CHANGES IN HEALTHCARE YOU NEED TO KNOW!

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DISCUSSION TOPICS

1. Background of Healthcare Landscape in Michigan
2. Challenges in the Current Healthcare System Model
3. PA 202
4. Programs To Change the Healthcare Paradigm
5. Michigan PA 152 update

The Michigan Healthcare Landscape

TODAY

- PA 152 – Helped reduce employer costs by increasing employee co-pays, deductibles and employee premium share
- Medical and drug costs continue to increase beyond the CPI
- So what's next? Do we continue to increase employee out-of-pocket costs?
- Smarter solutions to reduce plan costs; provide better options for employees
- Focus on long-term wellness and encourage healthy living
- PA 202 may force communities to look at more non-conventional ways to reign in healthcare costs

OBSTACLES IN OUR CURRENT HEALTHCARE SYSTEM

Cost & Transparency

- Provider networks do not guarantee high quality or low cost. There is significant variation among in-network fee-for-service pricing for an identical service - as much as 1,500%.
- 53% of patients say they could not pay a $500 medical bill

Access & Convenience

- Long waits to get an appointment
- Long waits upon arrival
- 6-8 minutes with a provider
- Additional trip (or 2) to the pharmacy

Quality

- The US is last in health when compared to 16 other developed nations
- Despite our wealth, Americans live shorter lives and experience more injuries and illnesses than people in other high-income countries

PUBLIC ACT 202

What is this Act and what is required of Michigan public employers?

Determination of Underfunded Status

Determination of Underfunded Status

- The state is required to create an evaluation system to identify underfunded communities and to require communities to submit a corrective action plan
- A local unit is considered underfunded if:
    1. AAL of the retirement health system is less than 40% funded and the ARC contributions were greater than 12% of annual general fund operating revenue
    2. AAL of the pension system is less than 60% funded and the ARC contributions were greater than 10% of annual general fund operating revenue
    3. Local unit fails to submit the annual Retiree Health Care Report to the State
    4. Local unit fails to make the required payments for new employee normal costs or for current retiree premiums

Determination of Underfunded Status

Determination of Underfunded Status

- Local unit may request a waiver from the State. The government's administrative officer and governing body must approve a plan that demonstrates that the underfunded status is being addressed
- State must approve said plan
- If a waiver is not approved, the State would conduct an interview of the local unit's retirement system which could include discussing changes or reforms

Municipal Stability Board

MSB

- Created by the Department of Treasury and has the powers, duties, and functions independent of the State Treasurer
- Board consists of three members, all appointed by the Governor
    1. One member must represent State officials
    2. One member must represent local officials
    3. One member must represent employees and retirees
- The Board will review strategies and assist underfunded local units in developing a corrective action plan
- Board must meet at least quarterly

Corrective Action Plan

Corrective Action Plan

- Every underfunded local unit of government must develop and submit a corrective action plan within 180 days of underfunded status
- The MSB will review and vote on approval of the local unit's plan
- A 45 day extension could be approved if the local unit submits a reasonable draft of a plan
- The corrective action plan should include corrective options that eliminate underfunded status. If the MSB does not approve of the final plan, they have 15 days to notify the local unit and provide a report detailing reasons for disapproval
- The local unit will then have 60 days to address and resubmit. The local unit has 180 days after approval of a plan to implement and achieve the necessary cost reductions to permanently correct its underfunded status

Corrective Options

Corrective Options

- Vague information, although the Act provides a few examples of corrective actions (not limited to)
    1. Pension – Close the db plan, implement a multiplier limit, reduce or eliminate new accrued benefits, and implement FAC standards
    2. Healthcare – require cost sharing of premiums and sufficient copays, capping employer costs
- It is our professional belief that it will be necessary for local units to assemble a team to effectively create a corrective action plan and monetize plan cost reductions

Programs That Impact Underlying Costs

"The government's administrative officer and governing body must approve a plan that demonstrates that the underfunded status is being addressed "

How will the Municipal Stability Board determine whether "a plan" meets the legislative intent of PA 202?

Moreover, how will you as an employer maintain competitive plans that are cost effective and sustainable?

