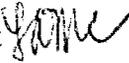


**MEMORANDUM**

February 7, 2012

TO: Health and Human Services Committee  
Government Operations and Fiscal Policy Committee

FROM: Linda McMillan, Senior Legislative Analyst 

SUBJECT: **Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs**

On December 6, 2011 the Council received a presentation from the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs. The Task Force was established by County Council Resolution 17-107 and included members representing the county and bi-county agencies, collective bargaining organizations, and public-at-large. A copy of the report is attached at ©1-82. Appendices to the report are available at: <http://www.montgomerycountymd.gov/csltmpl.asp?url=/content/council/WGITF/index.asp> An Executive Summary is included at ©6-10.

At this session, the joint Committee will have an opportunity to: (1) review the recommendations of the Task Force on employee wellness, disease management, and the potential for consolidation; (2) consider Council staff recommendations on ways to move forward with certain recommendations in the report, (3) determine whether the joint Committee wants to forward recommendations to the full Council, and (4) review additional analysis of the proposal from Kaiser that suggested \$27 million could be saved across all the agencies if Kaiser is the only HMO offering.

The Task Force report included the following points that the joint Committee may want to consider as it reviews and discusses the specific recommendations:

- The county and bi-county agencies are responsible for providing health insurance coverage for over 100,000 people when all enrolled members are included. The Task Force encourages the county to use this buying power. (©16-17)

- As a general rule, 80% of health care dollars are spent on 20% of enrolled members. Nationally, about 85% of health care dollars are spent on people with chronic conditions. (©26)
- The FY12 budgets for the county-funded agencies (County Government, Public Schools, and College) for agency group insurance for employees and retirees is \$389 million. (©17)
- The vast majority of spending is for reimbursement of claims. MCPS and County Government, which account for most health care spending, spend only 4½% and 6% on plan administration and stop-loss fees. (©27)
- There are no simple solutions to bending the health care cost curve. Improvements will take time and may require up-front investment. However, the Task Force reviewed the experience of employers that have implemented programs that have been evaluated and shown positive health results and documented savings. (©36-38)
- Efforts must be evaluated. Oversight and evaluation require regular cross-agency data collection and analysis of health care trends for enrolled members. (©28)

### **Employee Wellness Programs**

The following provides a summary of the recommendations regarding employee wellness programs. **The Task Force defined employee wellness as programs that are broadly promoted and targeted to keeping healthy people healthy and address health risk factors that have not yet developed into serious illness.**

#### **Overall Goal**

All five agencies should develop and implement employee wellness programs, working within the collective bargaining process as applicable. Employees should take an active role in their health by partnering with their employer in management and monitoring of their health outcomes. While any plan for employee wellness may begin by focusing on employees, long-term plans should look at ways to include employees, retirees, their spouses/partners, and dependents.

#### **Task Force Recommendations**

1. Create an organizational culture about wellness and make sure that management is providing leadership in this area. As a part of this recommendation, the Wellness Committee recommends that each of the agencies establish a health and wellness workgroup that includes represented employees, non-represented employees, and employer representatives. Creating a strong organizational culture around wellness requires investment. Each of the agencies should have an

individual who has primary responsibility for developing and implementing the wellness program. (©30-32)

2. Employee wellness programs should have goals, outcomes, and incentives in order to increase participation. (©32)

3. Employee wellness should look at a broad range of issues, including exercise/activity levels, weight, smoking, nutrition, and short-term mental health supports like those provided through employee assistance programs. (©32)

4. Increasing employee awareness through ongoing communication and reinforcement of the goals and availability of wellness programs is critical. (©33)

5. Health risk assessments may be an important tool for employee wellness programs, but there are many outstanding questions that must be answered before any decision is made whether or how they should be implemented. The key question is “What is the purpose of the health risk assessment?” With regard to voluntary employee wellness activities, is an HRA necessary, or should just the health information associated with the goals of the activity (such as having weigh-ins for weight loss programs) be obtained? (©33-34)

6. The agencies should review the standards that are used by accreditation organizations like the National Council on Quality Assurance (NCQA) to see if they can help in the development of employee wellness programs or the selection of health plans that will improve health outcomes. (©34)

### **Council Staff Recommendations for Action on Employee Wellness**

1. Request information from the agencies regarding the current resources that are allocated to their employee wellness/health promotion programs. The information should address:

- a. Whether the agency has a person who has primary responsibility for developing and implementing the wellness program (Wellness Program recommendation #1);
- b. The estimated annual cost of the program and the source or sources of funding;
- c. How often the agencies communicate with employees and retirees about wellness opportunities (Wellness Program recommendation #4); and,
- d. Whether the information is provided electronically or through mail or paper distribution.

Information should be provided by March 30<sup>th</sup> so that the joint Committee may review it during budget worksessions.

The Task Force report highlights some of the employee wellness efforts that have been undertaken by the agencies. MCPS and Montgomery College have easily accessible web-based information on employee wellness programs while Montgomery County Government’s Health Yourself program has been reduced over the past few years. The most recent MCPS Well Aware newsletter is attached at ©96-99. In his comments provided as follow-up to the December 6 Task Force presentation, Mr. Israel of MCEA highlights the efforts of MCPS to implement

employee wellness and health promotion programs (©90-95). Most recently, MCPS and Kaiser issued a press release regarding the results of the “MCPS on the Move” program (©100-101).

Council staff believes that making sure each of the agencies has sufficient resources and a process for communicating with employees about existing wellness information and programs is an important first step and should be addressed before the joint Committee looks at how programs might be enhanced in agencies. For example, there are discounts and programs already offered through current plans and Council staff believes that access to easy information about what already exists is uneven across the agencies. The use of web-based information and electronic newsletters should minimize costs. Regular communication is also critical to building a culture of wellness that is a part of the Task Force recommendations.

### **Disease Management Programs**

The following provides a summary of the recommendations regarding disease management. **The Task Force defined disease management as programs to help employees and dependents with chronic conditions. Disease management is a system of coordinated communications and intervention supports that serves a specific population, includes physicians and other health care providers, uses an evidenced-based plan of care, includes patient self-management education, emphasizes prevention, and measures outcomes.**

#### **Overall Goal**

The agencies should enhance current disease management programs to increase participation, make sure they are based on best practices, and have regular reporting on outcomes in order to improve the health of employees, spouses/partners, and dependents with one or more chronic conditions and reduce the number of employees who develop chronic diseases in the future.

#### **Task Force Recommendations**

1. The agencies should expand the current conversation about disease management to include not only members and plan providers but also doctors, hospitals, and pharmacists. (©38)
2. The agencies should explore value-based purchasing or contracting that moves away from a simple fee-for-service model, working with practitioner networks to find ways to reward outcomes and expand the range of care management models. (©39-40)
3. Montgomery County has an opportunity to create an innovative health care delivery system for its employees and their dependents. There may be an opportunity to start these efforts through a pilot program that approaches the request for proposal (RFP) and contracting process in a new way, focusing on wellness and aggressive disease management. (©40)
4. There should be incentives to increase participation in disease management programs. (©41)

5. The agencies should entertain disease management proposals separately from the health plan providers. This would allow for bids from a outside vendors, hospitals, physicians, and plan providers. (©41)

### **Council Staff Recommendations for Action on Disease Management**

1. Provide policy guidance to the agencies about the Council's expectations that the next bid process will include value-based requirements in requests for proposals for health plan providers.

#### ***What is value-based purchasing or contracting?***

Value-based purchasing is not only being pursued in the private insurance sector but is an important part of Medicare reform that is looking to contain cost increases by improving the quality of health care and reducing unnecessary health care expenses. (©39-40)

1997 and 2010 reports from the Agency for Healthcare Research and Quality (AHRQ - part of the U.S. Department of Health and Human Services) use the following definition of Value-based Purchasing:

“The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.”

The 2010 AHRQ report also cites a 2002 report from the Midwest Business Group on Health that estimated that the direct cost of poor quality care for employers was \$1,350 per employee per year, while the indirect cost of poor quality care, including lost time and productivity, was at least \$340 per year. The goals for value-based purchasing include: (1) improved health status, (2) greater satisfaction with health plans and care delivery, (3) lower costs, and (4) greater competitiveness in the labor market.

While value-based contracting does not mandate providers operate under the principles of patient-centered medical homes, this should be explored. Attached at ©102-104 are the 2007 “Joint Principles of the Patient-Centered Medical Home,” issued by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. The principles include each patient having a personal physician, that the physician take a whole person approach, and that care is coordinated across the health care system. Patients should have greater access to their medical home practice. Payment systems should recognize these enhanced services by the primary care physician and allow physicians to share in savings from reduced emergency room or specialty care visits. Maryland has undertaken a pilot program that seeks practices that will operate under the patient-

centered model. Information on the Maryland Health Care Commission website on this pilot program includes outcome information on reduced emergency room visits and hospitalizations. (105-106)

**Guidance to the agencies would recommend that RFPs seek providers that:**

- Can provide specific strategies that address the top cost-drivers in health spending by the agencies;
- Use principles associated with patient-centered medical homes;
- Can provide data to the agencies that will allow for evaluation of health care outcomes for enrolled members;
- Include disease management programs that are based on best practices for patient support; and,
- Address how incentive payments might be used to improve outcomes.
- In addition, the contracting process should also allow both health plan providers and outside providers and opportunity to bid on disease management programs.

As noted in the Task Force report (©43), the agencies have already worked to include many cost reduction strategies into group insurance contracts, however there are opportunities to strengthen the approach to disease management and to see whether the amount of overall spending may be reduced through an increased focus on outcomes rather than the traditional approach of reducing reimbursement rates in a fee for service model.

2. Designate a date or dates when it will be appropriate for the agencies to update the joint Committee on the RFP process and any impediments to contracting under an enhanced value-based approach.

### **Consolidation**

The Task Force report shares that the Consolidation Committee was not able to agree on a recommendation for a specific model or process for consolidation but did discuss that there can be consolidation of (1) data collection and analysis, (2) purchasing practices, (3) budgeting, and (4) administration. The Consolidation Committee did not explore consolidation through a uniform plan design that would be offered by the agencies. In addition to providing comments on reasons to look at consolidation (©42-43), benefits and drawbacks of consolidation (©48-49), criteria for examining consolidation options (49-50), and issues for further study (©51-52), the report includes three preliminary conclusions (©50-51).

## **Task Force Preliminary Conclusions about Consolidation of Agency Group Insurance Plans**

1. There should be one central source for collective agency knowledge (data collection, storage, analysis, and dissemination). Centralized information will increase the County's knowledge of the cost and use of health care by all County employees. Currently this information is segmented among the agencies, and policymakers would be better served by having cross-agency information about what is in the best interest of the employees and the taxpayers. This additional and better quality information could be generated by staff, through consultant services, or as a requirement of the evaluation of disease management programs. It will put the County in a better bargaining position to get the best quality care for the employees at the best possible cost. It will also enhance the ability of the County to use its buying power to contain costs and improve outcomes.
2. Such a focal point does not compel uniform plan design, although it may push the County in that direction simply because certain plan designs are "better" than others for achieving the collective goals of efficiency and effectiveness as defined by improved health outcomes and reduced claims.
3. Consolidation in purchasing does not require consolidation in administration, although it may lead in that direction.

### **Council Staff Recommendations for Action on Consolidation**

1. Develop a proto-type for an executive-level report that would provide information across all the agencies on the major health issues for enrolled members, top categories for spending on claims, and trends in whether health risk measures are improving or a growing problem. This report would be available to be used by the Council, Executive, Board of Education, Planning Commission, College Board of Trustees, and WSSC Commissioners. It would be at an aggregated level so as not to include protected information.

Internally, each of the agencies reviews this type of information for their employees and enrolled members. Some agencies discuss this type of information with their employee/employer wellness committees. However, there is not cross-agency reporting that can be used regularly by decision/policy makers when assessing budgets, expenditures, or discussing changes to health plan offerings.

Both the Wellness Committee and Consolidation Committee highlighted the need for good data and that data was not easily available to the Task Force. Concern was also raised about the county's ability to analyze health data across the agencies. While it might be assumed that county employees, retirees, and enrolled members have the same health care challenges as the general public, this might not be true. Not having an appropriate data or analysis may lead to wrong decisions about what types of wellness and disease management programs are needed. In addition, data is needed to measure short and long-term outcomes.

2. If the joint Committee agrees this type of report should be developed, Council staff and OLO staff would work with consultants and the agencies to develop such as report. Council staff believes that, with the assistance of consultants, this prototype could be worked on over the next four months while Council is in budget worksessions and then come back to the Committee in June or July for review.

### **Follow-up to Kaiser Proposal to be only HMO Offering**

As a part of its work, the Task Force invited Kaiser Permanente to present on how a staff-model HMO integrates wellness and disease management into its program and how this impacts health outcomes for its members. As a part of the presentation, Kaiser representatives shared, that in response to the last RFP process, Kaiser proposed that the agencies could save about \$27 million if Kaiser were the only HMO offering. (©72-79) Kaiser did not propose that it be the only offering, agencies would still offer other types of plans such as a Point-of-Service (POS) or Preferred Provider Plan (PPO). Task Force member Brian McTigue highlighted this proposal in his minority report (©61-82). At the December session, several Councilmembers asked questions about this proposal and why it was not more fully considered.

Following up on the Council questions, Council staff and OLO staff asked AON Hewitt to provide some analysis of the proposal. The report from AON is included at ©83-89. AON Hewitt clarified and assessed the validity of the assumptions used by Kaiser and then assessed the feasibility of achieving the assumed savings by looking at data for MCPS, which would provide a majority of the enrolled members and resulting savings.

AON Hewitt reports that:

- There are discrepancies between the rates assumed by Kaiser in their proposal and actual rates for the other HMO offerings.
- Kaiser's assumed savings include both the employer and employee share. The full \$27.4 million would not accrue to the agencies.
- Kaiser assumed that all employees and retirees currently in an HMO would select Kaiser. No adjustment was made for employees and retirees who might choose to move to one of the POS or PPO plans that might allow them to stay with their current HMO vendor (United HealthCare or Carefirst Blue-Cross Blue-Shield.)
- No adjustment was made for employees or retirees who do not live within 10 miles of a Kaiser center.

Using data for MCPS, AON Hewitt provides a table on ©87 that shows how the savings assumptions would change based on adjusting the rates used, showing only the savings to the

employer, excluding those without 10-mile access to a Kaiser center, adjusting for changes that could be made to other plan designs to achieve savings similar to Kaiser, and making an assumption that 50% of those currently in a non-Kaiser HMO would elect to move to a POS plan rather than to Kaiser. AON concludes that the savings for MCPS would be \$3.9 million rather than the \$24.2 million assumed by Kaiser.

Council staff believes that it is not important to reach a conclusion about whether the \$3.9 million is the exact savings that should be assumed, but rather to show that this type of review must be undertaken for any specific proposal for consolidation or plan design change from any vendor.

# TASK FORCE ON EMPLOYEE WELLNESS AND CONSOLIDATION OF AGENCY GROUP INSURANCE PROGRAMS

Established by Montgomery County Council Resolution 17-107



Sue DeGraba	Montgomery County Public Schools
Karen DeLong	American Federation of State, County & Municipal Employees Local 2380
Joan Fidler	Public Member
Erick Genser	International Association of Firefighters Local 1664
Denise Gill	Fraternal Order of Police Lodge 35
Wes Girling	Montgomery County Government
Lee Goldberg	Public Member
Paul Heylman	Public Member and Chair, Consolidation Committee
Tom Israel	Montgomery County Education Association
Rick Johnstone	Montgomery County Public Schools
Jan Lahr-Prock	Maryland-National Capital Park and Planning Commission
Mark Lutes	Public Member
Thomas McNutt	Public Member
Brian McTigue	Public Member
Edye Miller	Montgomery County Association of Administrators and Principals
William Mooney	Public Member and Task Force Chair
Richard Penn	American Association of University Professors
Gino Renne	Municipal & County Government Employees Organization Local 1994
Farzeneh Riar	Public Member and Chair, Wellness Committee
David Rodich	Service Employees International Union Local 500
Carole Silberhorn	Washington Suburban Sanitary Commission
Arthur Spengler	Public Member
Dr. Ulder Tillman	Montgomery County Government
Lynda von Bargaen	Montgomery College
Michael Young	Fraternal Order of Police Lodge 30

**FINAL REPORT**  
December 2, 2011

December 2, 2011

Dear Council President Ervin,

On behalf of the 25 members of the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs, I am pleased to submit our final report to the County Council. We look forward to presenting the report to the Council on Tuesday, December 6, 2011.

As you know, the Task Force's membership included designees from the County and bi-County agencies, the bargaining units for these agencies, and public members. The Council asked our group to address two major issues related to the provision of health care benefits to employees and retirees across the agencies: (1) Employee wellness and disease prevention programs, and (2) Consolidation of plan design and administration.

The Task Force held its initial meeting in late July and met weekly from early September through mid-November, with a final meeting on November 29. During this time, the Task Force received written information and multiple presentations on a wide range of issues related to the costs and structure of health benefits, wellness, disease management, and the management of health care costs through improved plan design.

I want to thank all of the Task Force members for their outstanding attendance and energetic participation in all aspects of the Task Force's work. The agency representatives provided overviews of current program and process, the union representatives emphasized their strong ongoing interest in the health and well being of employees and containing costs through improved health and health care, and our public members brought new perspectives and knowledge about ongoing changes in the field of health care benefits to the table. The collaborative spirit demonstrated by Task Force members throughout the study period facilitated a healthy and robust discussion of the complex issues that our group was asked to examine.

In particular, I want to acknowledge Farzanah Riar, who served as Chair of the Task Force's Wellness Committee, and Paul Heylman, who served as Chair of the Task Force's Consolidation Committee. They both gave generously of their time and professional expertise, especially when it came to developing the information, analysis, and recommendations that are contained in the final report.

