit” already picked
- Balance between benefit levels, insurance needs, and plan costs will be different for each employer……many difficult decisions loom

Background

- Today, school districts operate in a difficult environment
  - Public pressure to maintain/increase quality of services
  - Extensive collective bargaining agreements
  - Legal limitations in fact finding process
  - Budget driven by payroll and benefits
  - Caps on revenue increases
  - Rapidly rising health plan costs
- Thirty years of collective bargaining produced high level health benefit plans and bargaining units very focused on maintaining benefit levels
Growth in Health Care Costs vs. Wages

Average percentage increase in health insurance premiums compared to workers’ earnings, 1988-2007

The “Blob” Of Cost Above CPI

Drivers of Cost Increases
- Administrative costs
- New treatment developments
- Aging population continues to require more care
- Direct to consumer drug advertising
- Health status of population (obesity rates)
- Consumer rejection of managed care restraints
- All incentives for providers to provide more treatment
  - Payments based on treatment not outcome
  - Consumers demanding highest level of care
  - Legal climate adds pressure to take action

Source: Kaiser Family Foundation and Health Research and Education Trust
What’s Going On?

"Off hand, I’d say you’re suffering from an arrow through your head. But just to play it safe, I’m ordering a bunch of tests."

Health Plan Cost Structure

Cost savings available in all four areas, but greatest impact on plan cost requires minding P’s and Q’s

Some Drivers of Overhead

- Size of group – larger groups, lower cost per unit
- Level of insurance – higher deductible, lower cost
- Type of vendor – larger carriers with higher overhead burdens than smaller carriers and TPAs
- Number of claims and level of service required
- Number of services purchased – vendors offer a wide range of service levels
- Small groups overhead (under 50) of 25% or more
- Large groups overhead (over 5,000) of 10% or less
- Overhead reduction drives pooling discussion
Some Drivers of Claims

- New treatment developments
- Price increases on existing health care services
- Age of population (older typically require more care)
- Health status of population
- Increased awareness of and use of health care
- Direct to consumer drug advertising
- All incentives for providers to provide more treatment
  - Payments based on treatment not outcome
  - Consumers demanding highest level of care
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Special Challenge

National Survey vs. MI Public Schools

- National Survey

Source: Mercer National Survey of Employer-Sponsored Health Plans - "All Employers" category and MI estimate based on existing client gross cost of medical/Rx
What Drives Cost Difference?
Michigan K-12’s versus Others

- Demographics or health may be a factor
- Effect of provider discounting opportunities
- Level of benefit provided within plans
- Use of wellness and disease management
- Offset of premium cost to employees
- Number of dependents enrolling in plans
- Efficiency of plan funding mechanism

In Five Years - Impact On K-12 Schools
Cost For One Covered Employee Each Year Challenge

Per Employee Annual Healthcare Costs

<table>
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<th>Year</th>
<th>2009</th>
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<th>2011</th>
<th>2012</th>
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Current projected Rochester Schools employee annual cost increasing by noted trend rate

In Five Years - Impact On Employees
Holding Down Take Home Pay

Assumes 2007 average wage at $50,000/year, increased by 3% or 1% each year
Assumes $11,988 health plan cost increasing at 10% or 5% each year
**Oakland Schools**  
*Leadership Direction*

- Employee benefit plans an important element of total compensation
- Need thoughtful balance between take home pay and benefits
- Difficult to actually reduce benefit plan cost, but can try to slow it down  
  
  *We may not be able to stop the rain*  
  *But*  
  *An umbrella will help keep us dry…*  

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**Beginning The Process**

- Reviewed internal staff capabilities, capacity to complete a review, educate constituencies, and implement change  
- Concluded we needed assistance - technical knowledge, benefit plan marketplace, communication experience, and implementation of changes  
- Concluded we wanted any assistance to be provided on a full disclosure and direct fee basis  
- Solicited bids for benefit plan advisor listing specific project activities and timetables  
- Interviewed several vendors and made a selection – McGraw Wentworth
### Our Study Process

- **Data**
  - Gather and summarize plan information, audit plans details, provide benchmark comparisons, measure cost results over time

- **Evaluation**
  - Measure current plan effectiveness, compliance with relevant laws and regulations, internal capabilities