Whether you are fully -insured or self-insured you are subject to the underlying forces in the market. Unless you understand these forces, you will continue to experience healthcare cost increases inherent within the market.

Innovative Programs that reduce costs without passing more costs to employees/retirees:

1. Pharmacy programs- *Force Transparency; Reduce Hidden Fees*
2. Health & Wellness- *Impact High Cost Chronic Conditions*
3. Direct Contracting programs- *Demand better pricing*
4. Consortium- *Harness the Purchasing Power of Multiple Employer Groups*

Pharmacy Programs

- Transparent Pricing
- Pharmacogenomics
- Specialty Drugs

Transparent Prescription Drug Plans

1. Scrutinize your Pharmacy Benefit Management (PBM) contracts
   - ✓ AWP minus
   - ✓ WAC plus
   - ✓ Spread

2. “Acquisition Cost” models

3. Develop a plan to control “specialty” drug spend

4. Investigate and Challenge the status quo

Know Your PBM Price Model

- PBMs are constantly changing antiquated reimbursement strategies like MAC, WAC Plus or AWP Minus pricing methodologies
- A PBM may define a “guarantee” but won’t disclose all the monies retained (I.e. “spread”)

  Example:

  PBM Contract with Employer: AWP- 15% Brand; AWP-70% Generic

  PBM Contract with Pharmacy: AWP- 17% Brand; AWP-75 Generic

  For a generic drug with an AWP of $100 then the PBM bills the employer $30 ($100 minus 70%) while paying the pharmacy $25 ($100 minus 75%), effectively retaining $5

- A PBM may allow higher rebate drugs determine “formulary status”. If so, are all rebates passed on to the employer?

Acquisition Cost Models

- Unlike PBM's, a transparent pricing model provides payors with the assurance that what is billed to them is what was paid to the pharmacy.
- The solution, a reimbursement index that accounts for drug acquisition cost in combination with real time product availability in the marketplace.
- Put emphasis where it should be, out of the PBM and back into the pharmacy to offer the best point of care for members
- Use a model that receives electronic feeds from wholesalers and pharmacies and calculates reimbursements based off of acquisition price and availability and, is then regenerated every 24 hours

Pharmacogenomics

- Three types of genetic tests in the market today
    1. 23 and me (ancestry/heritage)
    2. Predisposition testing like BRCA 1 and BRCA 2
    3. Pharmacogenomics
- Landscape - $418 billion annually in pharmacy waste, according to Express Scripts
- Today FDA trials include small sample sizes – consumers are the “guinea pigs” of the pharmaceutical market
- Pharmacogenomics is the science of testing an individual’s unique gene structure to determine safe medication treatments
- Side effects or benign results exist today because each individual metabolizes and absorbs medications differently based on unique genes

Pharmacogenomics

- The FDA has begun publishing pharmacogenomic details on over 150 prescriptions to individuals with mutated gene structures
- Process – physician orders a pharmacogenomic test from a lab (several exist), a member provides saliva sample to the lab and results are sent back to the physician
- Customized member report includes an in-depth profile of unique genes and any potential abnormalities that could impact metabolism and absorption
- Members are protected by GINA to ensure employers and health insurers cannot use this information for punitive actions
- Through retrospective drug utilization reviews (RDUR) offer to clients a pharmacogenomic test and give employees an opportunity to voluntarily participate

Specialty Medications

- High-cost specialty drugs are rising, often representing 30% plus of a group's overall drug spend
- Patient Assistance Programs- licensed clinical staff monitors the status of all cost containment cases and tracks the confirmation of approval
- Targeted "treatment cost containment solutions" for members suffering from Hepatitis C and other conditions like rheumatoid arthritis, colitis, Crohn's, multiple sclerosis and more
- Medical Tourism

Employer Health and Wellness Centers

CHANGING THE HEALTHCARE PARADIGM

Breaking Barriers to Revolutionize Healthcare

Traditional Healthcare Model

- Fee - For Service
  - Incentivizes quantity of services/visits
  - Double/Triple booking appointments
  - Lack of pricing transparency
- Prevention & Wellness
  - Reactive model
  - Focus is on participation
- Management of Patient Health
  - Focus is short term cost reduction
  - Minimal health metrics measurements
- Patient Engagement
  - Depends on patient reaching out
  - Engaged when needed for intervention