Council President Valerie Ervin  
December 2, 2011

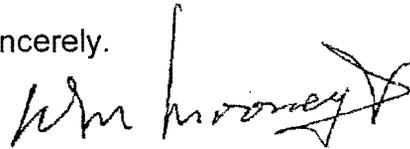
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The report contains a summary of the background information reviewed by the Task Force, and specific recommendations and comments from the Wellness Committee and Consolidation Committee. In sum, the Task Force recommends:

- The collection and analysis of aggregate health care claims data for all employees, retirees, and dependents covered by the County and bi-County agencies' health insurance plans. The County currently has over 100,000 enrolled members in agency plans. The Task Force encourages the County to use this buying power.
- The development and promotion of a workplace culture that values employee wellness and encourages the partnering of employees, employers, and health care providers to improve health outcomes.
- The implementation of wellness and disease management programs based on best-practices, to include outcome measures related to better management of chronic conditions that should contain costs through prevention of high-cost hospitalizations and medical services.
- Recognition that there are no simple solutions to bending the health care cost curve downward. And further, improvements will take time, may require upfront investment, and will likely be incremental.

It has been an honor and pleasure for us to serve on this Task Force. We hope the information and recommendations contained in our report provides a framework for continued Council action related to enhancing the wellness of employees, retirees, and their dependents, as well as the value of health care benefits offered by the County and bi-County agencies.

Sincerely,

A handwritten signature in black ink, appearing to read "William Mooney", with a stylized flourish at the end.

William Mooney, Chair

# Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs

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# TASK FORCE ON EMPLOYEE WELLNESS AND CONSOLIDATION OF AGENCY GROUP INSURANCE PROGRAMS

EXECUTIVE SUMMARY  
DECEMBER 2, 2011

On July 19, 2011, the County Council appointed the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs. The membership included designees from the County and bi-County agencies, the bargaining units for these agencies, and public members. The Council asked the group to address two major issues related to the provision of health care benefits to employees and retirees across the agencies: (1) employee wellness and disease prevention programs, and (2) consolidation of plan design and administration. The Task Force was not asked to examine the issue of "cost share", i.e., how the health premium cost is split between each agency and its respective employees.

## Task Force Members

Sue DeGraba, Montgomery County Public Schools	Brian McTigue, Public Member
Karen DeLong, American Federation of State, County, and Municipal Employees Local 2380	Edye Miller, Montgomery County Association of Administrators and Principals
Joan Fidler, Public Member	William Mooney, Public Member & Task Force Chair
Erick Genser, International Association of Fire Fighters Local 1664	Richard Penn, American Association of University Professors
Denise Gill, Fraternal Order of Police Lodge 35	Gino Renne, Municipal & County Government Employees Organization Local 1994
Wes Girling, Montgomery County Government	Farzeneh Riar, Public Member & Chair, Wellness Committee
Lee Goldberg, Public Member	David Rodich, Service Employees International Union Local 500
Paul Heylman, Public Member & Chair, Consolidation Committee	Carole Silberhorn, Washington Suburban Sanitary Commission
Tom Israel, Montgomery County Education Association	Arthur Spengler, Public Member
Rick Johnstone, Montgomery County Public Schools	Dr. Ulder Tillman, Montgomery County Government
Jan Lahr-Prock, Maryland-Nat'l Capital Park & Planning Comm.	Lynda von Bargaen, Montgomery College
Mark Lutes, Public Member	Michael Young, Fraternal Order of Police Lodge 30
Thomas McNutt, Public Member	

The Task Force held its initial meeting in July and met weekly from early September through mid-November, with a final meeting on November 29. In sum, the Task Force recommends:

- The collection and analysis of aggregate health care claims data for all employees, retirees, and dependents covered by the County and bi-County agencies' health insurance plans. This population currently totals over 100,000 enrolled members.
- The development and promotion of a workplace culture that values employee wellness and encourages the partnering of employees, employers, and health care providers to improve health outcomes.
- The implementation of wellness and disease management programs based on best-practices, to include outcome measures related to better management of chronic conditions.
- Recognition that there are no simple solutions to bending the health care cost curve downward. And further, that improvements will take time, may require upfront investment, and will likely be incremental.

## RECOMMENDATIONS AND COMMENTS FROM THE WELLNESS COMMITTEE

The Wellness Committee reviewed the potential benefits of implementing wellness and disease management programs. The experience of other jurisdictions shows that, over time, these programs can improve employee health and prevent illness, which in turn can reduce absenteeism and increase productivity. In short, these initiatives have demonstrated a positive return on investment through increasing the health and well-being of employees, retirees, and their dependents and reducing the cost of health care claims.

### Health Care Claims and the Impact of Chronic Disease

For the County and bi-County agencies, claims payments comprise about 95% of total health benefits costs. As a result, any substantial impact on future health care costs requires a reduction in the cost of claims. The Committee's review of literature on the impact of chronic disease on overall costs found that:

- As a general rule, approximately 80% of an organization's health care dollars are spent on 20% of the individuals covered.
- The Roberts Wood Johnson Foundation (2010) reports that 84% of health care dollars were spent on people with chronic conditions. Spending for someone with five or more chronic conditions was about 14 times greater than for someone with no chronic conditions.

### Examples of Cost Containment from Wellness/Disease Management Programs

The Committee reviewed the experience of other employers and learned that:

- King County (Washington) estimates a cumulative savings of \$26 million through its Health Reform Initiative, which reduced the annual growth in health care costs from a projected 11% to 9% between 2005 and 2009. The Health Reform Initiative put in place financial incentives for healthy behaviors.
- Johnson & Johnson estimates that its employee health and wellness efforts improved productivity and reduced health costs by \$400 per employee (2007). The company estimates its return on investment is \$2.71 for every dollar spent.
- Highmark Healthcare reports \$1.3 million in savings from a wellness effort that had \$808K in expenses (2008). A 2011 report estimated that health care costs increased at a 15% slower rate for employees who participated in the wellness program.
- A pilot project implemented by Boeing during 2006-2009 was estimated to reduce health care costs for people with chronic conditions by 20%. The program provided nurse case managers for 740 employees and dependents.
- Maryland's P-3 program engaged pharmacists to help reduce the cost of diabetes care. Two participating employers documented respective annual savings of \$109K and \$56K.

### Wellness Programs – Goal and Recommendations

The Wellness Committee identified the following goal regarding agency wellness programs:

**All five agencies should develop and implement agency wellness programs working within the collective bargaining process as applicable. Employees should take an active role in their health by partnering with their employer in managing and monitoring their health outcomes.**

In addition, the Wellness Committee offers the following recommendations and comments:

1. Agencies should create and foster an organizational culture about wellness and ensure that management is providing leadership in this area. Each agency should establish a health and wellness workgroup (that includes represented employees, non-represented employees, and employer representatives) and should have an individual who has primary responsibility for developing and implementing the wellness program.
2. Agency wellness programs should have goals, outcomes, and incentives in order to increase participation. The Wellness Committee agrees that inter-agency aggregate data collection and analysis should serve as the foundation for designing effective wellness and disease management efforts. (See recommendation from Consolidation Committee.)
3. Agency wellness programs should consider addressing a broad range of issues including exercise/activity levels, weight, smoking, nutrition, and short-term mental health supports like those provided through employee assistance programs.
4. Increasing employee awareness through ongoing communication and reinforcement of the goals and availability of wellness programs is critical.
5. Health risk assessments may be an important tool for employee wellness programs, but there are many outstanding questions that must be answered before any decision is made whether or how they should be implemented.
6. Agencies should review the standards used by accreditation organizations (such as the National Council on Quality Assurance) to help in the development of employee wellness programs or the selection of health plans that will improve health outcomes.

### **Disease Management Programs – Goal and Recommendations**

The Wellness Committee identified the following goal regarding disease management programs:

**The agencies should enhance current disease management programs to increase participation, make sure they are based on best practices, and have regular reporting on outcomes in order to improve the health of employees, spouses/partners, and dependents who have one or more chronic diseases and reduce the number of employees that develop chronic diseases in the future.**

The Wellness Committee believes that the County and bi-County agencies have an opportunity to create an innovative health care delivery system for its employees and their dependents. Toward this end, the Committee recommends that the agencies:

1. Expand the current conversation about disease management to include not only members and plan providers but also doctors, hospitals, and pharmacy benefit managers.
2. Explore value-based purchasing or contracting that moves away from a simple fee-for-service model; work with practitioner networks to reward outcomes; and expand the availability of care management models.
3. Pilot a program wherein health insurance contracting focuses on wellness and aggressive disease management.
4. Offer incentives to increase participation in disease management programs.
5. Explore carving disease management out of health plan contracts so that proposals can be entertained from a range of vendors, not just health plan providers.

## RECOMMENDATIONS AND COMMENTS FROM THE CONSOLIDATION COMMITTEE

The Consolidation Committee discussed different ways to consolidate health benefit practices across agency lines. Consolidated approaches can include: information sharing, data collection and analysis, purchasing, budgeting, and/or administration. Committee members concluded that consolidation could take many different forms, and also that administrative consolidation alone would yield extremely modest savings within the context of total plan costs.

The Committee learned that for over 20 years, the County and bi-County agencies have used a cooperative joint competitive bid process for selecting vendors to administer their group insurance programs. The agencies use a single coordinated request for proposals process for each type of group insurance, e.g., medical, prescription, dental, vision. As part of the joint procurement, vendors bid on administering each agency's existing plan design and level of benefits. In addition, vendors are asked to view the agencies as a single entity for the purpose of proposing fixed administrative fees and plan costs.

Historically, the joint bid process allowed, but did not require, the agencies to make uniform decisions about vendor selection. More recently the agencies agreed to make uniform decisions where possible, in order to capture savings from economies of scale. In particular, the joint bid process has led to administrative savings in prescription drug coverage, where the agencies selected a uniform vendor arrangement despite having different prescription drug plan designs.

**The Committee recommends establishing a focal point for inter-agency data collection and analysis of health care costs, to include understanding of aggregate cost trends and cost drivers.** Centralized data collection and analysis can increase the collective knowledge about health benefit needs and costs. In turn, this should enhance the capacity for the agencies to review best practices and strategize how to collectively contain costs and improve outcomes.

### Potential Advantages and Drawbacks of Consolidation

The Consolidation Committee reviewed potential advantages of the different forms of consolidation. Certain types of consolidation, for example, hold the potential to:

1. Facilitate data collection and analysis across the entire population of covered lives.
2. Increase the agencies' leverage/negotiating power in the health insurance market.
3. Maximize economies of scale through consolidated planning, administration, purchasing, and/or plan design.
4. Maximize the efficiency and return from investment that results from the design and implementation of various initiatives (such as value-based contracting, disease management programs) uniformly and once as opposed to five times.

The Consolidation Committee also reviewed the potential disadvantages of different forms of consolidation. The specific drawbacks discussed included:

1. Consolidation per se does not guarantee lower costs, particularly in a self-insured environment. The savings from administrative consolidation alone would not be material.
2. Consolidation would alter current group insurance decision-making structures, which carries implications for agency autonomy and current collective bargaining practices.
3. Consolidation could disrupt current health plan offerings to employees and retirees.
4. Consolidation would likely require an upfront investment, (e.g., to collect data; to design compatible IT systems), before yielding positive returns over time.

## Consolidated Insurance Programs/Consortiums in Other Jurisdictions

The Committee reviewed examples of consortiums and consolidated multi-agency health insurance programs in other places: Monterey County, CA; Baltimore County MD; Tompkins County, NY; and the County Employee Benefits Consortium of Ohio. This review showed that:

- There are varying models of consolidated public sector health insurance programs.
- The most common reasons cited for consolidating health insurance programs are to achieve economies of scale and mitigate increases in health insurance costs.
- Many consolidated multi-agency programs are governed by a Board of Directors with both agency and employee/union representation.
- The consolidation process is neither simple nor quick. Experience elsewhere shows that consolidation takes a substantial commitment of time and effort from all participants.
- A realistic implementation timeline and effective communication among all affected parties are integral components for a successful consolidation.

In Baltimore County, group insurance plan design and procurement is consolidated among agencies in the County Government's Division of Insurance. The other County agencies (including Baltimore County schools) adopt the common plan options but continue to collectively bargain the premium cost share with their respective employee groups.

## Criteria for Examining Consolidation Options

The Committee recommends the Council establish criteria for examining any potential consolidation options. Suggested criteria include the extent to which any proposed option:

- Assures quality of care for all participants.
- Addresses issues of agency autonomy and impact on collective bargaining.
- Maximizes incentives for cost containment and transparency.
- Minimizes cost increases, plan disruption, and implementation impediments.
- Minimizes creating a situation where the agencies are "captive" to any one provider.

## Issues for Further Study

**The Committee recommends the Council keep in mind that there are no magic bullets to cost savings in health care, and that any improvements will be incremental.** The Committee identified a number of issues for the Council to consider for further study:

- Whether to consolidate some or all plan offerings among the agencies.
- Whether to consolidate design and purchasing of wellness/disease management programs.
- Whether to consolidate purchasing for certain kinds of plans (e.g., HMO, POS) in a single vendor as a way to maximize savings from care coordination and increased use of disease prevention and management.
- Whether to establish a standard "core" benefit package for all agencies.
- Whether to evaluate the role and costs of the Third Party Administrator(s).
- Whether to consolidate staffing and administrative functions.
- Whether to consolidate budgeting for health care benefits.

## ADDITIONAL BACKGROUND INFORMATION

**Information Reviewed by the Task Force.** The Task Force received written information and multiple presentations on a wide range of issues related to the costs and structure of health benefits, wellness, disease management, and value-based plan design. Presenters included members of the Task Force, AON-Hewitt, Dr. Thomas Sawyer, Dr. Paul Fronstin, Ms. Laura Walsh, representatives from Kaiser Permanente, Assistant Chief Administrative Officer Fariba Kassiri, and staff from the Office of Legislative Oversight.

For an online copy of the complete Task Force report and the written material provided to the Task Force, follow the link to the Wellness and Group Insurance Task Force listed on the Council's home page ([www.montgomerycountymd.gov/council](http://www.montgomerycountymd.gov/council)).

**Role of Collective Bargaining.** The role of collective bargaining in the implementation of any Task Force recommendation is a decision to be made by the agencies and the Council. The Task Force acknowledges that changes to employee health benefits must be implemented through the applicable collective bargaining law and process.

**The County and Bi-County Agencies Provide Health Care Benefits to Over 100,000 Enrolled Members.** When one counts enrolled employees and retirees, their spouses/partners, and dependents, the County and bi-County agencies are providing health benefits to more than 100,000 people. (For the bi-County agencies, group health insurance is not procured separately for Montgomery vs. Prince George's County employees and retirees.)

Task Force members commented that such a large number of lives shows the buying power the agencies should be able to leverage when procuring group health services both in terms of costs from economies of scale and in requiring improved quality and health outcomes. The Task Force urges the Council to begin reviewing information on the total number of lives covered across all agencies when discussing how best to provide and fund health benefits.

For the two largest agencies, MCPS and County Government, the total group insurance expenditures for lives associated with active employees and retirees in FY12 (i.e., the cost of actual health care claims and administration) are projected to be \$537 million.

**AON-Hewitt – Overview of Programs Offered by Montgomery County Agencies.** As background for the Task Force's work, AON-Hewitt provided a report comparing major provisions and benefits of current plans. (See Appendix B for a copy of the full report.)

AON-Hewitt provided a comparison of per member or life covered (not just per employee) costs for MCPS and County Government associated with active employees. AON-Hewitt found that when averaged out over all lives covered (associated with active employees), the annual amount spent per person is almost the same. Further, AON-Hewitt concluded that the difference in premium costs for active employees in the two agencies is because County Government includes retirees with active employees in its pool for rate-setting while MCPS separates active employees and retirees into separate pools.

Note: Similar information comparing per member costs for Montgomery County and MCPS retirees and for active and retired employees in the other agencies (Montgomery College, M-NCPPC, and WSSC) has been requested and will be made available before this report goes to worksession.

**Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs**

**December 2, 2011**

**Appendices**

<b>A</b>	<b>Task Force Background Material</b> <ul style="list-style-type: none"><li>• Resolution 17-107, Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs</li><li>• List of Task Force Participants by Subcommittee</li></ul>
<b>B</b>	Full Report by Aon Hewitt Health and Benefits Consulting: "Overview of Programs Offered by Montgomery County Agencies." October 17, 20011; Revised November 21, 2011
<b>C</b>	<b>July 21, 2011 Meeting</b> <ul style="list-style-type: none"><li>• July 21 Meeting Agenda and Attached Background Information</li><li>• July 21 Meeting Minutes</li></ul>
<b>D</b>	<b>September 6, 2011 Meeting</b> <ul style="list-style-type: none"><li>• September 6 Meeting Agenda</li><li>• Presentation by Office of Legislative Oversight: "Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs."</li><li>• Presentation by Montgomery County Government: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• Presentation by Maryland National Capital Park and Planning Commission Presentation: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• September 6 Meeting Minutes</li></ul>
<b>E</b>	<b>September 13, 2011 Meeting</b> <ul style="list-style-type: none"><li>• September 13 Meeting Agenda</li><li>• Presentation by Montgomery County Public Schools: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• Presentation by Montgomery College: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• September 13 Meeting Minutes</li></ul>

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F	<p><b>September 20, 2011 Meeting</b></p> <ul style="list-style-type: none"><li>• September 20 Meeting Agenda</li><li>• Presentation by Washington Suburban Sanitary Commission: "Overview of Insurance Participant Demographics, Plan Offerings, and Wellness/Disease Management Efforts."</li><li>• September 20 Meeting Minutes</li></ul>
G	<p><b>September 27, 2011 Meeting</b></p> <ul style="list-style-type: none"><li>• September 27 Meeting Agenda</li><li>• Presentation by Dr. Tom Sawyer: "Alternatives to Cost Shifting; Managing through Improving Plan Value."</li><li>• Presentation by Aon Hewitt Health and Benefits Consulting: "Overview of Programs Offered by Montgomery County Agencies." Report Available in Appendix B</li><li>• September 27 Meeting Minutes</li></ul>
H	<p><b>October 4, 2011 Meeting</b></p> <ul style="list-style-type: none"><li>• October 4 Agenda</li><li>• "Health Care Cost Containment in MCPS" Distributed by Tom Israel, Montgomery County Education Association – where does this go? This is when it was introduced</li><li>• October 4 Meeting Minutes</li></ul>
I	<p><b>October 11, 2011 Meeting</b></p> <ul style="list-style-type: none"><li>• October 11 Agenda</li><li>• Presentation by Paul Fronstin, Employee Benefit Research Institute: "What Do We Know About Consumer-Driven Health Plans?"</li><li>• October 11 Meeting Minutes</li></ul>

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J	<p><b>October 18, 2011 Meeting</b></p> <ul style="list-style-type: none"><li>• October 18 Agenda</li><li>• Presentation Material, Fariba Kassiri, Assistant Chief Administrative Officer: "Overview of Cross-Agency Resource Sharing."</li><li>• Presentation Material, Wes Girling, Montgomery County Department of Human Resources: "Overview of Joint Procurement."</li><li>• Presentation by Laura Walsh, Associated Administrators LLC: "Contracting for Disease Management, Specialty Pharmacy, Step Therapy."</li><li>• Memorandum from Office of Legislative Oversight: "Comparative Information on Public Sector Health Insurance Consortiums."</li><li>• October 18 Meeting Minutes</li></ul>
K	<p><b>October 25, 2011 Meeting</b></p> <ul style="list-style-type: none"><li>• October 25 Agenda</li><li>• Presentation by Kaiser Permanente: "Kaiser Permanente, The Future of Healthcare is Now Open."</li><li>• Kaiser Permanente Follow-Up Material:<ul style="list-style-type: none"><li>○ Demographic Information on Kaiser Membership, Montgomery County, College, MCPS, and WSSC</li><li>○ Powerpoint Presentation "Montgomery County Agencies Doing Business with Kaiser Permanente"</li><li>○ Answers to Questions/Information Requests</li></ul></li><li>• October 25 Meeting Minutes</li></ul>
L	<p><b>Meeting Agendas from:</b></p> <ul style="list-style-type: none"><li>• November 1, 2011 Meeting</li><li>• November 8, 2011 Meeting</li><li>• November 15, 2011 Meeting</li><li>• November 29, 2011 Meeting</li></ul>

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<b>M</b>	<p><b>Wellness Material</b></p> <ul style="list-style-type: none"><li>• Summary of King County Health Reform Initiative, Prepared from August 2010 Final Health Reform Initiative Measurement and Evaluation Report</li><li>• Summary of Johnson &amp; Johnson Health and Wellness Program, Prepared from May 2002 Article in Journal of Occupational and Environmental Medicine "The Long-Term Impact of Johnson &amp; Johnson's Health and Wellness Program on Employee Health Risks."</li><li>• Summary of Maryland P3 Program, Prepared from January 2008-December 2008 Evaluation of P3 Program completed by Department of Health and Mental Hygiene</li><li>• Summary of National Committee for Quality Assurance Accreditation, Prepared from NCQA Website Accessed October 2011</li></ul>
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## Section 1

### Background to the Work of the Task Force

Resolution 17-107, which established the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs, includes the policy statement, "Access to affordable health care for all employees and all residents of Montgomery County is a primary goal of the Council." The resolution then asks the Task Force to "identify as much cost containment as possible." The Task Force is to address two issues: (1) employee wellness and disease prevention programs, and (2) consolidation of plan design and administration. As allowed by the resolution, the Task Force organized itself into two committees.

The resolution further asks the Task Force to review employee wellness plans currently in place in the agencies, review information on wellness programs in the public and private sector and look at evidence about whether they have reduced costs over time, make recommendations on improvements to agency employee wellness programs, compare the major provisions of the currently offered health plans, make recommendations on how to streamline and reduce the cost of current administration through consolidation, and make recommendations on other cost containment strategies and options. The Task Force understood that it was not in its mission to make recommendations or comments on the issue of employer/employee cost share, which has been the main focus of the "cost shifting" issue over the past year.

### **Information Reviewed by the Task Force**

The Task Force held a kick-off meeting on July 21, 2011 and then met weekly from September 5, 2011 through November 15, 2011 and again on November 29, 2011. The Committee received presentations from each of the agencies as well as from consultants and organizations on issues related to health care cost containment, contracting, consumer-driven health plans, and the advantages of a staff model health maintenance organization. A summary of these presentations is included in Section 4 of this report. Copies of these presentations are included in the appendices to this report.

### **The County and bi-County Agencies Provide Health Care Benefits to Over 100,000 Enrolled Members**

The County and bi-County agencies are providing health benefits to over 100,000 enrolled members when one includes enrolled employees and retirees and their spouses/partners and dependents. (For the bi-County agencies, group health insurance is not procured separately for Montgomery County and Prince George's County employees and retirees.) Task Force members commented that this shows the buying power the agencies should be able to leverage when procuring group health

services, both in terms of costs from economies of scale and in requiring improved quality and health outcomes.

In the past, information provided to the Council has generally discussed the number of employees or retirees enrolled. The Task Force urges the Council to review information on the total number of members covered when it discusses how best to provide and fund health benefits.

<b>MEDICAL BENEFIT for ACTIVE EMPLOYEES</b>	<b>Total Employees Enrolled</b>	<b>Total Covered (Employee and dependents)</b>
County Government	8,187	20,869
MCPS	19,132	49,052
Montgomery College	1,375	3,495
M-NCPPC (Park and Planning)	1,827	5,785
WSSC	1,345	3,497
<b>TOTAL - ALL AGENCIES</b>	<b>31,866</b>	<b>82,698</b>

<b>MEDICAL BENEFIT for RETIREES</b>	<b>Total Enrolled (retiree or surviving spouse)</b>	<b>Total Covered (retiree and dependents)</b>
County Government	4,603	7,642
MCPS	8,307	12,442
Montgomery College	481	568
M-NCPPC (Park and Planning)	863	1,357
WSSC	1,339	2,105
<b>TOTAL - ALL AGENCIES</b>	<b>15,593</b>	<b>24,114</b>

**Agency Group Health Insurance Budgets for MCPS, County Government and Montgomery College Total \$389 Million in FY12.**

M-NCPPC and WSSC as bi-County agencies do not approve separate budgets for group health insurance for just Montgomery County. However, the approved FY12 budgets for group insurance benefits for MCPS, County Government, and the College show the magnitude of funding that is required. This amount represents the County funding only and does not include the employee or retiree portion of the premium or out-of-pocket expenses incurred by employees or retirees throughout the year.

**FY12 Budget for Active and Retired Employees (in millions)**

	<b>FY12 Active Employees</b>	<b>FY12 Retirees</b>	<b>Total</b>
MCPS	\$215.5	\$48.1	\$263.6
County Government	\$ 76.5	\$32.5	\$109.0
Montgomery College	\$ 13.0	\$ 3.2	\$ 16.2
<b>TOTAL</b>	<b>\$305.0</b>	<b>\$83.8</b>	<b>\$388.8</b>

For the two largest agencies, MCPS and County Government, the total group insurance expenditures for lives associated with active employees and retirees in FY12 (i.e., the cost of actual health care claims and administration) are projected to be \$537 million.

In December 2010, the Office of Legislative Oversight provided the Council with information on the then-current and projected costs of group insurance for active retirees in the tax-supported agencies (WSSC excluded). OLO Report 2011-2 stated that "Over the past ten years (FY02-FY11), total agency spending on group insurance for active employees increased 134%, from \$134.4 million to \$314.6 million. The total costs of group insurance (assuming no change to the current structure) are estimated to increase another 55% to \$486.6 million by FY16."

OLO also said, "Over the past ten years (FY02-FY11), total agency spending on group insurance for retired employees more than doubled from about \$31 million to \$79 million. Absent changes to the current structure, these costs are estimated to increase another 57% to nearly \$124 million by FY16."

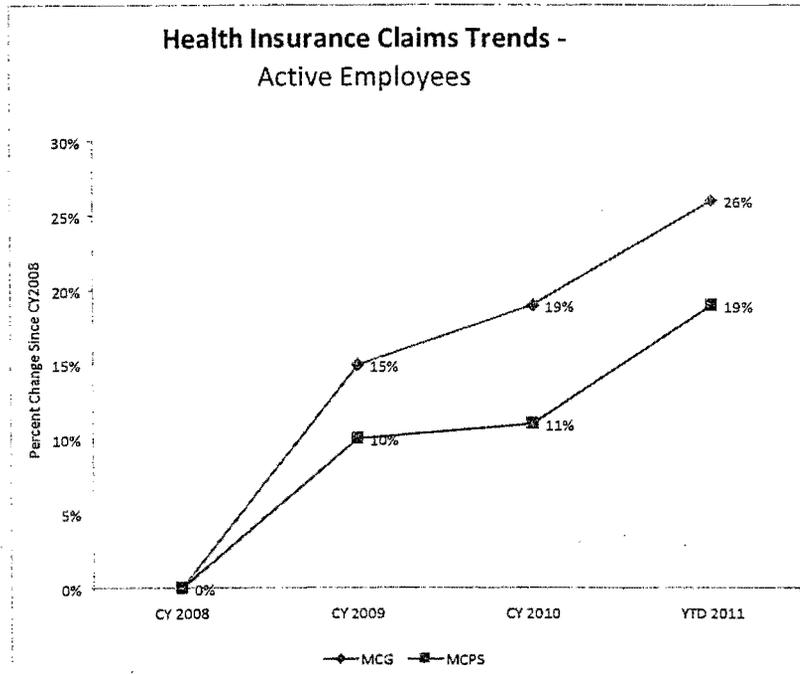
The OLO report included the following information based on 2010 actuarial data, plan designs, and cost share formulas:

(\$ in millions)

	FY11 Approved	FY16 Projected*	FY11-FY16 \$ Increase	FY11-FY16 % Increase
<b>Active Employees</b>	<b>\$314.6</b>	<b>\$486.6</b>	<b>\$172.0</b>	<b>55%</b>
<b>Retirees</b>	<b>\$79.0</b>	<b>\$123.7</b>	<b>\$44.7</b>	<b>57%</b>

\*Projected as of December 2010

While the cost of group health insurance is still increasing for calendar year 2012 (which crosses over FY12 and FY13), the Task Force was informed by the agencies that the increase in costs has slowed substantially from what was previously expected. Agencies are expecting 2012 increases of 2% to 5% instead of the 7% to 10% that was expected a year ago. There is no certainty about why this slower than expected growth occurred, it is not unique to Montgomery County, and there is no expectation that it will continue in the long-term. The graph on the following page shows how, for costs associated with active employees, the trend slowed from calendar year 2009 to calendar year 2010. Calendar year 2010 is the primary basis for pricing of 2012 premiums. The graph shows that costs have increased in the first half of calendar year 2011, but until the full year data is available, no conclusion should be made about the growth rate for the year or its implications for premiums in calendar year 2013.



Source: Overview of Programs Offered by Montgomery County Agencies, AON Hewitt, November 21, 2011. Prepared for the County Council Task Force on Employee Wellness and Consolidation of Agency Group Insurance, page 20

## AON-Hewitt – Overview of Programs Offered by Montgomery County Agencies

As background for the Task Force's work and in response to the requirement in Resolution 17-107 that the Task Force include in its report a comparison of major provisions and benefits of current plans, AON-Hewitt provided a comparison of plan offerings for the five County and bi-County agencies and an analysis of programs and costs for MCPS and County Government (the two largest consumers of health care benefits). A full copy of this report is included in Appendix B.

For 2012 the agencies are using many of the same medical plan providers. All the agencies use Caremark to administer prescription drug plans. All plans, with the exception of Kaiser, are self-insured. Each of the agencies offers employees a choice in the type of plan provided. Each offers at least one point-of-service (POS) option and at least one health-maintenance-organization (HMO) option. For 2012, Montgomery College will offer a Consumer Driven Health Care Plan (CDHP). They will be the only agency with a CDHP option.

MCPS	Co Govt	M-NCPPC	WSSC	College
United Healthcare	United Healthcare	United Healthcare	United Healthcare	
CareFirst BCBS	CareFirst BCBS			
Kaiser	Kaiser		Kaiser	Kaiser
		CIGNA		CIGNA
Caremark (Drug)	Caremark (Drug)	Caremark (Drug)	Caremark (Drug)	Caremark (Drug)

In 2011, MCPS and WSSC had the highest percentage of employees choosing to enroll in an HMO. MCPS and WSSC have had a lower premium cost to employees enrolled in an HMO. Starting in 2012, County Government will similarly have a lower employee cost share for its HMO plans (5% difference).

**% enrollment by type of plan (2011)**

	POS (or POS/PPO for WSSC and College)	HMO	Indemnity or Supplemental (for Retirees)
MCPS	27%	53%	20%
Co Government	64%	29%	7%
M-NCPPC	47%	40%	13%
WSSC	25%	60%	15%
College	65%	25%	n/a

In terms of the percentage of active employees who opt for employee only, employee+1, or family coverage, Montgomery College has the highest percentage of employee only enrollment. Montgomery College has the highest percentage of family enrollment as well, but this is because they do not offer an employee+1 option.

**% enrollment by level of coverage (Active Employees only - 2011)**

	Employee Only	Employee + 1	Family
MCPS	30%	25%	45%
Co Government	32%	24%	44%
M-NCPPC	37%	25%	39%
WSSC	38%	28%	34%
M College	43%	na	57%

The AON-Hewitt report contains information on plan design features for 2012. AON-Hewitt says, "The POS and HMO plans offered by MCPS and MCG are very comparable since almost all in-network coverage levels are 100% payment after relatively low co-pays of \$5 or \$10." The report notes that MCPS increased its co-pay for emergency room visits to \$100 in order to encourage people to use urgent care centers rather than emergency rooms. MCPS and Montgomery College are not considered "grandfathered plans" and therefore under healthcare reform may not have co-pays for certain preventive services. Generally speaking, co-pays for WSSC and Montgomery College plans are higher than for MCPS and County Government plans.

For those using in-network services in the POS and PPO plans, there are differences in plan design for items such as co-pays and deductibles, with MCPS generally having lower co-pays. Montgomery College is the only agency to have co-insurance for plans for active employees. While all of the agencies use Caremark as their prescription drug administrator, each agency's plan options have different co-pays

and out-of pocket structures. Montgomery College is the only agency to have a co-insurance model for prescription drugs (for their POS and CDHP plans).

The AON-Hewitt report summarizes the employee and retiree cost shares. Note that these are the cost shares for 2012 and reflect the change in County Government to have a higher cost share for non-HMO plans for active employees.

**Active Employees**

	MCPS	Co Govt	M-NCPPC	WSSC	College
HMO	5%	20%	15%	20%	25%
Non-HMO	10%	25%	15%	22%	25%
Rx	10%	25%	15%	20%/22%	25%

**Retirees**

	MCPS*	Co Govt*	M-NCPPC	WSSC	College
HMO	36%	30%	15%	20%	40%
Non-HMO	36%	30%	15%	20%/22%	40%
Rx	36%	30%	15%	20%/22%	40%

\*County Government and MCPS are average cost shares as cost share may be different for some retirees based on years of service.

AON-Hewitt provided two comparisons of per enrolled member (not per employee) costs for MCPS and County Government associated with active employees (not retirees). The first compared the average expense broken down by plan type. The second averaged costs across all plan types.

**Average expenditure per member by plan type**

	MCPS	Co Govt
HMO	\$3,553	\$3,996
POS	\$4,365	\$3,869
Kaiser*	\$4,843	\$4,911

\*Kaiser Rx is included in the average expenditure for Kaiser  
An average of \$1,273 would have to be added to MCPS and \$1,235 to County Government to compare an average total cost by plan type.

**Average expenditure per member across all plan types**

	MCPS	Co Govt
All Medical*	\$4,066	\$4,028
All Rx	\$1,273	\$1,235

\*Kaiser Rx is included in Medical

The tables show that while, on average, MCPS spends less than County Government on a member in an HMO plan, they spend more on a member in a POS

plan. When averaged out over all members covered (associated with active employees) the annual amount spent per member is almost the same.

AON Hewitt states that, "In sum, a detailed comparative analysis indicates that the primary reason behind the differences in premium costs for MCPS and MCG is that MCG includes retirees with active employees in its pool for rate setting while MCPS separates active employees and retirees into separate pools. The other factors have a nominal affect on cost differences."

AON-Hewitt provided the estimated average total premium cost for active employees. MCPS develops active employee premium rates based on claims experience of active employees only. The other agencies blend the claims experience of active and retired employees in setting premium rates. Premium rates are the amount charged per employee to cover expected costs of a specific plan, they are not the average amount spent per employee or the average amount spent per enrolled member (employee, spouse/partner, and dependent.)

Average 2012 Total Premium per Employee (employee and employer share)

	MCPS	Co Govt	M-NCPPC	WSSC	College
Total	\$13,206	\$15,201	\$13,714	\$15,140	\$10,695

AON-Hewitt also used its actuarial model to give a relative "value" to the plans offered by MCPS and County Government (MCG). AON-Hewitt concludes, "The POS and HMO plans offered by MCPS and MCG are very comparable since almost all in-network coverage levels are 100% payment after relatively low copays of \$5 or \$10. The MCG emergency room copay is much less than MCPS (\$25 vs. \$100). MCPS increased their co-pay in 2011 to incent greater use of urgent care facilities instead of more costly emergency rooms."

### Role of Collective Bargaining

Each of the agencies provides group health insurance to represented and non-represented employees.

The Wellness and Consolidation Committees' recommendations and comments do not specifically address whether or how collective bargaining should be a part of the implementation process.

Each of the members from the collective bargaining organizations strongly stated that changes to health benefits must be implemented through the applicable collective bargaining laws and processes. Members also discussed the interests of their organizations in improving health and wellness of their members and containing costs.

The Montgomery County Education Association (MCEA) provided a summary, *Health Care Cost Containment in MCPS*, (Appendix H) that lists changes implemented

over the past ten years to contain costs. MCEA noted that these changes were implemented through the work of the "Joint Employee Benefits Committee" that includes representatives from MCPS administration and MCEA, SEIU Local 500, and MCAAP. Measures include incentives for enrolling in HMOs, incentives for the use of lower cost mail order drugs, disincentive to use of emergency rooms, focusing on reducing high cost claims (more than \$50,000 per year), promoting smoking cessation, and wellness promotion.