- **General Education**
  - Meet with leadership, community / constituents, and all employees to explain important concepts

- **Employee Input**
  - Open to opportunities for feedback through focus group meetings and surveys

### Our Study Process

- **Vendor Reviews**
  - Meet current vendors to measure ability to deliver needed programs

- **Market Bidding**
  - Bid all programs with all potential vendors to evaluate price / service

- **Report**
  - Concise information with key findings and recommendations for change

- **Decision Support**
  - Develop alternatives plan designs and corresponding financial outcome models to support discussions and decision process with administration and board

- **Implementation**
  - Ensure that any changes negotiated translated into action

- **Follow-Up**
  - Measure results, communicate results, evaluate next steps

### Our Implementation Process

- **Documentation**
  - Written confirmation of all changes to benefit plan designs, employee costs and procedures

- **Timeline**
  - Clear action plan including timetable for completing each step

- **Vendor communication**
  - Written instructions and action to follow changes through completion

- **Agreements and contracts**
  - Vendor contracts gathered to review for accuracy / completeness

- **Compliance**
  - Investigated regulatory and legal to be certain all requirements met

- **Employee Communication**
  - Power point presentations, newsletters, enrollment materials
**Our Implementation Process**

- **Customized Enrollment**: Pre-populated enrollment forms develop for every employees to simplify enrollment process.
- **Group Employee Meetings**: Led by HR staff, with assistance from McGraw Wentworth and vendors.
- **Individual Meetings**: Every employee offered meeting with HR staff member to ensure understanding and respond to questions.
- **Plan Administration**: Specific procedures to gather enrollment, provide enrollment to vendors, adjust payroll, and confirm employee choices.

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Strategic Thought Process

- Both employees and district need a high quality health plan that remains affordable
- Rising cost of health plan threatens employees direct pay increases and district educational service improvements
- Health plan cost primarily driven by use of services determined by individuals and physicians – not our district
- Cost affected by vendor factors that need regular review
- Employee health improvement in everyone’s best interest
- Thoughtful financial incentives help ensure cost considered and upper limits ensure cost not prevent access

Tactics

- **Annual endeavor** - management of health plan as a regular (at least annual) conversation with board and employees
- **Reduce Overhead Cost First** – every plan put out to bid to ensure all controllable cost factors (overhead) managed first
- **Employee Engagement** – provide employees with information about health plan and how they can help
- **Increase Accountability** – modify benefits to encourage thoughtful use of healthcare services, and offer choices
- **Rational Choices** – set employee premiums to reflect benefit levels of plan chosen by employee with all plans “safe”
- **Simplify Choices** – all health plans cover same healthcare services, only difference coverage level

Year One

- Open enrollment July 1
- Change from $5 copay prescriptions
  - To $10 Generic and $20 Brand
  - Mandatory switch to Generic (when available)
- Maintained all current health plan options
- Announced move to January 1 open enrollment
  - Blue Cross and many vendors use calendar year to re-set important plan benefit features
  - Move to January 1 avoided situations where a deductible change could be effective on July 1 and then re-set at January 1
Year Two

- Move to new choice plan with three options
- Base Plan - Community Blue PPO #2 (90% coverage)
  - No cost to employees
- Buy-Up Plan - PPO #1 (100% coverage)
  - Employee pays any premium difference
- H.S.A. Plan - Flexible Blue (high deductible)
  - Employee paid bonus and H.S.A. contribution
- Continue to offer non-standard plans
  - Employees pay any cost difference
- Eliminate CMM and HMO bonus for Employee Premium

Year Three

- Eliminate all non-standard plans except HMO
- Move to new choice plan with three options
- Base Plan - Community Blue PPO #2 (90% coverage)
  - 5% of premium cost to employees
- Buy-Up Plan - PPO #1 (100% coverage)
  - Employee pays any premium difference plus 5%
- H.S.A. Plan - Flexible Blue (high deductible)
  - Employee paid bonus and H.S.A. contribution
- New spousal surcharge if other coverage available
  - 5% of two person premium