Direct Contract Model

- Transparent – Pass-through
  - Single visit appointment slots
  - Operating costs are a pass through/No mark-up
- Focus is on disease prevention
  - Proactive Wellness model
  - Outcomes based prescriptive approach
- Meaningful Population Health Management
  - Robust analytic engine; predictive ability
  - Isolates chronic disease in employees
- Available and accessible
  - 24/7 Support Center
  - Mobile outreach - CareHere! Connect

Opportunity

- On-site employee/dependent health and wellness centers are becoming more prevalent in the public sector
    - **Centers can assist in the reduction of health plan costs to employers and reduce out of pocket expenses to employees/dependents**
- Typically these centers focus on providing primary care initially and increase to providing Wellness, Disease Management and some Occupational Health and Workers Comp related triage

What is an Employee Health and Wellness Center?

- Convenient, exclusive health care center for eligible members (employees, in-area non-Medicare retirees, dependents)
    - **Not available for public use**
- Provides primary care, acute & episodic care, Rx dispensary, wellness coaching and chronic condition management
- Employees will be able to pick up most prescriptions at the center (up to a 90 day supply)
- Center can conduct pre and post employment screening
- Can become the “hub” for delivering wellness initiatives and introducing future healthcare services
- Co-exists with current insurance plans

Why Health and Wellness Center Collaborations Work

- Shared use increases economies of scale
- Overhead spread among more parties reduce expense to all
- More appointment slots for everyone to use
- Extended hours or Saturday hours become available
- Greater selection & retention of providers
- Everyone pays their fair share of appointments and expenses
- Operational functions reach their maximum efficiency
- More medications can be stocked and replenished
- Additional services or equipment is more easily introduced

Health & Wellness Center Collaborations

Calhoun County & Battle Creek Collaborative

Calhoun County | Musashi | City of Battle Creek | Systex

Toyota Tsusho

MiLife Collaborative

City of Ferndale | City of Hazel Park | City of Oak Park | City of Royal Oak

City of Madison Heights

Georgetown Area Collaborative

City of Georgetown | Green Metals | TLD Logistics | Toyota Tshusho

Other Health & Wellness Centers

Anderson County | City of Columbia | City of Kingsport | City of Bristol

City of Bowling Green

How are Savings Achieved?

- Reduced Professional Costs

    1. **Staff is hired by a professional third party management firm.**

    2. **Staff is paid an hourly wage for their services. No PPO fee schedules or "fee for service" reimbursement model to deal with. Flat rates.**

- Greater Efficiency/Transparency

    1. **Providers can provide longer appointments and make the same or better income. Savings from efficiency is passed on.**

    2. **All supplies, labs and office costs are purchased through large national contracts and are passed on "at cost"--- no up-charges**

How are Savings Achieved?

- Reduced Prescription Costs

    1. **No pharmacy dispensing fees and approximately 50% savings on medication dispensed at the health center. Supplies reflect 30-40% savings over retail.**

- Reduced Lab Costs

    1. **Depending on PPO and insurance fee schedules, lab tests often impose a 60-80% markup. These additional costs are eliminated**

- Identify early and impact chronic/pre-chronic conditions sooner (Wellness Savings!)

    1. **Forty to fifty percent of your healthcare costs come from ten to twenty percent of your employee/retiree population**

MANAGEMENT COMPANY SERVICES

Medical & Health Services

- Primary Care
- Acute Care
- Episodic Care
- Patient Medication Adherence
- Pharmaceutical Dispensary
- Mail Order Medication
- Immunizations
- Sports Physicals
- Plan of Care Compliance

Staffing

- Staffing
- Wellness Coaches
- Accounting
- Training
- Pharmacist
- Director of Clinic/ Client Operations
- Care Coordinator/Case Manager
- Medical Staff Management
- Medical Provider Management
- Medical Provider Recruitment
- Medical Staff Recruitment
- Medical Malpractice Insurance