MCGEO Local 1994 invited Dr. Thomas Sawyer (MCGEO's health care consultant) to present cost containment recommendations to the Task Force and told the Task Force that MCGEO has been trying to bring these ideas to the table but has not been able to engage County Government in meaningful discussion about wellness and disease management. The Fraternal Order of Police, Lodge 35, stated its position that benefits are a mandatory subject of bargaining, but there are areas of administration and purchasing that can be changed to achieve overall cost savings.

Members representing the collective bargaining organizations emphasized the importance of communication and collaboration and their opposition to change being imposed outside of the collective bargaining process.

Some of the public members provided a different perspective. Collaboration regarding health care benefits currently constitutes discussions among numerous autonomous entities. It is unclear whether this process, which perpetuates fragmentation, maximizes efficiency and effectiveness. While autonomy may serve the interests of the political leadership, the career managers, and the numerous bargaining units, it may not be the most cost effective system for local taxpayers. It was noted in discussion that the existing organizational arrangements should not be fixed in concrete and that, since they were statutorily created, they can be changed in similar fashion.

## Section 2

### Recommendations and Comments from the Wellness Committee

The Wellness Committee is providing recommendations and comments around two strategies: (1) **Employee Wellness** programs that are broadly promoted and targeted to keeping healthy people healthy and address health risk factors that have not yet developed into a serious illness, and (2) **Disease management** programs to help employees and dependents with chronic conditions. Disease management is a system of coordinated communication and intervention supports that serves a specific population, includes physicians and other health care providers, uses an evidenced-based plan of care, includes patient self-management education, emphasizes prevention, and measures outcomes. Some of the largest chronic conditions include heart disease, diabetes, Chronic Obstructive Pulmonary Disease (COPD), high cholesterol, and asthma.

There are many reasons why all of the County and bi-County agencies should develop and implement wellness and disease management programs. As employers, every agency should look out for the well-being of its workforce, their spouses/partners, and dependents. There are also very practical reasons. Improved wellness can reduce costs associated with absenteeism (to care both for one's self and for family) and "presenteeism," which is a loss of productivity when employees come to work sick or are trying to manage a family member's illness while still working everyday. Most critically, an increasing number of people have chronic conditions, which is adding significantly to the cost of providing health care. If health care costs are to be contained, not just shifted, then effective wellness and disease management programs must be implemented. There needs to be a concurrent reduction in demand for health services through integrated prevention, risk reduction, and disease management practices.

### **Background – The Impact of Chronic Conditions**

The 2010 Robert Wood Johnson Foundation (RWJ) report, "Chronic Care: Making the Case for Ongoing Care," notes that in 2009, 145 million people lived with a chronic condition. This is 10 million more than the 2009 projection developed in 2002. The percent of all Americans with two or more chronic conditions grew from 24% in 2001 to 28% in 2006. As many as 6% of females and 4% of males have 5 or more chronic conditions. Annual out-of-pocket spending increased by nearly 30% from 2001 to 2006 for those with one or more chronic condition.

Nationally, the RWJ report notes that 84% of 2009 health care dollars were spent on people with chronic conditions. Most people with chronic conditions (78 million) are working age people and 54% of those people have private insurance. These people account for 73% of private insurance spending. Almost all Medicare dollars and about

80% of Medicaid dollars are spent on people with chronic conditions. In 2006, health care spending for someone with one chronic condition was about 3 times greater than for someone without a chronic condition (\$1,081 vs. \$2,844) Spending for someone with five or more chronic conditions was about 14 times greater than for those with no chronic condition (\$14,768 vs. \$1,081).

People with multiple chronic conditions are much more likely to be hospitalized. People without chronic conditions accounted for 4% of people with inpatient hospital stays while people with 5 or more chronic conditions accounted for 27% of people with inpatient hospital stays.

People with no chronic conditions spent an average of \$70 per year on prescriptions compared to \$4,053 per year for people with 5 or more chronic conditions.

A 2010 Issue Brief from the Center for Healthcare Research and Transformation reports that after childbirth, the most common reasons for in-patient hospitalizations are related to cardiovascular disease. It notes that in 2007, heart disease accounted for \$143 billion in national spending, the highest total spending for any condition. "Among the most common reasons for hospitalization are conditions that are defined as 'potentially preventable' – that is, those that may be preventable with high quality primary and preventive care. Thus, higher rates of 'potentially preventable hospitalizations' – including hospitalizations for heart failure and pneumonia – highlight specific areas where targeted improvements can be made."

The March 2011 document "Chronic Disease in Maryland: Facts and Figures" (Department of Health and Mental Hygiene - DHMH) states that "Chronic Disease is the leading cause of death, disability, and health care costs in Maryland." In 2009, heart disease was the leading cause of death in Maryland (25.5% of all deaths) while 37.4% of adults reported high cholesterol and 30.1% of adults reported high blood pressure, both risk factors for heart disease. While diabetes was the 6<sup>th</sup> leading cause of death, it also contributes to death from heart disease, stroke, and kidney disease.

The DHMH report includes information from the World Health Organization that at least 80% of heart disease, stroke, and Type 2 diabetes and 40% of some cancers are preventable through proper nutrition, daily physical activity, and smoking cessation. It also notes that tobacco use is the single most preventable cause of death in the United States and is estimated to cause 80% of COPD.

In terms of cost, the DHMH report notes that in 2007, over \$550 million was spent in Medicaid for prevalent chronic diseases. The Milliken Institute estimated that in 2003 chronic conditions cost the State of Maryland \$5.2 billion in treatment expenditures and \$20.5 billion in lost productivity.

## The 80/20 Rule

The Task Force heard many times from presenters and its own members about the 80/20 rule – that about 80% of health care dollars are spent on 20% of people. While some of the 20% in any given year are people with a high-expense health claim from a serious injury or from complication of childbirth (for mother or baby), most are high-cost, high-risk individuals with more than one chronic condition.

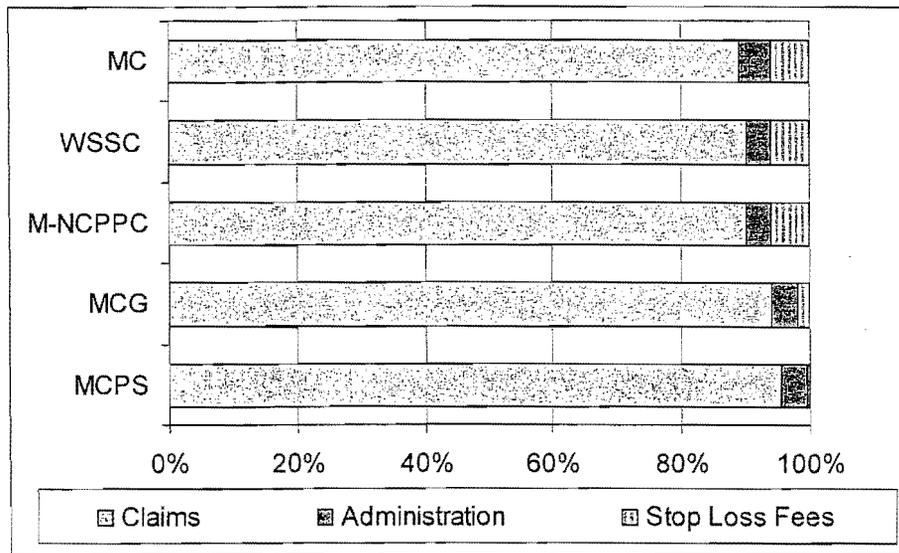
Another way to look at this issue is by reviewing four categories of people, as shown in the following table. The goals of employee wellness and disease management programs are to (1) keep healthy people healthy, (2) find ways to reduce the overuse of health care services (such as the overuse of the MRI when someone has a complaint about back pain), and (3) get those who are sicker than they think to have their conditions identified and managed so that they do not become high-risk.

<p align="center"><b>“Healthy People”</b></p> <p>About <b>75%</b> of the population They identify themselves as healthy and their physicians view them as healthy. They have minimal health care costs and average about 3 visits per year.</p>	<p align="center"><b>“Sicker than they think”</b></p> <p>About <b>10%</b> of the population These people believe they are healthier than they actually are. Many have unattended chronic conditions. They avoid medical care and average about 5 visits per year.</p>
<p align="center"><b>“Over-users of Medical Services”</b></p> <p>About <b>10%</b> of the population These people have complaints about real or perceived illness or injury that end up over-using medical resources. They have unnecessary health care costs and average almost 10 visits per year.</p>	<p align="center"><b>“High-Risk”</b></p> <p>About <b>5%</b> of the population Multiple chronic health conditions that have high costs and increased chance of hospitalization. They average about 9½ visits per year.</p>

Adapted from polakoff/boland and EpsteinBeckerGreen (data from Predictive Health 2005, 2011)

## The Rising Cost of Health Care Claims Can Be Reduced by Wellness and Disease Management Programs

This Task Force was asked to look for cost containment and cost savings through consolidation and improved employee wellness. While there are many lenses to look through for containing the growth in health care costs, what is clear is that to have significant and sustained savings, spending for health care claims must be impacted. MCPS and County Government, which account for most of the health care spending, spend only 4½% to 6% on plan administration and stop loss fees; 94% of County Government spending and 95.5% of MCPS spending is for medical claims.



One way to reduce the cost of health care claims is for the plans to negotiate lower reimbursements for a fee-for-service, but this does nothing to stop the inefficient or ineffective use of medical services. In the long-term, improving people's health and wellness is the most effective way to impact total spending on health care.

This report will later discuss in more detail initiatives that have been shown to reduce the increase in health care spending. They are generally structured, multi-year efforts. In terms of estimated savings:

- King County (Washington) estimates that it saved \$26 million from 2005 to 2009 through its Health Reform Initiative by "bending the trend on health care expenses" from a projected 11% per year to 9%. The Health Reform Initiative put in place financial incentives for healthy behaviors. Since 2009, additional savings have been realized from increased use of generic drugs and an increase in the percent of employees enrolling in a less costly health plan that emphasizes preventive care and evidenced-based medicine.
- Johnson & Johnson has a long-standing employee health and wellness effort and estimates that it has helped to reduce their per-capita health plan costs by \$400 per employee (2007) and has significantly improved productivity. In 2002, it was estimated that Johnson & Johnson was saving about \$8.8 million annually and a 2010 Harvard Business Review article says that Johnson & Johnson estimates their return on investment is \$2.71 for every dollar spent.
- A 2008 study estimated that over four years Highmark Healthcare achieved \$1.335 million in savings from a wellness effort that had \$808,000 in expenses, a return on investment of \$1.65 for every dollar spent on the program. A 2011 report estimated that health care costs at Highmark rose at a 15% slower rate for employees who participated in the wellness program.

- A pilot project implemented at Boeing during 2006-2009 was estimated to reduce health care costs for people with chronic conditions by 20%. The program provided nurse case managers for 740 employees and dependents. Savings were estimated to come primarily from a reduction in emergency room visits and hospitalizations.

Information presented by Kaiser Permanente to the Task Force discussed the importance of following medical best practices for managing chronic disease. For example, prescribing aspirin and blood pressure and cholesterol medication to people over the age of 55 with diabetes or hypertension can prevent heart attack and stroke. Studies show that it costs \$10,113 to treat 57 people with these medications, but this would prevent one heart attack that costs \$33,740. This is a 333% return on investment.

### **Efforts Must Be Evaluated**

The Committee's recommendations for both wellness and disease management programs emphasize the need for outcomes. This implies that there must also be the resources to evaluate efforts to determine if goals are being reached and if savings are being realized. In 2007, the Wellness Councils of America highlighted the following reasons about why evaluation is important:

- To obtain feedback so that you can improve your programming efforts;
- To demonstrate the value of your program;
- To measure change;
- To secure continued funding;
- To establish accountability; and
- To compare the efficacy of different interventions.

Oversight and evaluation require regular **cross-agency data and analysis of health care trends for enrolled members**. While each of the agencies provided data on their organization and the Task Force was able to review the AON-Hewitt cross-agency report, the Task Force was not able to review a cross-agency utilization report that would provide a baseline for recommending or evaluating specific changes. A long-term wellness and disease management effort will require that cross-agency data be readily available. The Consolidation Committee recommends improved data as one of its preliminary conclusions about consolidation.

## Employee Wellness Programs

### Overall Goal

All five agencies should develop and implement employee wellness programs, working within the collective bargaining process as applicable. Employees should take an active role in their health by partnering with their employer in management and monitoring of their health outcomes. While any plan for employee wellness may begin by focusing on employees, long-term plans should look at ways to include employees, retirees, their spouses/partners, and dependents.

### Background

As a part of the initial agency presentations to the Task Force, each agency representative was asked to give an overview of their wellness program. While each agency has access to programs offered through the medical insurance providers, there are currently very different levels of effort regarding employee wellness. MCPS, Montgomery College, and WSSC have the most organized efforts.

### *Montgomery County Public Schools*

- MCPS initiated a joint wellness program in 2009 when the Joint Workgroup on Health Care Cost Containment and Employee Wellness looked at data showing that about \$36 million in health care costs were due to asthma, diabetes, obesity, and cardiovascular disease – all preventable and/or manageable.
- In the fall of 2010 MCPS implemented the “Well Aware” program that includes “MCPS on the Move” activities. The MCPS on the Move effort was available to 10,000 employees and 5,300 participated. Outcomes included 103,000 hours of logged activity and weight loss of 16,490 pounds. Average body mass index (BMI) started at 26.2 and ended at 22.4, moving the group from the obese category to the normal weight category.
- MCPS has a full-time Wellness Coordinator to work on enhancing and expanding efforts to all employees.
- MCPS and Kaiser have partnered to offer an 8-week smoking cessation program that will include group support. The program is available to Kaiser and non-Kaiser members. There will be an evaluation to determine if the program is successful.

## **Montgomery College**

- The College runs several competition-based wellness programs each year, most around increased activity such as walking.
- The College has a full-time Wellness Coordinator to assist with rolling these programs out to all employees.
- The College has an advantage as it has on-site athletic and fitness facilities that can be used by faculty and staff.
- The College offers up to 1½ hours of “release time” weekly that is matched by staff employees’ time to provide extra flexibility for opportunities such as lunch-time workouts.

## **Washington Suburban Sanitary Commission**

- WSSC has an Employee Development Group and holds a Wellness Fair as a part of Open Enrollment. WSSC is emphasizing the theme “eating well, being well, staying well.”
- There are ongoing programs such as “Lunch N Learn” and “Morning Wellness Sessions at the Depot.”
- For the coming year, the Employee Development Committee is considering a variety of wellness sessions in the areas of exercise and fitness, heart health, and men’s health.

## **Recommendations and Comments**

### **1. Create an organizational culture about wellness and make sure that management is providing leadership in this area.**

The Wellness Committee agrees that this is the key to an effective program. There must be buy-in at the highest level, and employees must feel that their efforts to improve their health are supported.

Studies show that the views of management are critical to the effectiveness of wellness programs. For example, the 2010 evaluation report for the King County (Washington) Health Reform Initiative included in its five key recommendations the need to “reinvigorate leadership investment in creating a healthy workplace culture. Individual healthy behaviors thrive when change is supported and rewarded.” The King County Health Reform Initiative was based in part on the understanding that the program would not be successful unless there was a very high level of participation (90% to 95%). After four years, a survey found that 89% of employees still rated the importance of reducing health risks and maintaining healthy habits as a 4 or 5 on a

scale of 1 to 5. However, the evaluation showed that management support slipped after a couple of years.

Johnson & Johnson, which has had a long standing employee health and wellness program, emphasizes the importance of participation and support by the entire organization. (Additional discussion of Johnson & Johnson and King County is included in the discussion of disease management on pages 21-22.)

In March 2011, Mercer and the Health Enhancement Research Organization (HERO) released information from their Employee Health Management Best Practices Scorecard that concluded that organizations with senior management commitment to wellness have higher participation rates for health management programs. For example, 53% of employees in organizations with strong leadership took advantage of biometric screening programs versus 38% for organizations reporting little or no organizational support.

In its overview presentation to the Task Force, WSSC commented how important it is for managers to support employee efforts to improve wellness. If job coverage needs minor adjustments to allow people to attend appropriate activities, it is important that employees know that managers support this. Montgomery College noted that they are able to provide some flextime to staff to fit work-outs or other wellness activities into their schedules. This sends a message that the organization supports employee health.

As a part of this recommendation, **the Wellness Committee recommends that each of the agencies establish a health and wellness workgroup that includes represented employees, non-represented employees, and employer representatives.** The agencies have varying levels of this in place already, but the Wellness Committee believes that dialogue is important to developing an organizational culture around wellness. The Committee discussed MCPS' Joint Employee Benefits Committee, which has been meeting for 10 years to discuss a range of issues and proposals including cost containment measures and wellness efforts. Montgomery College also meets with its union representatives in a joint work group to review benefit issues. Park and Planning has an employee council that looks at developing wellness programs that are offered through the year. Representatives from the Montgomery County Government Employees' Organization Local 1994 (MCGEO) and the International Association of Fire Fighters Local 1664 (IAFF) said that the County Government unions all would like to have employee health committees but they have not yet been successfully established. The Wellness Committee is not recommending how the agencies might or might not work with these workgroups in the collective bargaining process, rather that regular joint dialogue about trends in employee health care needs, claims, and costs creates trust and a common understanding about efforts to improve health and wellness.

**Lastly, the Wellness Committee agrees that creating a strong organizational culture around wellness requires investment. Each of the**

**agencies should have an individual who has primary responsibility for developing and implementing the wellness program.**

**2. Employee wellness programs should have goals, outcomes, and incentives in order to increase participation.**

The Wellness Committee had significant discussion about the need to find ways to increase participation in voluntary employee wellness programs. MCPS was pleased that about half of the 10,000 employees eligible for the original rollout of the "Well Aware" program participated but wants to find ways to engage the other half.