Year Four

- Rx plans to $10 generic and $30 brand name copay
- All office visits to $15 copay
- All employee costs to salary based scale
- Base Plan - Community Blue PPO #10 (higher deductible)
  - 10% employee cost, but move to salary based scale
  - 6% to 13% of premium cost to employees (based on pay)
- Buy-Up Plan - PPO #2 (90% coverage)
  - Employee pays any premium difference plus 6% to 13%
- H.S.A. Plan - Flexible Blue (high deductible)
  - Employee paid bonus and H.S.A. contribution
- Spousal surcharge to 10% of two person premium
Annual Review Process

- Regular internal meetings with HR/Finance team to measure progress against overall cost benchmarks
- Regular tracking of claims cost to measure affect of changes to benefit levels
- Regular updates to employees both through employee committee and broader communications (not just at open enrollment)
- Annual presentations to board updating progress
- Take advantage of success both to build stability (risk related activities fund) and modify strategy

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First Outcome - Modifications

- Actual cost results by year three better than anticipated
- Through annual review process able to achieve consensus (with board) to modify year three and four
- Year Three Base Plan
  - Original 5% employee cost held at 2%
  - All buy ups from 2% level
- Year Four
  - Prescription drugs $5 and $30 (not $10 / $30)
  - Hold PPO#12 as base plan (not move to PPO#10)
  - Hold PPO#1 as buy-up plan (not move to PPO#2)
  - Original 10% employee cost held at 3%
  - Salary scale from 2% to 8% of premium
  - Spousal surcharge to 6% (not 10%) of two person cost
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Board Take Away

- Need to learn about health plan issues
  - Understand your district and the alternatives
  - It’s worth a study session
- Develop metrics for annual review
  - Enrollment by plan and status (single, two, family)
  - Claims activity within health plan
  - Overhead cost to operate health plan
  - Annual cost per employee enrolled in health plan
- Regular employee communication and engagement
  - Cost and value of benefits
  - Benefit plan environment at Public Schools and other employers
  - Use of health care services affect on health plan cost
  - Personal health (wellness) affects use of health care services
  - Health care purchase decisions can reduce cost (generic drugs)
**Common Themes**

**Employee Engagement:**
Organizations successfully control cost by helping employees understand how making good decisions are best for them and the organization

- Is role of employee in helping manage plan cost clear?
- Are employees educated about information available and how to make good health decisions?
- Do employees recognize impact of their lifestyle choices on their health status and health care needs?
- Do employees understand how their purchase of health care services directly affects plan cost?
- Does plan design provide an incentive to employees to purchase health care efficiently?

**Culture of Health**

**Create a Culture of Health:**
Organizations successfully control cost by encouraging wellness and care management

- Is wellness participation encouraged through communication or financial incentives?
- Are information resources provided that help employees improve health and use of care?
- Are employees rewarded for achievement of personal health goals?
- Do employees recognize value of personal health and role it plays in success of organization?

**Accountability**

**Increase Accountability:**
Organizations successfully control cost by increasing employee understanding of how health care decisions affect cost of health plan:

- Is true cost of health care visible to employee?
- Are employees accountable for lifestyle decisions that affect their own health and well being?
- Are employees involved in cost of using health care - thoughtful deductibles, coinsurance, and copays?
**Measurement**

**Focus on Plan Data:**
Organizations successfully control cost by studying data in depth and take action based on analysis:

- Is plan design benchmarked to other organizations?
- Is plan spending benchmarked to other organizations?
- Are plan design changes focused on areas where data deviates from benchmarks?
- Have metrics been established that provide specific measurement of anticipated affect of any changes?
- Are results from plan changes analyzed to measure actual effect of plan cost against metrics?

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**Open Minded Skepticism**

**Consider New Ideas Carefully:**
Organizations successfully control cost by being open to and carefully considering new ideas

- Is door open for new ideas?

Are new ideas subject to intensive scrutiny to understand specific impact on your plan and your employees?

- What type of health plans benefit (HMO, PPO, Insured, Self Funded)
- If overhead cost reduced and by what amount and for how long
- If price of health care service lowered, by what amount and could change limit access to health care providers
- If quantity of services lowered, by what amount and could there be any adverse effects on health care quality

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**It’s An Oldie….But A Goodie**

We All Change "X" And We All Save Money

"I think you should be more explicit here in step two."
Questions