Wellness

- Case Management
- Weight Management
- Hypertension Management
- Addiction Intervention
- Pre-Diabetes Management Lipid Management
- Nutritional Counseling
- Plan of Care Compliance
- Mental Health Management
- Disease Management
- Stress Management
- Tobacco Cessation
- Exercise Adherence
- Cardiovascular Risk Reduction
- Health Risk Assessment/30 Panel Biometric Blood Draw

Technology

- Electronic Medical Record
- CareHere Connect
- Information Technology
- Online Appointment Scheduler
- Smartphone Application
- EMR Access & Integration with Outside Specialist/PCP/ER

Clinical Outcome Services

- Self-Care Education Tools
- Reporting
- Purchasing Coordination
- Clinic Inventory Management
- Patient Survey Feedback
- Clinic Best Practices Sharing
- ROI Analysis Budget Adherence

Support Services

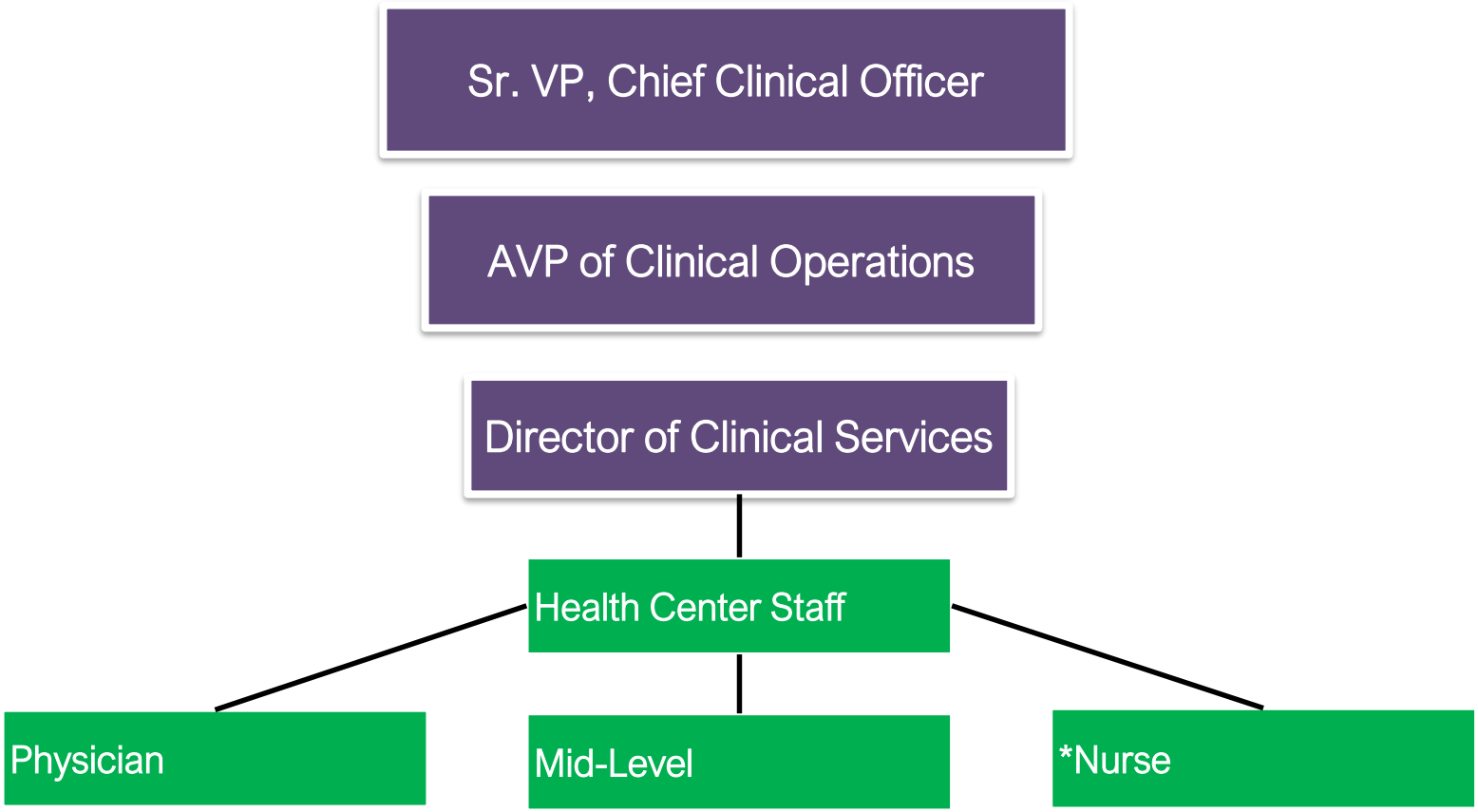
- 24/7 Call-Center
- 1-800 Customer Support
- Education Tools
- Marketing
- Information Technology Support
- HRA Employee Events