MCPS and the College have kept data regarding outcomes for some of the programs they have implemented. Some of these are activity-based, such as logging hours of activity, and some are results-based, such as weight loss and reduction in body-mass index. As programs are increased, the agencies should collect outcome data so that programs can be evaluated.

The Wellness Committee also discussed the potential long-term savings that could occur if the MCPS/Kaiser smoking cessation program is filled and is shown to be effective. MCPS expects there will be a substantial return on investment for this program as Kaiser estimates that a smoker's annual health care costs are \$3,400 more per year than a non-smoker's. The first class has room for 25 participants. Reducing the number of employees and spouses/partners and dependents who smoke could reduce health care costs in the long term.

MCPS and the College noted that relatively small incentives such as gift cards can really increase the interest and participation in employee wellness programs. Agency funding of these types of incentives should be looked at in a positive manner if they improve outcomes. The issue of incentives can also be an important tool to increasing participation in disease management programs. Examples of these types of incentives will be noted in the recommendations and comments on disease management.

**3. Employee wellness should look at a broad range of issues, including exercise/activity levels, weight, smoking, nutrition, and short-term mental health supports like those provided through employee assistance programs.**

Efforts to increase wellness should look at a broad range of opportunities including improved access to gyms and county facilities (there are some discounts to private facilities already available through the health plans) and changes to food in vending machines, cafeterias, and at meetings.

**4. Increasing employee awareness through ongoing communication and reinforcement of the goals and availability of wellness programs is critical.**

The agencies currently have different amounts and types of communication with employees. Not all the agencies have the same level of regular, easy to access information, updates, and newsletters about health and wellness. Both MCPS (Well Aware) and Montgomery College (Wellness Connection) have easily found, well-developed information on their websites. For the other agencies, wellness offerings can be found in information on overall benefits and employee assistance programs. Regular communications through newsletters (which can be electronic) and e-mail updates can help build the organizational culture that is the #1 recommendation of the Wellness Committee.

**5. Health risk assessments may be an important tool for employee wellness programs, but there are many outstanding questions that must be answered before any decision is made whether or how they should be implemented.**

The health risk assessment (HRA) typically serves as a core measurement and intervention tool when combined with appropriate follow-up and referral. The primary goals of an HRA are to: 1) raise employee awareness, 2) motivate employees to seek appropriate interventions and reinforce progress through follow-up assessments, 3) identify the distribution of risk (e.g., percentage of low-risk and high-risk employees) across the population, and 4) serve as a benchmarking, planning, and evaluation tool. HRAs are currently a very popular tool for obtaining baseline information and identifying health risks that might be addressed through wellness or disease management programs. Emerging evidence shows that to be most effective, HRAs should include health coaching (face-to-face, telephonic, and/or Internet) to reinforce healthful behavior change. However, the Wellness Committee believes that the agencies must address several questions before they consider implementing them. The key question is “What is the purpose of the health risk assessment?” With regard to voluntary employee wellness activities like those being addressed in this section, is an HRA necessary, or should just the health information associated with the goals of the activity (such as having weigh-ins for weight loss programs) be obtained?

Most often, an HRA is a self-reporting survey tool. The Wellness Committee questions whether this is the best tool for identifying health risks and making sure that the health information is accurate. For example, would a better investment be to provide incentives to employees and their spouse/partner and dependents to have an annual physical that would include certain health care screenings? It was noted that under the federal health care reform law, certain preventive services must be offered without a co-pay, and for the “grandfathered” plans, co-pays for physicals are already generally very small.

If a self-reporting tool is used, it must be clear who will have access to the information, what information is confidential and HIPAA protected, and how information

will be used. If the health assessment is done through an annual physical, then the information would be handled by the health care practice and the health plan as it is now. Aggregated information can be provided by the health plan to the agencies for use in evaluation and oversight. Communication about the goals of an HRA or annual physical must occur as there must be trust between the agency and the employee about how health information will be used.

The use of the HRA as part of an overall program that is structured on incentives and interventions will be discussed further as a part of disease management.

**6. The agencies should review the standards that are used by accreditation organizations like the National Council on Quality Assurance (NCQA) to see if they can help in the development of employee wellness programs or the selection of health plans that will improve health outcomes.**

The Wellness Committee is not recommending accreditation but discussed that accreditation standards do focus on best practices and performance measures. The Wellness Committee did not think that accreditation should be a goal for wellness programs or necessarily be a requirement for medical plan providers. However, there may be value in reviewing the requirements for accreditation for employee wellness programs and discussing which of these standards might help the agencies develop better and more effective wellness programs.

Standards are a critical issue to disease management and value-based purchasing, which is addressed in the next series of recommendations on disease management programs.

## **Disease Management Programs**

### **Overall Goal**

**The agencies should enhance current disease management programs to increase participation, make sure they are based on best practices, and have regular reporting on outcomes in order to improve the health of employees, spouses/partners, and dependents with one or more chronic conditions and reduce the number of employees who develop chronic diseases in the future.**

### **Background**

All the agencies currently contract with the health insurance companies for disease management programs that are available to the plan's members. Chronic conditions that are usually covered include: asthma, coronary artery disease, chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes, heart failure, and lower back pain.

In these programs, the plan is responsible for identifying patients who have been diagnosed with one or more chronic conditions. There is then outreach through the mail or by phone to determine what kind of support might help the patient manage their condition(s). Participation in these programs is voluntary. The agencies receive information from the plan providers on utilization and patient compliance with medication use and care coordination.

As part of the agency overview presentations, Montgomery College noted that for their plan offered through CIGNA:

- 53% of all identified individuals are participating in the disease management program; 32% of those participating are engaged by telephone.
- 56% of engaged individuals have an acute or high need.
- The diabetes program has the greatest number participating.
- The lower back pain program has the greatest number of people that opt out.
- CIGNA estimates that the program generated \$200,000 in savings.

Park and Planning noted that the disease management plan offered through United Healthcare:

- Offers behavioral health and co-morbidity management based on national guidelines.
- Works to reduce variation in clinical quality and cost management by improving patient self-management and providing guidance to designated physicians and networks.
- Focuses on members who have a significant impact on medical spending.

The full Task Force received a presentation from Kaiser Permanente, which is a staff-model Health Maintenance Organization (HMO). Kaiser does not have a separate disease management program because prevention and disease management are integrated into their model. Kaiser said that their comprehensive electronic medical records, emphasis on prevention, standards around best practices, and ability to communicate in multiple ways with doctors and other Kaiser health care professionals provide an effective disease management model.

The Task Force also received a presentation from Ms. Laura Walsh, CEO of Associated Administrators LLC, on contracting for disease management. Ms. Walsh discussed some of the requirements that should be included if one is contracting for an outside disease management firm (as opposed to using the programs offered by the medical plan). These must include clarity for responsibilities, HIPAA protections, types of outreach services, performance metrics, regular reporting to those responsible for the plan, audit rights, any requirement for return-on-investment (ROI), and whether the program is voluntary or mandatory. She said that "disease management programs are generally well received by the participant, but, ironically, poorly utilized."

In addition to the information provided to the Task Force, the Wellness Committee reviewed information on the Johnson & Johnson Health and Wellness Program, the King County Health Reform Initiative, and the Maryland P-3 Program. The following provides some summary points about each program. Additional information is included in Appendix M.

### **A. Johnson & Johnson Health and Wellness Program**

Johnson & Johnson introduced the “Live for Life” program in 1979. The purpose of the program was to make Johnson & Johnson employees the healthiest in the world. Johnson & Johnson regularly evaluated its program.

The program underwent revisions and in 1993 and was recast as “Johnson & Johnson Health and Wellness Program (HWP).” Integrated health, wellness, disability management, employee assistance, and occupational medical were included. The goal is to reduce individual behavioral and psychosocial risk factors before they are transformed into disease and disability.

There is a financial incentive for employees. A 2002 evaluation noted that a \$500 medical benefit plan credit was given to those who completed the health risk assessment and participated in recommended high-risk intervention programs (named Pathways to Change). People with borderline risks received targeted mailings and low-risk employees received general health education materials. It is participation in the risk assessment and intervention program that made the employee eligible for the credit, not the outcome from participation. The financial incentive and corporate culture result in 90% of the domestic US employees participating (about 43,000 employees).

The risk areas targeted are: nutrition, aerobic exercise, tobacco use, motor vehicle safety, blood pressure, cholesterol, body composition, and diabetes.

A review of data from 1995 to 1999 showed there were statistically significant changes for 8 of 13 risk factors for Health and Wellness Program participants. However, the program was not successful in reducing risk factors associated with increased age: high body weight, risk for diabetes, and a high fat diet.

Important lessons from this effort include the positive impact on all employees who participated in the Health and Wellness Program whether they participated in the Pathways to Change programs or not, and evidence that demonstrates that a complex, large scale health management program can be implemented in a large corporation and have a very high participation rate.

### **B. King County (Washington) Health Reform Initiative**

The King County Health Reform Initiative (HRI) was launched in 2005. The HRI has 3 goals: (1) improve the health of employees and their families; (2) reduce the rate of cost increase for health care; and (3) determine whether employee productivity

increased as a result of improvements in health. The third goal was added in 2007. The HRI required evaluation and peer review.

The 2010 Final Evaluation Report notes that King County negotiates with 92 bargaining units. "The county and unions started the HRI with an emphasis on improving health behaviors with the intention to change plan design to encourage the use of higher value care and discourage the use of lower value care as shared tools and information on cost and quality became more available."

Health care costs were rising at 3 times the CPI when the HRI was enacted. Five percent of all people covered accounted for 58% of costs. Low back pain, cancer, depression, diabetes, coronary artery disease, and asthma were the most costly conditions, and high cholesterol and high blood pressure were the most common risk factors.

Fourteen percent (14%) of people covered had five or more chronic conditions. For each chronic condition a person had, it was estimated that the cost of health care doubled.

The HRI has a Wellness Assessment and an Individual Action Plan component. There are financial incentives for employees and their spouses/domestic partners to complete the assessment and participate in the Individual Action Plans. Incentives are structured through three cost tiers for health insurance: Bronze (does not take health assessment or participate in action plan), Silver (takes health assessment, does not participate in action plan), and Gold (takes assessment and participates in action plan). There is no employee cost share for the premium, but there are significant differences for deductibles, co-insurance, and co-pays. For example, the annual deductible for a family in the "Gold" plan is \$300 compared to \$1,500 for the "Bronze" plan, and the hospital co-pay for Gold plan is \$200 compared to \$600 for the Bronze plan. The overall structure of the program has resulted in a participation rate of about 90% for completing the wellness assessment and between 80% and 90% for completing action plans.

From 2006 to 2009, employees and spouses/domestic partners showed improvement in 12 of 14 health-related behaviors and risk factors as measured in the health risk assessment. For two measures, physical activity and blood glucose, the changes were not significant.

In 2010, funding for the HRI will cost \$16.71 per month per person for contribution to the Puget Sound Health Alliance, workplace health promotion, and benefit plan design.

King County estimates that the HRI has saved \$26 million when comparing actual cost increases to cost increases that were projected before the HRI was implemented.

### **C. Maryland P-3 Patients Pharmacists Partnership (P-3) Program**

The Maryland Patients Pharmacists Partnership (P-3) Program was designed in 2006 to reduce employee and employer costs by eliminating obstacles to diabetes care and improving overall health outcomes.

Pharmacist-coaches from Maryland Pharmacist Association and University of Maryland use best practice guidelines to provide patient-centered care to promote medication adherence, lifestyle changes, and improve disease self-management knowledge.

In 2008, the P-3 Program served 225 employees at four employer sites in Alleghany County, Frederick County, Howard County, and Baltimore City. There were 138 trained pharmacists in 2008, but 30 provided direct care to patients during the evaluation period. Employers were responsible for enrolling participants, sharing data from third party administrators and pharmacy benefits managers, and making payments to pharmacists providing services.

Evaluation compared P-3 participants at the end of the program with comparison groups from the Health Plan Employer Data and Information Set (HEDIS). It shows that 9.1% of P-3 patients had poor control of HbA1c levels at the end of the year compared to 30% of diabetes patients in Maryland commercial insurance plans and 45.9% of those in Maryland Medicaid. Slightly more than half of P-3 patients met their therapeutic goals.

With regard to cholesterol, 39.4% of P-3 patients had LDL levels of less than 100 mg/dl compared to 46% of diabetes patients in Maryland commercial insurance plans and 35.4% in Maryland Medicaid. Blood pressure readings showed that 71% of P3 patients had blood pressure below 140/90 mmHg compared to 56% of diabetes patients in Maryland commercial insurance plans and 51% in Maryland Medicaid.

Two participating employers documented savings of \$109,112 and \$56,120 respectively.

#### **Recommendations and Comments**

**1. The agencies should expand the current conversation about disease management to include not only members and plan providers but also doctors, hospitals, and pharmacists.**

Preventive healthcare and disease management must be improved if trends in county health care cost are to be contained. The county has significant buying power (over 100,000 enrolled members) and should use its buying power to change contracting so that vendors have "more skin in the game."

**2. The agencies should explore value-based purchasing or contracting that moves away from a simple fee-for-service model, working with practitioner networks to find ways to reward outcomes and expand the range of care management models.**

There may need to be incentives to practitioners for improved care management. While Montgomery County employees do not all live in Montgomery County, compared to a large national business, employees are relatively close in terms of geography, and there should be ways to move networks to a more integrated, outcome based system. At the same time, care needs to be taken to focus resources on those with chronic conditions and not waste resources by having a one size fits all approach that would provide extra management to people who don't need much management.

These comments are not about a short-term solution but rather a long-term strategy to change the health care delivery system.

***What is value-based purchasing or contracting?***

Value-based purchasing is not only being pursued in the private insurance sector but is an important part of Medicare reform that is looking to contain cost increases by improving the quality of health care and reducing unnecessary health care expenses.

1997 and 2010 reports from the Agency for Healthcare Research and Quality (AHRQ - part of the U.S. Department of Health and Human Services) use the following definition of Value-based Purchasing:

“The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.”

The 2010 AHRQ report also cites a 2002 report from the Midwest Business Group on Health that estimated that the direct cost of poor quality care for employers was \$1,350 per employee per year, while the indirect cost of poor quality care, including lost time and productivity, was at least \$340 per year. The goals for value-based purchasing include: (1) improved health status, (2) greater satisfaction with health plans and care delivery, (3) lower costs, and (4) greater competitiveness in the labor market.

In October 2011, The Taconic (New York) Health Information Network and Community (THINC) issued a report on a February 2011 workgroup session with health

plan representatives and health care providers to discuss issues regarding collaboratively forming value-based payment arrangements. The report says, "Providers and health plans are being motivated by a growing sense that costs and budgetary constraints will inevitably require significant movement away from the fee-for-service model." The report highlights the need to resolve issues around how risk will be shared between providers and plans (gain-sharing vs. loss-sharing), access to information including utilization and prescription drugs, and funding support for professionals such as case managers, nutritionists, and home health workers to coordinate care in a less costly setting. Providers and health plans are concerned about how quality will be evaluated, and some health plans are concerned that the value-based approach will fail to result in the cost savings and quality that are the intended outcomes.

In part, the move to develop value-based purchasing models is being driven by the Medicare Shared Savings Program, a voluntary program under the federal health care reform law to move providers from traditional fee-for-service to providing more effective coordination of care through Accountable Care Organizations (ACOs). Accountable Care Organizations are provider led organizations that tie provider reimbursement to quality and outcome of care. They can have different reimbursement models that include fee-for-service or capitation, but there is an incentive, or shared savings or loss, attached to improving health outcomes and reducing the cost of overall care.

Medicare has also begun providing information to consumers about quality through a 5-Star rating system for Medicare Plan providers. There are measures associated with each of five domains: (1) Staying Healthy: Screenings, Tests, and Vaccines; (2) Managing Chronic (Long Term) Conditions; (3) Ratings of Health Plan Responsiveness and Care; (4) Health Plan Members' Complaints and Appeals; and (5) Health Plan Telephone Customer Service. This rating system is not just a useful example of consumer information, it is also a basis on which the Center for Medicare and Medicaid Services (CMS) will provide bonuses or penalize plans both in terms of rates and whether they are allowed to enroll beneficiaries year round (high star plans will but others are confined to a limited period of enrollment).

**3. Montgomery County has an opportunity to create an innovative health care delivery system for its employees and their dependents. There may be an opportunity to start these efforts through a pilot program that approaches the request for proposal (RFP) and contracting process in a new way, focusing on wellness and aggressive disease management.**

The pilot program could focus on one or more groups of employees so that it could address their specific needs and conditions and evaluate specific outcomes. The Wellness Committee agrees that this effort will require spending in the short-term but should result in long-term savings and improved health.

**4. There should be incentives to increase participation in disease management programs.**

The King County Health Reform Initiative uses monetary incentives related to out-of-pocket expenses for health care (deductibles, co-insurance, and co-pays), which has resulted in very high participation rates (80% to 90%). The incentive is based on completing an HRA and participating in an action plan – not on a specific health result such as weight lost or a reduction in high blood pressure.

In the previous section on employee wellness, the Task Force voiced concerns over HRAs which would still have to be addressed if a King County or Johnson & Johnson type model were pursued.

The Wellness Committee recommends that the agencies should start to look at incentives for participating in disease management programs given the long-term savings that could result if chronic conditions are controlled. This is not a recommendation for a full restructuring, but there should also not be a prohibition about looking in the longer term at something innovative with proven results.

**5. The agencies should entertain disease management proposals separately from the health plan providers.**

The Wellness Committee is intrigued by the information that was provided on using an outside entity for disease management (as opposed to the plan provider). There may be more effective program models than those offered by the health plans. In addition, a single disease management program could be implemented regardless of which health plan the employee elects (with the exception of Kaiser). On the other hand, having a separate disease management program could add costs (if plan providers do not reduce costs by the amount of the outside contract), and there would have to be strict agreements in place about the sharing of patient information from the plans to the disease manager. The plan providers may propose increased costs based on the need to share information.

The agencies should consider issuing a separate competitive request for disease management services that could be bid on by a range of outside vendors, hospitals, and physicians, as well as plan providers.

