Delaware Valley Health Trust

Near-Site Health and Wellness Center
RFP Process and Overview

Presented to:

agrip
ASSOCIATION OF GOVERNMENTAL RISK POOLS

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What Today’s Presentation Will Cover

- Review the factors which led the Delaware Valley Health Trust (DVHT) to open a pool-owned “near-site” health clinic
- Discuss some of the execution risks considered by DVHT before opening the clinic
- Outline key aspects of the RFP process
- Consider the “lessons learned” through the RFP and implementation process
- Highlight preliminary results
What is DVHT?

- Self-insured risk pool serving Municipalities, School Districts, Counties, and Authorities throughout the State of Pennsylvania and Delaware

- Endorsed programs for County Commissioners Association of PA (CCAP) and PA Municipal Authorities Association (PMAA)

- Formed in 1999 under the PA Intergovernmental Cooperation Law

- Third insurance trust formed by SEPA municipalities (Property and Casualty Trust in 1989 and Workers’ Compensation in 1992)

- Now covers 128 public entities with 7,800 employee lives (over 20,000 member lives)

- Opened *Delaware Valley Health Trust Center* in December 2015
WHY CREATE AN “ON-SITE OR NEAR-SITE” HEALTH AND WELLNESS CENTER?
Unsustainable Trajectory of Health Insurance Costs

Cumulative Increases in Health Insurance and Contributions, Inflation, and Earnings 1999-2014

DVHT Not Immune to the “Macro” Factors Driving Health Care Costs

- Aging Population
  - 2.5-3% higher medical costs—incidence of disability increases every year over age 40
- Advanced Medical Technology
- Increased Demand for Services
- Waste, Fraud, and Abuse
- Lifestyle Behaviors
- Chronic Disease
  - Typically account for 50-55% of costs
- Return of hyper-inflation in prescription drug costs
  - Drug trend and utilization
  - Expansion of very expensive “Specialty” Medication Channel
    - Specialty drug costs now account for 10-15% of typical plan sponsor rx costs—projected to increase to as much as 50% in five years
- Provider Consolidation
- Fee for Service reimbursement system
- Affordable Care Act
  - Benefit mandates
  - Taxes/fees
  - Plan Administration
DVHT Specific Factors for Considering a Clinic to Address Rising Health Care Costs

- Extremely Rich Plan Designs
  - Medical cost sharing (plan design) 4.4% of costs vs. benchmark of 14.5%
  - Pharmacy cost sharing (copayments) 10% vs. public employer benchmark of 15-18%

- Very slow pace of change due to collective bargaining and interest arbitration
  - Nearly all of the normal cost containment “tools” must be negotiated

- Low (if any) employee contribution levels

- Sub-Par member engagement and a strong entitlement mentality
  - Robust (voluntary) Member Wellness Initiative ROI elusive

- DVHT has successfully leveraged administrative expense savings to lowest possible level (7.5%)
  - Includes claims and Pool administration
  - Reinsurance
  - ACA
  - Wellness/Value Added services
  - Trust Center
Typical Plan Sponsor Approach to Managing Health Care Costs

**Claim Costs**
- 80-85% of costs
- Provider discounts
- Network utilization

**Utilization**
- Frequency
- Plan Design
- Utilization Review

**Health Care Costs**

**Care Management**
- Identify High Risk EEs/Dependents
- Manage High Risks
- Prevent/reduce Risks

**Fixed Costs**
- Administration
- Risk Charges
- Profit
- Commissions
Components of Individual Health:
Holistic View

- Health care and access to care: 10%
- Environment: 20%
- Lifestyle/Behavior: 50%
- Genetics: 20%

Source: University of California @ San Francisco 2000 Blue Sky Initiative
Disproportionate Distribution of Risk
(Percentage of Claimants by Claim Dollar Range)

*Claim Dollar Ranges*

- Under $1,000: 54.1%
- $1,000-$9,999: 37.2%
- $10,000-$49,999: 7.4%
- $50,000+: 1.3%

*Percentage of Paid Claims/(Prior Year)*

- Under $1,000: 4.4%/4.5%
- $1,000-$9,999: 27.6%/27.5%
- $10,000-$49,999: 35.3%/31%
- $50,000+: 32.7%/37%

**Conclusion:** 8.7% account for 68% of claims

**Notes:**
- Current year data reflects 2014 complete plan year as presented in 2015
- Percentages reflect rounding
LEVERAGING POOLED MEMBERSHIP TO ADDRESS THE COST OF CARE
How does a Health and Wellness Center Help Reduce Health Benefit Costs?

• Reduce medical claim costs by moving away from fee for service model

• Develop trusted relationship with primary care provider/improve engagement

• Emphasis on wellness and managing chronically ill population

• A way to achieve cost savings without creating gaps in care or creating barriers to treatment

• Significant reduction in RX costs
  – Cost savings on prescription drugs
  – Higher conversion rate to generic drugs
  – Better compliance with treatment regimen

The Health and Wellness Center is not a “silver bullet.” Controlling health care costs will require efforts on many fronts. It is, however, a cost effective way to maximize savings with immediate results.
Will it Work?
DVHT Specific Concerns

Achieving savings and return on investment will be driven by participation levels. Making sure we understand the obstacles and select a partner with a plan to best address these obstacles is critical.