ON-SITE MEDICATION MANAGEMENT

Breaking Barriers to Revolutionize Healthcare

ACCOUNT MANAGEMENT / STAFFING

Breaking Barriers to Revolutionize Healthcare



*The nurse hours also to include care coordination and health education and administrative duties

OCC. HEALTH AND WORKERS' COMP.

Breaking Barriers to Revolutionize Healthcare

Occupational Health

- Pre-Employment Services
- DOT Physicals
- Random Drug Testing Program
- Assist with Job Placement
- Hearing Conservation Program Management
- Annual Fit for Duty (FFD) Exams
- Case Management (On-Site)
- Respiratory Fit Testing
- Spirometry Testing (Pulmonary Function Testing)
- EKG Testing
- HazMat Physicals
- Lift Testing
- Breath Alcohol Testing (BAT)

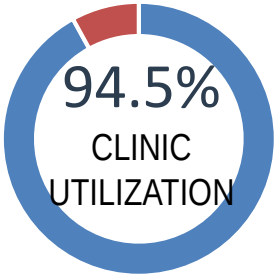
Workers' Compensation

- Medical Management of Work Related Injuries/Illnesses
- Ergonomic Job Analysis
- Coordination of Care/Collaborative Model
- Maintain Productivity
- Restriction of Work vs. Disability
- Integrated Disability Case Management: Systems Approach
- Understand Workplace Culture
- Negotiate & Manage Referrals
- Disability Management
- Ergonomics Job Analysis
- On-Site/Near-Site Physical Therapy
- Understanding Clients Environment
- Control Costs
- Preserve Patient Satisfaction

CLINICAL OUTCOMES

City Government: 850 employees
Reporting Period: 12-month period between 7/1/2014 and 6/30/2015