## Section 3

### Recommendations and Comments from the Consolidation Committee

#### Reasons to Look at Consolidation

The Council asked the Task Force to study the potential for containing costs through plan and administrative consolidation. After reviewing the information provided to the full Task Force, additional information on CARS, and examples of jurisdictions or organizations that have consolidated models, the Consolidation Committee offers the following as important reasons for analyzing various consolidation options. The Committee acknowledges the work that all of the agency staffs have done to coordinate the procurement of health care benefits, to work within their current organizational structures to leverage economies of scale, to make difficult choices that may require eliminating a health plan, and to work within constrained budgets.

1. Health care benefit costs have increased substantially over the last decade. Despite having slower growth than expected in FY11, health care costs are projected to increase substantially in future years. Everyone involved in this process, employees, agencies, unions, and taxpayers, has a very real interest in working to reduce the rate of increase.
2. Both the agencies and the unions have put a great deal of thought and work into health care benefit issues, and both have a great deal of information that should be considered. Moreover, the collective bargaining process has been an influential element in the development of the current system of health care benefits.
3. Health care benefits are changing in ways both large and small, both obvious and subtle:
  - a. As the federal health care reform law is implemented we are likely to see systemic changes in the provision of health care benefits.
  - b. Even if the federal health care reform law is revoked or substantially modified, health care benefit cost increases will likely also drive changes in the provision of health care benefits.
  - c. Given increasing market choices, making the best-informed collective judgment across the entire spectrum of health care benefits is important.
4. Health care benefits are an essential employee benefit. Providing health care benefits is a core agency commitment, although the actual purchase of health care benefits is not the core function of any County agency.

5. There are multiple examples and varying models of health insurance consortiums for local units of government across the country:
  - a. The most common reasons cited by other jurisdictions for establishing a health insurance consortium across agencies were to achieve economies of scale and reduce and/or stabilize health insurance costs.
  - b. There are different ways to establish the governance structure for a health insurance consortium. Many consortiums with consolidated plan administration are governed by a Board of Directors with both agency and employee/union representation.
  - c. The process for establishing a consortium is neither simple nor quick. It takes a substantial commitment of time and effort from all participants.
  - d. A successful consolidation requires a realistic implementation timeline and effective communication among all affected parties.

### **Existing Process for Cross-Agency Collaboration**

For over twenty years, the County and bi-County agencies have used a cooperative joint competitive bid process for selecting vendors to administer their group insurance programs. The agencies use a single coordinated request for proposal (RFP) process for each type of group insurance (medical, prescription, dental, vision, etc.). As part of the joint procurement, the agencies ask that vendors bid on administering each agency's existing plan design and level of benefits. In addition, vendors are asked to view the agencies as a single entity for the purpose of proposing fixed administrative fees and plan costs. Depending on agency needs and timing, joint RFPs have covered two or more agencies.

Historically, the joint bid process allowed, but did not require, agencies to make uniform decisions about which plan vendors to select. In most instances, the RFPs have included a provision that vendor selection decisions may vary from agency to agency. More recently the agencies agreed to make uniform decisions where possible, thereby maximizing economies of scale.

Overall, the joint process requires a high level of collaboration and coordination between agency staff in terms of preparing material for the bid process and reviewing and analyzing vendor responses.

Agency staff note that while each agency has traditionally made separate decisions on group insurance vendors, the joint bid process has led to significant savings in administration through creating economies of scale. In particular, the joint bid process has led to administrative savings in prescription drug coverage, where the agencies have uniform vendor arrangements despite having different prescription drug plan designs.

## **What Does It Mean To Consolidate?**

The Committee discussed that consolidation of group insurance can mean different things to different people. Resolution 17-107 put forth three ways to look at consolidation: consolidate agency plans under fewer vendors, consolidate offerings under one administrative unit, and consolidate offerings under a uniform plan design. The Committee did not explore consolidation under a uniform plan design but chose to look at other ways to consolidate.

The Consolidation Committee discussed different forms of consolidation, including:

### **1. Consolidate data collection and analysis**

No formal process exists for collecting and analyzing claims and related cost data across the agencies. Currently, agency staff work closely together in developing requests for proposals and contracting and have some shared understanding of the health care trends facing each agency. However, there is no analysis for policy makers to use in assessing how models of administrative or plan design consolidation might impact health outcomes or costs. One form of consolidation could involve joint collection and analysis of multi-agency health claims and cost data.

### **2. Consolidate Purchasing Practices**

As previously described, the agencies coordinate the procurement of their RFPs for health care. However, at this time, each agency makes separate and independent decisions on what to buy, the type of plan, and plan designs. Greater consolidation of purchasing could include: (a) consolidated decision making on what to buy (possibly including common plan design); (b) coordinating vendor selection across agencies; and/or (c) using common criteria to evaluate vendor bids.

### **3. Consolidate Budgeting**

Currently, each agency develops its own budget for health care benefits. Alternatively, the County could create a single, unified budgeting process encompassing health care benefits for all County agencies.

### **4. Consolidate Administration**

Consolidation of administration, even in the absence of consolidation of health plan designs, could improve the efficiency of dealing with health plan administrators (both third party administrators and health maintenance organizations), communicating and responding to covered participants in the health plans, and administering associated programs in wellness and disease management.

The Committee asked staff to provide examples of existing multi-agency arrangements to administer public sector employee group insurance programs in a coordinated fashion.

### ***Models of Consolidated Insurance Pools***

The Consolidation Committee reviewed information on four examples of consolidated public sector insurance consortiums. The following provides a brief summary of each. Additional information is included in Appendix J.

#### **A. Monterey County (CA) Schools Insurance Group**

The Monterey County Schools Insurance Group (MCSIG) is a Joint Power Authority that was created and operates under the Governance Code and Education Code of the State of California. The MCSIG has 25 participating agencies that are mostly local school districts but also include one community college and two charter school organizations. There are 5,700 active enrollees and 1,200 retirees. MCSIG operates a self-insured health fund. MCSIG coordinates all health plan administration and management and has seven full-time staff.

When MCSIG was first established in 1982, each member organization had its own individual plan designs. Consolidated plan designs for medical and prescription drugs were created in 1989 and for vision and dental in 1996. MCSIG staff reports the process for each took about two years. Currently, MCSIG offers five medical plans (each with bundled prescription), two dental plans, one vision plan, and carve-out plans for behavioral health and chiropractic services. Each type of coverage is offered through a single provider. The contracts are competitively bid on three-year cycles. Pre-Medicare retirees are offered the same plans as active employees. Medicare eligible retirees have an option to stay in a full-coverage PPO plan or move to a Medicare supplement plan.

MCSIG does not negotiate with any collective bargaining organizations. Local school districts bargain with their own unions, but there are no separate plan designs for different jurisdictions. Premium cost share is determined by each school district.

MCSIG is governed by a 35-member Board of Directors that includes one representative from each participating agency, nine labor representatives, and one retiree representative. The Board has five standing committees: Executive Committee, Advisory Committee, Claim Appeal Committee, Wellness Committee, and Finance Committee.

MCSIG staff shared the following four “lessons learned” and/or recommendations to share with other agencies considering consolidation:

- It is important that every agency has a seat on the board;

- Employees should be involved in the governance structure of the program (MCSIG staff reports that most Joint Powers Authorities in California do not have labor representatives);
- Health costs should be tracked and rates set by the entire pool as opposed to separate rate setting from each participating agency; and
- A realistic implementation timeline and effective communication are integral components for consolidation.

## **B. Baltimore County, Maryland**

The Baltimore County Government Office of Budget and Finance's Division of Insurance administers most elements of the employee health insurance program for the five participating agencies: Baltimore County Government, Baltimore County Public Schools, Baltimore County Public Libraries, Baltimore County Revenue Authority, and the Community College of Baltimore County. The Division of Insurance has six staff members responsible for managing health insurance offerings. Human Resource offices in each of the participating agencies manage open enrollment.

Baltimore County agencies offer four medical plans (each bundled with prescription coverage), three dental plans, and one vision plan. The contracts are competitively bid on a three-year cycle. With the exception of Kaiser Permanente, the group insurance plans are self-insured.

The participating agencies bargain health insurance premium cost shares with their employee unions.

The County Office of Budget and Finance consults with other agencies regarding employee health insurance offerings. Union representatives, sitting on the "Health Care Review Committee," develop labor's positions on group insurance offerings for submission to the County Executive and the agencies' governing bodies. Ultimately, the County Office of Budget and Finance makes final decisions about health insurance bidding, selection of providers, plan design, premiums, and claims management.

The current structure has been in place since the mid-1990's. While there is no written statement of goals for consolidation (and current staff was not in place when consolidation occurred), there is a general understanding is that the structure was put in place to save money.

## **C. County Employee Benefits Consortium of Ohio (CEBCO)**

The County Employee Benefits Consortium of Ohio (CEBCO) is a health benefits consortium available to county governments in Ohio. It was created by the County Commissions Association of Ohio in 2004. CEBCO limits participation to "smaller counties" (the largest has 1,500 employees). There are 9,700 active employees enrolled. There are no retirees because retiree group insurance is offered through the state-run Public Employees Retirement System. There are currently 23 participating

counties and two more are expected to join. CEBCO has a staff of six full-time equivalents to coordinate most of the functions associated with providing group insurance (plan design, open enrollment, bidding, claims, and eligibility).

CEBCO offers five medical plans, four prescription drug plans, three dental plans, one vision plan, and one life insurance plan for participating counties to choose from. There is a single vendor for each type of coverage. All plans are self-insured. Contracts are competitively bid on a three-year cycle. Counties must commit to participate in CEBCO for three years. CEBCO sets premiums each year but uses separate rating pools so the premiums may vary among the members. Counties are allowed to purchase outside of CEBCO offerings, but only one county does so.

CEBCO does not negotiate with collective bargaining organizations. Health benefits are subject to collective bargaining at the county level. Bargaining occurs between county governments and their employees about whether to participate in CEBCO's plans. Premium cost share is determined individually by each county.

CEBCO is governed by a 12-member Board of Directors comprised of representatives of counties that participate in the program. Currently, ten of the Board members are County Commissioners and two non-elected officials of participating agencies. There is no union representation on the Board.

The goal of the consortium was to achieve savings in health insurance costs for member counties and to stabilize premiums. CEBCO staff reports the following as indicators of success:

- They have not had a participating county leave the consortium;
- Six counties out of 23 total will have rate decreases this coming year; and
- Medical and prescription rate renewals were lower than the industry average from 2006 through 2009.

#### **D. Greater Tompkins County (NY) Municipal Health Insurance Consortium**

The Greater Tompkins County (NY) Municipal Health Insurance Consortium was created in January 2011 by the Tompkins County Council of Governments to pool the group insurance offerings of local municipal governments. Participating agencies include the Tompkins County Government and 12 city, town, and village governments. There are 2,000 active employees enrolled and 500 retirees. There is one staff member who supports the work of the Consortium.

The Consortium administers a total of 22 different health insurance plans on behalf of the 13 participating governments. Many of the plans are similar in design but coverage, co-pay, and deductible levels vary by agency. Pre-Medicare retirees are offered the same plans as active employees. Medicare eligible retirees participate in a Medicare-supplement plan.

Each participating government separately bargains health insurance benefits with their employee unions within the parameters of the Consortium-selected offerings.

The Board of Directors is the governing body and is responsible for management, control, and administration of benefit plans. The 15-member Board consists of one representative from each of the participating governments and two union representatives. The Joint Committee on Plan Structure and Design makes recommendations to the Board regarding changes to the Consortium plan offerings. The Joint Committee has 37 voting members, one from each participating government and one from each of 24 bargaining units.

The Consortium was established with the stated mission of providing “affordable health insurance to its employees and eligible retirees...without diminishing benefits.” The Consortium recently completed a comparison that showed the average premium cost to be 3.1% lower under the Consortium’s self-insured model. Consortium staff identified three major successes of consolidation:

- Reduction in premium cost through pooling of administrative expenses;
- Retention or improvement of benefit levels for all employees; and
- Widespread acceptance of the program by both labor and elected officials.

### **Benefits and Drawbacks of Consolidation – Criteria for Evaluation**

The Consolidation Committee was not able in the time available to develop recommendations on whether to consolidate all or parts of the agencies’ group insurance plans or plan administration. However, the Committee had robust discussion that brought forth important potential advantages and disadvantages of various approaches and enabled the Committee to identify criteria that should be used to evaluate the outcomes of any proposed model for consolidation.

Different types of consolidation present different potential benefits and potential drawbacks. Some potential benefits and drawbacks apply primarily, though not necessarily exclusively, to a specific type of consolidation. Others apply to more than one type of consolidation.

#### **A. Possible Benefits of Consolidation:**

1. The potential for increased leverage/negotiating power in the health insurance market that comes with a larger pool of members.
2. The potential for maximizing economies of scale through combined planning, administration, purchasing and/or plan design.

3. The potential for more macro-data collection across the entire population of covered members, thereby allowing for improved understanding of health cost drivers and opportunities for cost containment.
4. The potential to increase the efficiency and return from implementing various initiatives (e.g., disease management program) uniformly and once.

#### **B. Possible Drawbacks of Consolidation:**

1. Under some forms of consolidation, employees may encounter changes in plan offerings.
2. Administrative savings alone are relatively minimal, if any.
3. Depending upon decisions made on specific plan designs, there are no guarantees that larger pools of enrolled employees will translate into potential cost containment, particularly in a self-insured environment.
4. When any function is consolidated, the decision-making structure that currently operated within the individual participating agencies inevitably has to be adjusted.
5. An impact on agency autonomy.
6. An impact on collective bargaining.

#### **C. Criteria for examining consolidation options**

To best evaluate the likely outcomes of possible consolidation (or a decision not to consolidate), decision-makers need to apply uniform criteria. The Committee has identified the following non-weighted criteria for consideration:

1. Minimize long-term costs. The agencies need to obtain the most efficient (i.e., least cost) delivery of effective health care benefits that meet the needs of County employees and the obligations under the collective bargaining agreements.
2. Address the long-term impact on taxpayers. This may or may not result in accepting a bid with the lowest short-term savings.
3. Maximize incentives to contain costs.
4. Minimize disruption costs. Changing providers frequently is disruptive to both employers and employees.

5. Minimize internally imposed capture. The health care benefit system should not be captive to any provider entity, whether a Third Party Administrator or HMO, due to potential disruption to plan participants if vendor changes were made. Additionally, the County needs at least the possibility of change to enable agencies to negotiate effectively. The disruption of changing an insurer necessarily imposes some capture, but the County should work to minimize disruption.
6. Assure quality of care for all participants.
7. Address issues of agency autonomy and impact on collective bargaining.
8. Address substitution incentives. For example, participants often select plans because they want to retain their doctors. This could discourage participants from considering HMO participation.
9. Maximize the competitive position in relevant labor markets. Retain the ability to recruit, motivate, and retain a high quality work force.
10. Minimize implementation impediments. For example, agencies have different bidding cycles.
11. Provide maximum transparency.

### **Preliminary Conclusions about Consolidation**

While the Consolidation Committee is unable to recommend a model for consolidation of group insurance in Montgomery County, it has reached three preliminary conclusions:

1. There should be one central source for collective agency knowledge (data collection, storage, and dissemination). Centralized information will increase the County's knowledge of the cost and use of health care by all County employees. Currently this information is segmented among the agencies, and policymakers would be better served by having cross-agency information about what is in the best interest of the employees and the taxpayers. This additional and better quality information could be generated by staff, through consultant services, or as a requirement of the evaluation of disease management programs. It will put the County in a better bargaining position to get the best quality care for the employees at the best possible cost. It will also enhance the ability of the County to use its buying power to contain costs and improve outcomes.
2. Such a focal point does not compel uniform plan design, although it may push the County in that direction simply because certain plan designs are "better" than others for achieving the collective goals of efficiency and effectiveness as defined by improved health outcomes and reduced claims.

3. Consolidation in purchasing does not require consolidation in administration, although it may lead in that direction.

### **Issues for Further Study**

The Committee has also identified the following issues as needing further study before a decision is made on any specific proposal for consolidation:

1. Whether to consolidate some or all plan offerings among the agencies. A vast array of alternatives could be considered. For example, select one provider for HMOs or dental or vision or all medical plans.
2. Whether to establish a standard "core" benefit package for all agencies and all active members. A standard core plan could be limited to dependents or new hires. Bargaining could be permitted for enhancements to a "core" plan.
3. Whether to create incentives for consumers to contain costs.
4. Whether to consolidate wellness programs across agencies.
5. Whether to consolidate disease management programs across agencies. The cost of health care benefits is heavily weighted toward a small percentage of the total employee population. While we should not, and must not, stigmatize people for large health care benefit costs, acting in ignorance of how the budgeted dollars are being spent is equally inappropriate. This will require further analysis on how to proceed. The Wellness Committee report discusses the 80%/20% rule that, in general, 80% of expenditures are made for 20% of people covered.
6. How to evaluate the role of the Third Party Administrator. It may not be accurate to look at the network affiliated with a given Third Party Administrator as if it is just a claims administrator. Rather, the Third Party Administrator may have a financial interest in maximizing provider revenue that goes beyond simply a percentage of claims paid. We need to understand more completely what financial benefits the Third Party Administrator derives from their networks. Put another way, buying a Third Party Administrator with a network may not be so "self-insured" as we traditionally assume.
7. Whether to consolidate budgeting for health care benefits. The health care benefit plans offered by County agencies are part of complex and intricate organizational and compensation systems with numerous moving parts and a variety of stakeholders. Developing an efficient and effective multi-agency system for health care benefits using an externally mandated top-down strategy will be extremely difficult. The County budget process (such as a modification to the spending affordability process) could offer an opportunity to establish a framework to limit resources and have the autonomous entities set priorities and

make choices. An alternative would be to create incentives for a bottom-up approach where the participants are motivated to develop the changes.

8. Whether to consolidate staffing and administrative functions.
9. Whether to generate cross-agency data collection and analysis. The cost of technology changes that may be needed to generate cross-agency data or to consolidate administrative functions must be a part of any further study.
10. Whether to consolidate plan purchasing in a single HMO option as a means to maximize savings from care coordination and increased use of disease prevention and management.