- A universe of potential participants comprised of 3,191 employees from 17 different employers (reflects total employee lives living or working within 10 miles of Center)

- Communicating effectively with a disparate population while relying on HR contacts and management

- Savings/Return on Investment phased in over first 3 years

- Extremely rich benefit levels-minimizes the copay savings normally driving participation

- Developing trust

- Significant union population (primarily police and public works)

- Other institutional concerns
# Key Project Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Project Milestone</th>
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<tbody>
<tr>
<td>01/21/2015</td>
<td>RFP distributed to qualified vendors</td>
</tr>
<tr>
<td>01/28/2015</td>
<td>Meeting held with architect to review plans</td>
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<tr>
<td>01/30/2015</td>
<td>Vendor questions received</td>
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<tr>
<td>02/03/2015</td>
<td>Architect drawings distributed for vendor comment</td>
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<tr>
<td>02/09/2015</td>
<td>Initial response to Q&amp;A released to vendors</td>
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<tr>
<td>02/11/2015</td>
<td>Architectural responses from vendors received</td>
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<tr>
<td>02/12/2015</td>
<td>Distributed comments from bidders re: building plans</td>
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<tr>
<td>02/26/2015</td>
<td>Proposals received</td>
</tr>
<tr>
<td>03/06/2015</td>
<td>Follow-up discussion held with architects</td>
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<tr>
<td>04/07/2015</td>
<td>RFP analysis presented to DVHT Executive Committee/Finalists selected</td>
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<tr>
<td>04/08/2015</td>
<td>Finalist presentations</td>
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<tr>
<td>05/06/2015</td>
<td>Selection of CareHere! to operate DVHT “Center”</td>
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<tr>
<td>09/01/2015</td>
<td>Projected Opening of Center* (physical space was completed on schedule)</td>
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<tr>
<td>12/07/2015</td>
<td>Actual Opening of Center</td>
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RFP Process

• Began by getting input and buy-in from key stakeholders
  — Presentations providing overview of on-site health model to Executive Committee, HR managers and key employers (large and local)

• Developed comprehensive RFP

• Identified potential partners
  — On-site clinic operators
  — Local hospital systems
  — Urgent care providers
  — Others

• Analyzed proposals and presented results and recommendations to Executive Committee and Pool Management staff

• Finalists selected

• Finalist presentations to Executive Committee, Trust Management, and Advisors

• Additional Financial/ROI Analysis

• Selected CareHere! as partner
Finalist Presentations
Conducted April 8, 2015

Outline of Agenda:
- Introductions
- Overview/presentation
- What makes your company the best partner for DVHT?
- How does HWC reduce costs?
- How do you drive participation?
- How do you measure ROI?
- Q&A (at least 20 minutes)

Key Issues:
- How do we reconcile large variance in cost projections?
- Which staffing model is most appropriate for DVHT start-up recognizing cost of staffing?
- Who can best “sell” the concept to DVHT employees?
- Who is best equipped to manage expansion?
Key Selection Criteria

- **General Vendor Analysis**
  - Qualifications/Experience
  - Legal Requirements
  - Compliance
  - Account Management
  - Implementation Plan
  - Scope of Services
  - Integration with DVHT Providers
  - Reporting
  - Communications
  - Performance Guarantees

- **Financial Analysis**
  - Administrative Fees
  - Transparency of Fees
  - Savings Projections
  - Utilization Projections
  - Staffing Model/Scalability
  - Primary Care Costs
  - Pharmacy Costs
  - Return on Investment Projection

- **Technical Criteria**
- **Management Criteria**
- **Other Criteria**
  - Pharmacy Philosophy
  - Existing PA Footprint
  - Cultural Compatibility
  - References
Lessons Learned

1. **Time Frame (start early and anticipate things you can’t control):**
   - Contract negotiations
   - Provider recruitment and notification

2. **Selection of a Clinic Operator is Just the Beginning**
   - Implementation and management requires interdisciplinary Pool staff
   - Pool medical staff have to be reminded to avoid the temptation of being too directly involved
   - What’s in a name?

3. **Special Handling Required**
   - Access for members with HSA plans
   - Referral process for capitated products
   - Support from health insurance partner required
   - Billing “pass through” RX costs for members with carve-out PBM
Lessons Learned

4. Meetings Matter and Member Communications Critical
   — Significant commitment of staff time
   — Customizing communications for your audience

5. Define Organizational Reporting Requirements
   — Billing/finance
   — Pass through costs
   — Contract enforcement
   — Utilization

6. Cost Offsets
   — Rx reimbursement for pass-through members
   — Capitation payments for members selecting center as PCP

7. Clinic Manager: the linchpin between Pool and company operating the Center. Critical to success in variety of ways.
Results

After two months, It’s premature to say, BUT…

• Program has received overwhelmingly positive reception from:
  — Members during orientation meetings
  — Members using center
  — “When can we have one at our township?!?”

• Opened with reduced capacity (1 full time doctor) and in early December
  — Trust Center averaging 62 physician visits per week
  — 30 different member entities have had at least one employee access the Center (some traveling 20+ miles to Center)
  — Members already making Center physicians their Primary Care Physician
  — Hours, accessibility, and ease of scheduling are very popular

• Several “high risk” cases already under management
  — 72 members have completed a physician administered Health Risk Assessment
  — Top 20 diagnosis include:
    - High Cholesterol
    - High Blood Pressure
    - Diabetes
Results (continued)

• Prescription Drug (Generic) Savings estimated at 50%
  — $39.56/rx plan savings
  — $14.95/rx member savings

• Center and the near-site model have proven to be an excellent marketing and (we expect) a group-retention tool
  — Also DVHT management team credited with forward thinking and tackling the problem of increasing health care costs

• Tempered savings projections provide “breathing space” for Center to realize potential

• Execution has not been flawless but transition issues have been manageable
Questions?

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