CLINIC ACTIVITY

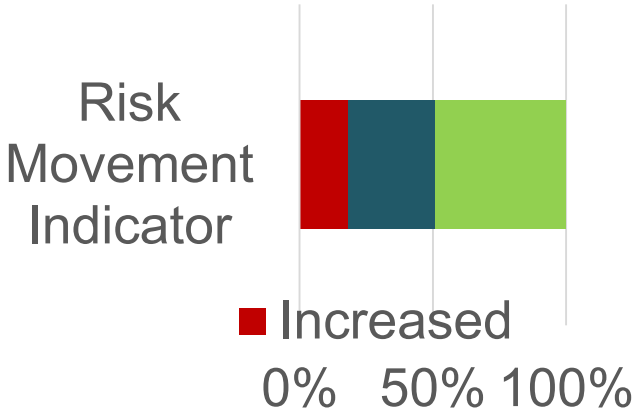


10,078
VISITS IN REPORTING PERIOD

1,270
UNIQUE PATIENTS

97%
OF EES VISITED THE HEALTH CENTER

CLINICAL OUTCOMES



82%
OF HRA PARTICIPANTS MAINTAINED OR DECREASED HEALTH RISK FACTORS

78%
OF EMPLOYEES RECEIVED HRA

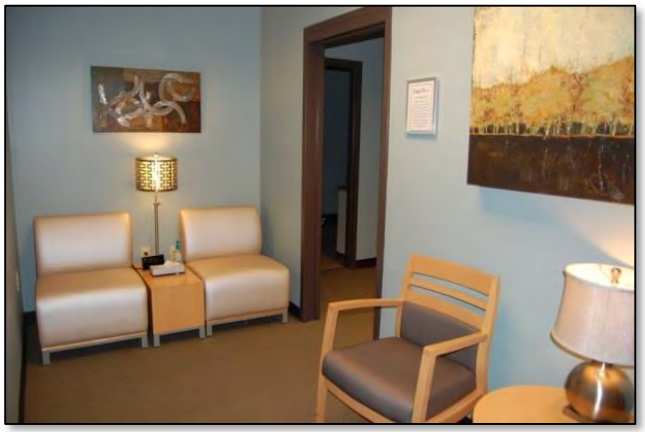
$11,772,689
IN POTENTIAL SAVINGS FROM EARLY DETECTION OF 5 RISK CONDITIONS

FINANCIAL OUTCOMES

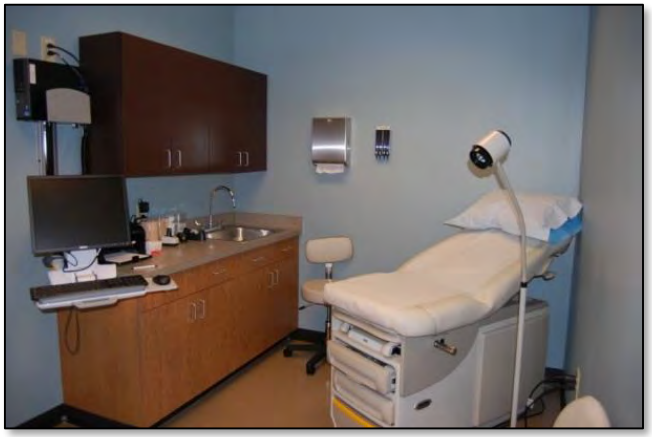
$708,737
OFFICE VISIT SAVINGS

$2,366,922
TREND SAVINGS

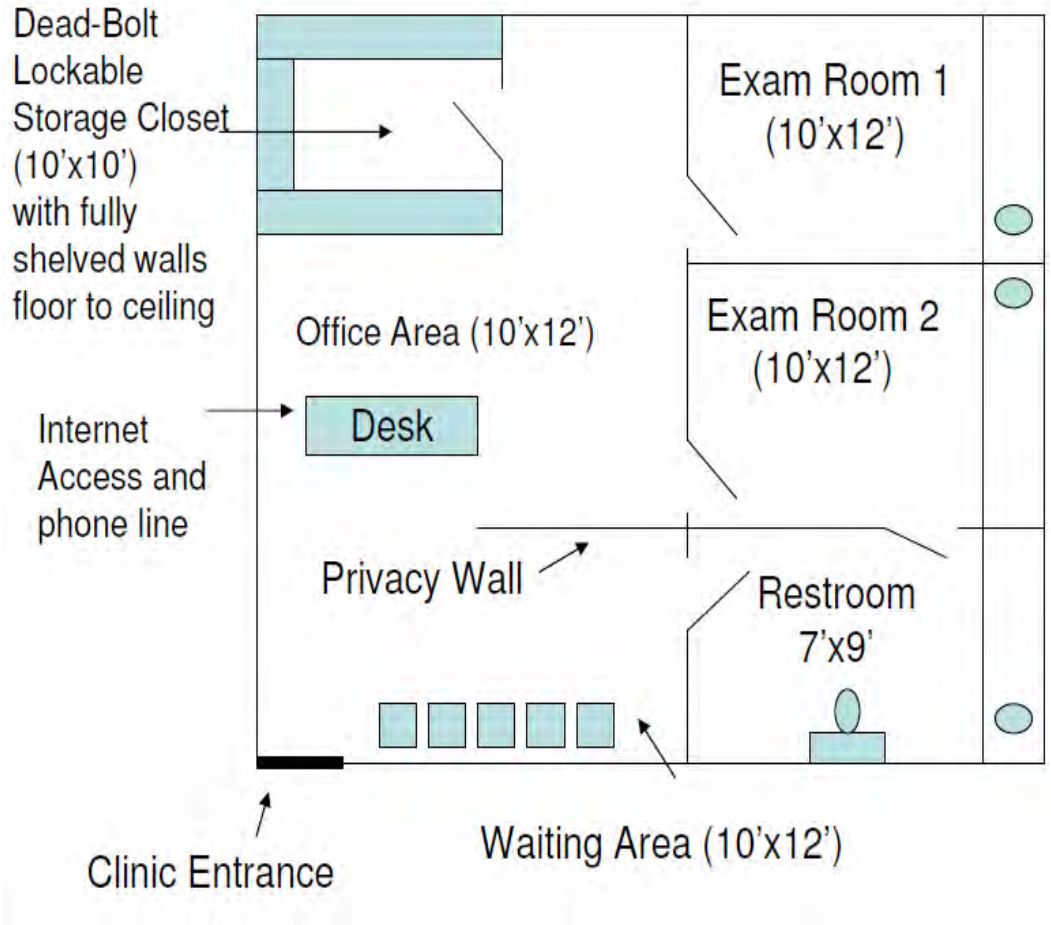
SAMPLE HEALTH CENTER LAYOUT



Waiting Room



Exam Room



Direct Contracting

Custom Networks

Bundled Care Services

Problem – Trend impact on medical spend and what needs to happen

- Bend the cost curve
- True Control of Network and Plan Design = Patient satisfaction + Financial performance
- True transparency of data – manage what you measure

What Needs To Happen?

- Bend the cost curve.
- True Control of Network and Plan Design = Patient satisfaction + Financial performance
- True transparency of data – manage what you measure.

What is a Custom Network?

- Employer works with consultants to build a network
- Providers chosen specifically by (for) our employees
- Selection based on preference/costs/experience (data)
- Class leading discounts and performance with steerage
- Direct provider contracts based on Medicare methodology
- Network calibrated to match plan design (and vice versa)
- Very limited amount of disruption

Benefits to Providers

- Equitable reimbursement from employers
- Straight forward direct contracting
- Steerage/Preference for HPN providers
- Reduced patient financial liability/responsibility
- Timely payment
- Easy to model/understand contracts that auto renew
- Provider inclusiveness in the process – Employer, Health Plan design

Bundled Care Services

- Focus on high cost procedures (Top 400)
- Negotiate direct with outpatient centers
- Emphasize “quality of care”
- Incentivize employees to choose “preferred” centers
- Service will co-exist with current BUCA plan