### **Observations Regarding Consolidation of Administrative Staffing**

There are no magic bullets in health care, and any changes will be incremental. Staff consolidation may not reduce total administrative cost. In any event, the maximum potential savings from staff reduction would likely be extremely modest in the context of total plan costs.

The Consolidation Committee makes this statement based on its review of the FY11 staffing and personnel costs included in the March 22, 2011 OLO memorandum to Councilmembers that showed a total of 24.2 workyears and about \$2.3 million in personnel costs for administration of the MCPS, County Government, and Montgomery College group insurance plans. Even a substantial percentage reduction would be a minimal dollar amount compared to the amount that could be saved by finding ways to reduce the amount of money spent paying claims

While significant savings will not come from reduced staffing in a consolidated single administrative entity, there is potential benefit from improved efficiency and effectiveness in the overall plan operation. Reorganizing within a single entity could allow for staffing with a broader skill set without increasing the budget. This could help achieve a reduction in claims and in the costs associated with processing claims. The ever increasing complexity of the health benefit world will require a broad set of skills to keep up with and analyze the changes that are sure to come. For example:

1. Taking advantage of the changes – indeed not getting run over by them – will require:
  - a) Several people with comprehensive knowledge of a complex and sometimes very opaque system; and
  - b) Adequate flexibility (keeping in mind factors such as the disruption of changing providers and the requirements of collective bargaining).
2. To be most effective, the procurement process going forward will require significant, ongoing effort in at least two areas:

- a) Expertise about actual provider costs (either in-house or retained) to negotiate most effectively with providers; and
  - b) Greater understanding of the actual costs to the agencies and employees of various coverage options.
3. Consolidation could take the form of an independent entity or an office in one of the agencies (for example, the Baltimore County office is in the Executive Branch Office of Budget and Finance).
  4. An alternative for further analysis is California's Joint Powers Authority as implemented by the California Public Employees' Retirement System (CalPERS). Based on anecdotal data, it may offer some useful approaches both as an organizational model and for cost reduction.

## Section 4

### Summary of Presentations to the Task Force

The Task Force held a kick-off meeting on July 21, 2011 and then met weekly from September 5, 2011 through November 15, 2011 and again on November 29, 2011. The Committee received presentations from each of the agencies as well as from consultants and organizations on issues related to health care cost containment, contracting, consumer-driven health plans, and the advantages of a staff model health maintenance organization. Copies of these presentations are included in the appendices to this report. The following provides a summary of the information reviewed by the Task Force.

- The Task Force received a presentation from the **Office of Legislative Oversight (OLO)** on health care trends and options for consolidation previously provided to the Council.
- The Task Force received **overview presentations from Montgomery County Public Schools (MCPS), Montgomery County Government (County Government), Maryland-National Capital Park and Planning Commission (M-NCPPC), Montgomery College (College), and the Washington Suburban Sanitary Commission (WSSC)** on the numbers of people enrolled in health plans, their current and planned 2012 health plan offerings, and employee wellness and disease management programs. (Appendices D, E, and F)
- At the September 27 meeting, **AON-Hewitt** presented information **comparing the 2012 agency health plan offerings and 2011 enrollment data** and analyzing population and expenditure information for MCPS and County Government. This information was provided in an October 17, 2011 report. A revised version of the report, forwarded by AON-Hewitt on November 21, 2011 is included in Appendix B. The report includes information on insurance carriers, plan types, percentages of actives and retirees covered by the plans, opt-out rates, and type of coverage (single, family), employee contributions, and average premium costs for active employees. For MCPS and County Government, AON-Hewitt reviewed per member costs (associated with active employees), demographics of enrollees, enrollment trends, claims history, and plan design differences.
- At the September 27 meeting, the Task Force also received a presentation from **Dr. Thomas Sawyer**, Health Directions Consulting LLC and consultant to MCGEO Local 1994, ***Alternatives to Cost Shifting: Managing Cost through Improving Plan Value***. Dr. Sawyer's presentation is included in Appendix G. Dr. Sawyer highlighted the reasons why employers and employees are so focused on the cost of providing health care: declining revenues, aging workforce, increased cost for health services and new specialty drugs. His

presentation focused on alternatives to cost shifting, which he said impacts the poorest and the sickest the most. He emphasized focusing on clinical outcomes and wasted health care dollars. Dr. Sawyer noted that implementation of cost savings measures such as step therapy could save the County Government as much as \$5 million. Dr. Sawyer recommended regular audits of prescription drug programs. Better care coordination and the unbundling of services (including administration and stop-loss insurance) could also help contain costs. Dr. Sawyer said that many organizations are moving to value-based design. He also said that as a general rule, about 15% of people use 80% of health care dollars.

- At the October 11 meeting, the Task Force received a presentation from **Dr. Paul Fronstin** of the Employee Benefits Research Institute, ***What Do We Know About Consumer-Driven Health Plans?*** Dr. Fronstin's presentation is included in Appendix I. Consumer-Driven Health Plans (CDHPs) are generally high-deductible health plans that are partnered with a Health Reimbursement Account (HRA) or a Health Savings Account (HSA). With an HRA, the employer holds the account that is used to reimburse the employee for out-of-pocket expenses. In an HSA, the employer puts money into an account that is owned by the employee. The employee manages the account and the employee may save the money from year to year and can retain the account after leaving the employer. In 2011, 23% of firms offering health plans offered a high-deductible health plan with an HRA or HSA. There does not tend to be an age difference for those in CDHPs compared to other plans, but they tend to be less likely to smoke or be obese and are more likely to exercise. People with higher incomes are more likely to take the risk of a high-deductible plan. Because high-deductible plans have lower premiums than traditional plans, savings from lower premiums can be recycled into the HSA to cover out-of-pocket costs. Dr. Fronstin also noted that in terms of savings, one study showed annual savings of 4.5% but after adjusting for risk selection (healthier people tend to select CDHPs) this dropped to 1.5%. While there are savings to employers in the first year of adopting CDHPs because of the lower premiums associated with high-deductible plans, the trajectory for percentage increases will eventually be the same as for traditional plans. There is a need to educate people about CDHPs if they are implemented. With regard to wellness, Dr. Fronstin said that surveys shows that higher percentages of those in CDHPs are more likely to participate in health risk assessments and health promotion programs if they are offered. Dr. Fronstin noted that with regard to engaging people in disease management, some people are moving away from traditional programs that are telephone-based and are focusing on value-based contracting.
- At the October 18 meeting, the Task Force received a presentation from **Laura Walsh**, CEO of Associated Administrators, LLC, ***Contracting for Disease Management, Specialty Pharmacy, and Step Therapy.*** Ms. Walsh's presentation is included in Appendix J. Ms. Walsh is a Third Party Administrator for multiple health care funds, including Taft-Hartley Funds. Ms. Walsh noted that cost containment can be modeled around chronic conditions, such as

diabetes and heart disease, or around people with medical expenses that exceed a certain amount. When contracting for disease management, it must be clear who is responsible for identifying people for services, and there must be an evaluation of how sophisticated the model is that is being used to identify those with chronic conditions. The funds she works with generally consider proposals from several disease management firms. Metrics that can be included in a contract include return-on-investment (ROI) and number of interventions. Vendors must be clear on how they will calculate ROI. For example, one avoided hospitalization might cover the cost of the disease management programs for several months. Successful disease management requires information be shared regularly between the medical plan and the disease manager, and the disease manager should provide regular reports to those supervising the fund. Ms. Walsh discussed specialty pharmacy programs that focus on very expensive injectable drugs. In a specialty pharmacy program, the patient learns to self-inject at home instead of going to a doctor's office. There can be substantial savings; she noted that a drug that might cost \$5,000 in a doctor's office and cost \$1,000 if it is delivered to the patient's home. Ms. Walsh noted that specialty pharmacy contracting can be very complicated and that information must be HIPAA protected. Step Therapy requires the use of certain generic or preferred drugs before a brand-named drug can be used. Because of the proliferation of generic drugs, Step Therapy is becoming less popular and somewhat obsolete. It is usually an adjunct to a pharmacy contract.

- At the October 18 meeting, the Task Force also received a presentation from **Fariba Kassiri, Assistant Chief Administrative Officer for Montgomery County**, on the **Cross-Agency Resource-Sharing (CARS) initiative**. Information on CARS is included in Appendix J. Wes Girling, Benefits Manager for Montgomery County Government, had previously shared some information about CARS during the agency overview presentations. Ms. Kassiri told the Task Force that the goal for CARS, which started in February 2010, was to find \$1 million in savings for FY12 and that the goal was achieved. With regard to the employee and retiree benefit plans, ten possible ways to achieve savings were suggested by the Benefits Subcommittee for CARS: (1) Consolidate employee benefit plan offerings, (2) Combine COBRA and Flexible Spending Plan administration, (3) Consolidate and bring payment of retiree benefits in house, (4) Consolidate defined benefit retirement programs of County agencies under one program, (5) Consolidate employee benefits plan offerings of County agencies under one administrative unit that supports all County agencies, (6) Jointly develop wellness and disease management strategies, (7) Jointly approach light duty and return to work strategies expanding County Government Occupational Medical as a resource for all county agencies, (8) Consider a uniform plan design across agency lines whether or not the plans are consolidated, (9) Consider combining drug and alcohol testing across the agency lines and explore leveraging the contracts with health insurance vendors, and (10) Consolidate the County Government and MCPS (and perhaps other agency) processes to evaluate applications for disability retirement. Mr. Girling noted that Items #1, #5,

and #8, which consider consolidation and uniform plan design, are all part of the work of the Task Force and are extremely complicated issues. He said that the members of the CARS Benefits Subcommittee are all agency representatives of the Task Force and have deferred further work as CARS while the Task Force completes its work.

- At the October 25 meeting, the Task Force received a presentation (Appendix K) from **Dawn Audia**, Executive Director of Account Management for the Kaiser Foundation Health Plan of the Mid Atlantic States, **Dr. Jaewon Ryu**, Associate Medical Director, and **Patricia Nicholson**, National Coordinator for the Coalition of Kaiser Permanente Unions. The Task Force asked Kaiser to present because they are a staff-model health maintenance organization. Kaiser representatives said that wellness and disease management are integrated into their health services. In contrast to the fee-for-service model in which patients must coordinate their own primary, specialist, and pharmacy care, all Kaiser providers have access to a comprehensive medical record for each patient that identifies best practices specific to each patient's conditions and treatments. Dr. Ryu described how following best practices for people over age 55 taking certain diabetes medications can result in reduced hospitalizations. With regard to pharmacy, Kaiser members fill their prescriptions 95% of the time because pharmacies are a part of the medical center. In fee-for-service systems prescriptions are filled only about 80% of the time. Kaiser is the second largest purchaser of pharmaceuticals after the Federal government, and this helps Kaiser contain costs. Kaiser was asked whether they have local capacity to serve a substantial number of new clients. Kaiser responded that they could accept many new members as they are expanding their facility capacity, including opening a new center in Gaithersburg. Kaiser responded to concerns raised by Task Force members regarding perceptions about the time it takes to see a doctor, the ability to select a specialist, and the ability to select alternative treatments. Kaiser said that most people can see a doctor on their first call and that the time to see a specialist has improved. In-house doctors are used first, but Kaiser has contracts with outside specialists for cases where Kaiser staff does not have the needed expertise. Kaiser said that it sets rates based on claims experience and risk. Kaiser said that it has lower rates than other providers when combining the cost of medical and pharmacy plans. Kaiser estimated that if all the agency members currently in HMOs elected Kaiser, the County would save \$27 million per year. The Task Force also received information from Kaiser on its partnership with its unions and its labor-management wellness committee.

**Section 5**

**Comments from Individual Task Force Members/Minority Views**

**Minority Opinion**  
**Joan Fidler, Public Member**

This minority opinion focuses, in large part, on the Consolidation section of the Report. It does not in any way gainsay the time, effort and thought expended by all the members of the Task Force in developing the final report. It must be stated, however, that the representational makeup of the Task Force - county workers, union representatives and public members - fostered discussion but mitigated against unanimous approval of all the recommendations.

It should be noted that this minority opinion represents the view of a Montgomery County taxpayer, whereas not all county workers and union representatives are taxpayers in Montgomery County and thus might share a different view. And yes, some public members might subscribe to the same view as that of county workers and union representatives.

Both the Background and Consolidation sections, but especially the latter, appear to be largely in support of the *status quo* and are therefore disappointing. There is little discussion on affordability, actual costs and savings, without which the Report quickly becomes a compendium of ideas almost all of which will require further analysis. The Background section on Collective Bargaining, a subject that constantly injected its way into any discussion related to change, cast a pall on new ideas. While admittedly collective bargaining is a right and a reality in the governance of Montgomery County, for purposes of this Task Force, and in my view, it was a barrier to the advancement of many avenues of discussion. "That will be a subject for collective bargaining" or a variation thereof was the leitmotif of many discussions.

And now to the Consolidation section of the report. Coordination, it was claimed by both county workers and union representatives, works very well among the 5 agencies. However it appears that this coordination has rarely resulted in consolidation. There appears to be a gentleman's agreement to not intrude on another agency's turf. This was quite apparent in many of the discussions of the Consolidation Committee.

Many arguments were made about the uniqueness of each of the five agencies, a uniqueness that has resulted in 5 different health care systems. Worse, it has created a caste system whereby MCPS workers pay an exceedingly low share of their health care premiums (5-10%), M-NCPPC workers pay 15%, WSSC 20 - 22%, Montgomery County Government workers 20-25%, while Montgomery College workers pay the highest share (25%) (AON Hewitt Report presented to the Task Force on September 27, 2011). This smacks of gross inequity. Yet, remarkably, any attempts to discuss uniformity of plan design were studiously and deliberately avoided. In December 2010, OLO Report 2011-12 stated that the savings that would accrue from a uniform design where all workers paid 25% of their health care premiums would be around \$46 million in FY 2012 rising to \$123 million by FY 2016. The Task Force did not address these cost savings.

While I agree with the first "Preliminary Conclusions about Consolidation", I do not agree with the tentative nature of the other two.

Thus in the Task Force report, the second "Preliminary Conclusions about Consolidation", reads thus:

"Such a focal point does not compel uniform design (though it may push us in that direction simply because certain such plan designs are "better" than others for achieving the collective goals of efficiency and effectiveness as defined by improved health outcomes and reduced claims)"."

My minority version reads thus:

"While information centralization does not compel uniformity in plan design, there is no reason it should not. All county employees work within the relatively small area of the county which should be attractive to health insurers. By having uniformity in plan design, it would further the stated goal of the County Council to treat all employees equally".

Again, in the Task Force Report, the third "Preliminary Conclusions about Consolidation" reads thus:

"Consolidation in purchasing does not require consolidation in administration – though it may lead in that direction".

My minority version:

"Along with the consolidation of purchasing it logically follows that there should be a consolidation of administration. These two activities function most effectively when they work together. To have consolidation of purchasing while maintaining decentralized administration will not allow the system to work as effectively as possible. The Federal Government has 8 million participants spread around the world. Yet it operates with consolidated purchasing and administration in the Office of Personnel Management. And given that many of the county's taxpayers are federal employees and retirees, many will wonder why the county can't similarly consolidate. (For more information on this conclusion, see Task Force Report section on Observations Regarding the Consolidation of Administrative Staffing).

In conclusion, the emphasis is on maintenance of agency autonomy and impact on collective bargaining than on fiscal affordability and impact on county governance.

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Joan Fidler  
Public Member

## **Minority Report and Additional Views**

### **Brian McTigue, Public Member**

Council President Ervin and Council Members,

This Minority Report presents my separate views on the work of the Task Force, and focuses on Consolidation.

At the outset, let me state my understanding of my role. As a Public Member, I understood that my role was to identify and recommend policies which might reduce the cost of health insurance programs for five government entities which serve the County.<sup>1</sup> I did not see my role as identifying less expensive health care programs if they would offer inferior care to county employees.<sup>2</sup>

#### **\$27.4 Million in Potential Savings**

I believe that significant savings can be achieved if two or more of the Agencies, for example, MCG and MCPS, would agree in advance, or at least during the process of negotiating over bids, to do no more than accept the bid of a single HMO to provide HMO coverage. The materials cited in this Minority Report suggest these savings are in the order of \$27.4 million per year.

To achieve these savings there is no need to for agencies to eliminate offering other types of coverage, i.e. POS/POS health insurance plans, or accept only one insurance company's bid for these other types of coverage.

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<sup>1</sup> The five entities are MCG, MCPS, MC, NCPPC, and WSSC (the "Five Agencies" or merely "Agencies"). Only the first agency is under the direct authority of the Council. MCPS employee health benefits are subject to the Board of Education. WSSC and NCPPC employee health benefits are subject to each entity's board of directors, half of which are named by MC Council and half named by PG County Council. MC's employee health benefits are subject to the college's Board of Trustees. For the sake of simplicity, but unfortunately not clarity, I refer to employees of all five agencies a County Agency Employees.

<sup>2</sup> This appears to be in line with the Wellness Committee's recommendation that Value-based purchasing be used when contracting with Health Insurance companies, see Draft Wellness Committee Report "buyers should hold providers of health care accountable for both cost and quality of care... This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved." (quoting the AHRQ), Task Force Report, @ p. 24.

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

Early in its work, the Task Force was provided a report by the Office of Legislative Oversight (OLO) that concluded the County faces a “structural deficit... into the foreseeable future”.<sup>3</sup> These deficits are in the range of \$250 million per year.<sup>4</sup>

Given the serious and pressing nature of the problem, I view the Task Force’s Report as tepid, offering no practical suggestions which would lower the cost of health care. For the most part, when the Task Force Report does make affirmative statements, they are vague, and lack specifics, e.g. the Consolidation Committee Report suggests areas for further study, but provides little in the way of concrete proposals linked to the Agencies. When specifics are discussed, such as Consolidated Insurance Pools, many require changes in state legislation, a high barrier to their adoption, and not one in the control of the Council. This is not pointed out in the Task Force Report. If they can be achieved by the common consent of multiple agencies, without the necessity of enabling legislation, especially state enabling legislation, the Task Force fails to inquire why the five Agencies have not already done this or notice where it has been done.