- Medical Tourism- lower administrative costs; lower cost of labor; cost of travel covered

Latest Developments- Consortium Model

Latest Developments

The Ohio consortium is currently in the approval process to enter the Michigan market

- Existing consortium (over 30 years in existence) of over 300 public sector plan sponsors with over $130 million in assets within reserve.
- Current consortium composition – 60% OH schools and 40% OH municipal
- Self funded model, with risk sharing. Each employer group (or sub pool if small groups) has its own reserve
- Due to self funded nature, doesn't fit into PA 106 "box" and therefore needs to consider alternative avenue for approval
- Intention is to combine Michigan risk with the existing Ohio risk/50,000 members currently covered
- **Currently pushing for approval from the Governor's office (legal counsel) and subsequent support through an Attorney General 's opinion**

Public Act 152 Update

Update

- Shelby Township's Command officers filed a ULP against the Township in 2012 regarding it's application of PA 152
- Union grieved that the Township shouldn't have used "blended" BCBSM rates for 80/20 calculations and also that the union had the right to negotiate the amount of their share as long as the Township paid no more than 80% across its entire group
- Appealed by the Township to a MERC panel, then the Appeals Court, and finally the State Supreme Court
- The Supreme Court tied 3-3 (one recusal), so the case went down to the Appellate Court but that decision wasn't published. Therefore, MERC opinion stands

Update

- The Township was ordered to negotiate the amount of contribution with each union as a mandatory subject of bargaining
- Can no longer use “blended” carrier (BCBSM) rates
- How does this impact individual groups? Speak with your attorneys
- BCBSM is creating a tool for consultants that will convert their blended rates to unblended factors/rates. Our assessment is that the mechanics of this tool do not meet the spirit or letter of the order. Blue is rolling out sometime early in 2018

QUESTIONS & DISCUSSION