At other times the Task Force Report mystifies rather than clarifies solutions. For example, the Consolidation Committee Section states that “Providing health care benefits is a core commitment, though the actual purchase of health care benefits is not the core function of the agencies.”<sup>5</sup> If, as the Consolidation Committee also states, “Health Care benefits are an essential employee benefit” how can the purchase of \$450 to \$600 million a year<sup>6</sup> in health benefits for some 100,000 people *not* be a core function of the agencies? Put another way, if the WSSC has the sole authority to purchase health benefits for its staff, and benefits are essential, how can the purchase of them not be a core function of the WSSC?

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<sup>3</sup> OLO Report 2011-2, @p. 3. The OLO report looked at the four of the five agencies subject to Task Force review, only the WSSC was excepted, as it was not financed with County taxes.

<sup>4</sup> OLO Report to Task Force, dated September 6, 2011, @p. 1.

<sup>5</sup> Task Force Report, @ pp. 27-28.

<sup>6</sup> For the \$600 million number see the CARS Employee and Retiree Benefits Subcommittee, First Quarterly Report, September 15, 2010, @p. 1. This number does not include the cost of funding the \$2.7 billion in unfunded, vested retiree health care, known as Other Post-Employment Employee Benefits (OPEB); see OLO Report 2011-2, Pt. 2, Ex. Summary @ p. 5. This unfunded retiree health liability grew 33% to \$3.6 billion in a year, see Memo to Government Operations Committee #3, dated May 3, 2011, @circle 47.

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

The Consolidation Committee, of which I was a member, did not put a dollar value on any savings proposal in its section of the Task Force Report.

In other words, the Task Force, when it goes into specifics, offers vague or problematic solutions. For the most part, the Final Report does little more than weakly second policy options already proposed to the Council by its OLO and foreshadowed by the poorly-named Cross Agency Resources Sharing (CARS) Committee.

If the Council wanted the Task Force to ratify pre-existing proposals, I think the Council's charge to the Task Force would have been different.

In sum, I think the Task Force Report does not do enough. It could have done more.

There was an attempt to consolidate purchasing and plan offerings a year and a half ago, which bears directly on two areas the Task Force Report recommends for further study: consolidation of 1) plan offerings among the agencies, and 2) purchasing of certain kinds of plans (e.g. HMO, POS) in a single vendor. The Task Force could have better explored this, but did not. In my view it should have. This Minority Report is an attempt to do that.

The five Agencies purchase health care benefits in three-year cycles. The last cycle began March 15, 2010, with a joint Request For Proposals (RFP) issued by the five agencies.

At the time, and now, Kaiser was an incumbent provider of HMO benefits to four of the County Agencies, MCG, MCPS, MC, and WSSC, but not the NCPPC. Kaiser responded to the RFP with a series of proposals. One would have involved a real, although modest, attempt to consolidate health care purchasing and plan offerings -- two areas the Task Force Report suggests to the Council may produce savings in health care. It is important that the proposal was put forth by a bidder, not by any of the County Agencies. This suggests that the procurement process for health care benefits needs greater scrutiny.

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

The Kaiser Offer

Kaiser's offer was made to AON Hewitt, the benefits consulting firm which acts as agent for each of the Five Agencies.<sup>7</sup> Kaiser estimated that, if each of the five agencies would offer Kaiser as its exclusive HMO, Kaiser's bid cost would save the Agencies \$27.4 million annually.<sup>8</sup> If accepted, coverage would begin January 1, 2011. Since bids covered three years, a first year with two annual renewals, the potential savings were larger than \$27.4 million.

Kaiser's bid proposal did not require that Kaiser be the sole health benefit plan provided to the Agencies employees, merely the only HMO offered. Each of the agencies could offer as many other types of health insurance products, e.g. POS, PPO, HSA, CDHP, etc., as each agency wanted.

If Kaiser's proposal to be the exclusive HMO provider had been accepted, it would have consolidated HMO coverage in one vendor and likely resulted in significant savings without any loss in the quality of care provided. It would not have required further legislation, only an agreement among the Agencies that they would accept a common bid for HMO coverage.

The agreement by the Agencies need not have been in advance of the bidding, only in response to it. It is unclear whether Kaiser's exclusive proposal was given serious consideration. Kaiser informs me that after it was submitted there were only a few questions by the Agencies. Contracts were awarded August 1st; Kaiser's exclusive proposal was not among them. I understand that while controlling county law does not require acceptance of a low bid, it does require at least a memo documenting why a low bid is rejected.

Kaiser's proposal appears to have been relegated to obscurity for the last year and half. It came to light during Kaiser's presentation to the Task Force this October 25th. I requested the presentation because I felt the prior presentations to the Task Force focused only on health plans offered by insurance companies, not by staff-model HMOs such as Kaiser's.<sup>9</sup> Since the Task

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<sup>7</sup> AON Hewitt also served as the consultant to the Task Force, a contract which I understand cost \$40,000.

<sup>8</sup> Kaiser, "Montgomery County Agencies Doing Business with Kaiser Permanente", Nov. 8th Task Force meeting.

<sup>9</sup> For example, when I asked presenters on disease management and wellness how Kaiser handled those issues, they responded that they did not know or that Kaiser's model was unique.

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

Force included representatives of County employee unions, I also asked that Kaiser's presentation include information on its unique labor-management partnership, another Kaiser characteristic not shared by other bidders.

Kaiser's presentation focused on the labor partnership and its medical information technology, including electronic medical records management. At the end of its presentation, Kaiser surprised the Task Force, or at least those members such as I who had not received the bid in 2010<sup>10</sup>, by asking the Task Force why the Agencies had rejected Kaiser's 2010 bid proposal with its estimate of \$27.4 million in savings. Several Task Force members questioned Kaiser about the bid, including where the \$27.4 million in estimated annual savings would come from. Kaiser provided written answers.<sup>11</sup> These stated, "The savings would come from a reduction in administrative expenses due to economies of scale on additional members, but more importantly, it came from an overall reduction in estimated claims costs based on [Kaiser's] ability to control cost."<sup>12</sup> Presumably the savings largely result from Kaiser's unique structure where nearly all Kaiser staff are Kaiser employees or doctors working exclusively for Kaiser.<sup>13</sup>

I asked the County staff who were members of the Task Force, and who were involved with the bid proposal in 2010, to provide the Task Force with the Kaiser bid.<sup>14</sup>

When Task Force turned to drafting its final report, I was asked to provide a section on Kaiser's presentation. I offered a draft. It was struck from the report for two reasons: 1) Kaiser's estimate of \$27 million in savings "has not been verified for accuracy according to

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<sup>10</sup> It appears that the Task Force includes the top benefits staffers of each of the Agencies who issued the 2010 RFP and received the Kaiser exclusive bid proposal. These staffers had not mentioned the bid to the Task Force.

<sup>11</sup> Kaiser, "Follow-up Information from Kaiser Permanente to Task Force" Nov. 8th Task Force meeting.

<sup>12</sup> Kaiser, "Follow-up Information from Kaiser Permanente to Task Force" at p. 2.

<sup>13</sup> Apparently these savings do not come at the expense of Kaiser employees, or at least collectively bargained wages, benefits, and working conditions. Kaiser informed the Task Force that 80%, or 131,000, of eligible employees are members of a union, and all Kaiser employees have an old-style defined benefit plan. (In such a plan retirees cannot outlive their benefits, which makes these plans expensive.)

<sup>14</sup> Kaiser, "Montgomery County Agencies Doing business with Kaiser Permanente" provided to the Task Force November 5, 2011.

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

AON Hewitt who had conducted the RFP<sup>15</sup>, and 2) other HMO companies had not been asked to present their views.

Since I do not agree with these reasons, and I consider the handling of the Kaiser Proposal by Agencies to illustrate the benefits and the problems with consolidation of health benefit purchasing and administration, I chose to discuss the Kaiser Proposal in this Minority Report.

As to the representation by AON that Kaiser's estimate of \$27.4 million in savings was not verified, it should be noted that AON Hewitt was a consultant to the five County Agencies when they received Kaiser's 2010 Bid. The Agencies and AON should have verified the estimated savings then, and determined, independently of Kaiser, whether the Bid was in the economic interest of the Agencies. If it had been verified, it could have served then as basis for the Agencies responses. Apparently, it was not verified. Some impressionistic conclusions appear to have been drawn by the Agencies, but there appears to be no documentation. The objection, made by AON and Agency staff on the Task Force, that the savings were not verified, underscores their failure to verify the estimated savings when verification would have mattered.

I asked Kaiser last week to provide me with its estimate of savings. Kaiser provided a spreadsheet.<sup>16</sup> The spreadsheet shows that Kaiser estimates total savings at \$33.4 million. Kaiser apparently then reduced these estimated savings. The reduction presumably accounts for a number of factors, such as County Agency employees who would choose another type of plan rather than transfer to Kaiser HMO coverage, and still other employees who might move to the Kaiser HMO coverage from another type of plan, for example, because Kaiser HMO premiums were lower.

As for the other HMO companies not being asked for presentations. Task Force members agreed with my request that Kaiser be invited to give a presentation. Kaiser came and made a presentation. The Task Force submitted follow-up questions and Kaiser provided written

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<sup>15</sup> This AON communication appears to have been made to others in their capacity as Task Force members, but not to me.

<sup>16</sup> MCA ANALYSIS re 2011 RFP, attached

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

responses. Task Force members could have invited other HMO providers; not doing so was the other member's decision.

Despite claims today that the Kaiser proposal lacks verification, the County saw enough merit in it to revisit the proposal this year. Kaiser informed me the County reopened discussions with it about the exclusive HMO bid earlier this year, apparently as part of the Executive's search for cost savings after the emergence of the structural deficit. According to Kaiser, these discussions were more than cursory. This suggests the Agencies were more interested in costs this year than last. Although members of the Task Force were part of these renewed discussions, they did not inform the Task Force about them.

**Consolidation and the Future**

Consolidation of procurement and administration of health benefits is already taking place. All five Agencies have consolidated the purchasing of prescription drugs for years. All five agencies contract with Caremark as their exclusive prescription drug vendor.<sup>17</sup> There are already a number of smaller County government entities that opt-in or "participate" in the health benefits programs contracted for and administered by the MCG. The county provides health care plans for these agency employees. These municipalities, e.g. Chevy Chase View, the Village of Friendship Heights, and the Town of Chevy Chase; and special purpose entities such as the Montgomery County Television, the Bethesda Urban Partnership, and Strathmore Hall Foundation. I would assume there is a contract between the County and each entity spelling out the coverage, payment mechanisms, reimbursement rates for county administrative staff for the share of their time (and their benefits) devoted to administering medical benefits for the "participating" entity's staff, etc.<sup>18</sup> This suggests that "consensual" consolidation works when it provides lower costs/premiums through increased bargaining power. The question this raises is why these savings did not work in the case of the Kaiser Proposal.

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<sup>17</sup> CARS Subcommittee Report, dated September 15, 2010, p.1.

<sup>18</sup> It appears this is not always the case, as the County, not the municipality or special purpose entity, pays employees costs if their claims exceed their premiums. OLO Report 2011-2 at circle page 98.

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

There will surely be more consolidation in the future. In this Task Force member's view, the issues are whether it will be too late and too little to provide the citizenry with the administration of health benefits they deserve.

Finally, let me suggest that a review of the Kaiser Proposal suggests that consolidation need not involve all five agencies. Kaiser informs me that roughly 80% of the estimated savings come from two agencies, MCG and MCPS. Each is an exclusive Montgomery County government agency, not a bi-county entity. Montgomery College would be involved in any Kaiser HMO consolidation since MC already offered Kaiser as its exclusive HMO. Thus, the bulk of consolidation, and related dollar savings, in the case of the Kaiser proposal could have come from consensus of just two agencies. This should have made the process of consolidation and consensus building less daunting. I doubt that Kaiser would have continued to insist that all five agencies accept its Proposal if MCPS and MCG had agreed to offer Kaiser as their exclusive HMO. In addition, WSSC, the next largest provider of health benefits was already planning, when the 2010 Kaiser Proposal was negotiated, on dropping CareFirst HMO coverage, which would leave WSSC offering only Kaiser and another HMO offering. (WSSC in fact, dropped CareFirst on the first renewal round.<sup>19</sup>)

**The Cross Agency Resources Sharing (CARS) Committee**

The earliest candid, yet still incomplete, assessment of the benefits and difficulties of consolidation was in a report issued by a subcommittee of the Cross Agency Resources Sharing (CARS) Committee.<sup>20</sup> The Report came only six weeks after the close of the 2010 bidding cycle in which Kaiser made its Proposal. The CARS Employee and Retiree Benefits Subcommittee found that "Discussions with vendors and analysis of data provided in recent plan bids suggests that lower costs could be achieved by consolidating to fewer/common vendors."<sup>21</sup>

The Report recommended that the five agencies medical, vision, and dental benefits be consolidated under fewer vendors. It further recommended that this begin this year, with the

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<sup>19</sup> Task Force Minutes, September 20, 2011.

<sup>20</sup> CARS Employee and Retiree Benefits Subcommittee Report, September 15, 2010, p. 1.

<sup>21</sup> *Id.*

**Minority Report and Additional Views**  
**Brian McTigue, Public Member**

issuance of RFPs over a period of time, for instance, medical in year one, and dental the following year. Although the Subcommittee Report states that each of the member agencies was in support of the recommendation, RFPs have not been issued. Had an RFP for exclusive HMO coverage been issued, consolidation under fewer vendors might have occurred, and the County might have realized some or all of the savings estimated by Kaiser.

If there is to be additional consolidation of health benefits beyond prescription drugs, I believe it will involve the CARS, especially its Benefits Subcommittee. The CARS Committee contains more than a kernel of a future County-wide "Super Committee" to respond to the financial crisis as it affects the County. Although the full CARS Committee appears to hold open meetings, I do not believe the Subcommittee meetings are open and noticed beforehand. The Employee and Retiree Benefits Subcommittee certainly serves in a central position, clearing reports and policies between the Five Agencies, serving much as a governmental advisory committee, especially as its constituent entities stretch beyond county government. Too little is known about its workings, and what is known publicly is not available in time to act on it.

**Recommendation for the CARS Subcommittee**

I recommend that the Council consider whether the Subcommittee meetings should be noticed in advance and open to the public, and whether representatives of the County public should be appointed to at least serve on the Subcommittee, if not vote. These public representatives should be conversant with the arcane language and methodologies of employee health benefits, and have an outstanding, proven commitment to the public interest. Open and full disclosure may be the best mechanism to vet the benefits and downsides of consolidation in the administration and procurement of employee benefits. It would "sharpen the game" of each of the affected groups, County Residents, Taxpayers, Employees, Unions, the Executive, and the Council. In that interplay of forces may be found better policies, savings, and consensus.

Brian McTigue

Public Member

# Cross Agency Resource Sharing (CARS)

First Quarterly Report of Employee and Retiree Benefits Subcommittee

September 15, 2010

## Proposed Project/Target Opportunity/Action:

Consolidate the Employee Benefit Plan Offerings (medical, dental, vision) of County Agencies under fewer vendor arrangements. Prescription coverage is already consolidated.

**Description/Purpose:** The combined annual health plan cost for the five County agencies exceeds \$600 million. 90% of coverage is offered on a self-insured basis.

The primary health care vendor are UnitedHealthcare for MCPS and MNCPPC, Carefirst BlueCross BlueShield, for the County, and CIGNA for the College. Discussions with vendors and analysis of data provided in recent plan bids suggests that lower costs could be achieved by consolidating to fewer/common vendors.

## Preliminary Implementation Steps or any Obstacles/Issues to be resolved:

The County agencies have historically joined in competitive bid efforts, but past RFPs have always included a provision that decisions could be different from agency to agency. As a result, some agencies offer a menu of vendors that may or may not offer the most competitive pricing. To achieve maximum savings in a competitive bid process agencies should agree at the onset to fewer/common vendors.

Several agencies just completed bids on their medical, dental, vision and life programs. Timing of a new bid could lead vendors to conclude that the recently completed bids which asked for three year pricing agreements should be honored.

Barriers that need to be addressed include an agency willingness to make changes, and labor's role in decision making.

**Level of Service Potential:** Generally service delivery would be unchanged because this opportunity does not include making changes to plan designs. There could be some short term pain associated with changing vendors because plan participant doctor/patient relationships could be impacted. It is believed that disruption of current doctor patient relationships could be kept to a minimum if the county agency business is consolidated because chosen vendors would have additional leverage to recruit providers to participate in their plan(s).

## Cost Containment/ Estimate of Annual Savings:

- Less than \$100,000
- More than \$100,000 but less than \$500,000,
- More than \$500,000 but less than \$1M
- More than \$1M but less than \$3M
- More than \$3M

## **Cross Agency Resource Sharing (CARS)**

First Quarterly Report of Employee and Retiree Benefits Subcommittee  
September 15, 2010

### **Reasonable Timeframe for Successful Implementation:**

Midyear FY 12 would coincide with January 1, 2012 plan year. New RFPs would have to be issued in later FY 11. Issuance of RFPs could be staged over a period of time (for instance, medical in year 1, dental in year 2, etc.).

### **Level-of-Work Required to Implement:**

Significant  Moderate  Minimal

Issues would include time to issue and evaluate competitive bids and the need to develop a detailed communication plan to participants in an agency where vendor changes are made.

### **Up-front Implementation Cost (if any)**

No  Yes There will be cost to preparing, releasing and evaluating an RFP as well as developing communication plans. Generally, the agencies have resources in place to accomplish this.

### **Need for Coordination with any Other Working group or Outside Agency/Entity?**

No  Yes If yes, what group/s: Procurement, depending on how many other recommendations will require competitive bids.

### **This Proposed Project was recommended by the following Subcommittee members:**

All

### **This Proposed Project was not endorsed by the following Subcommittee members:**

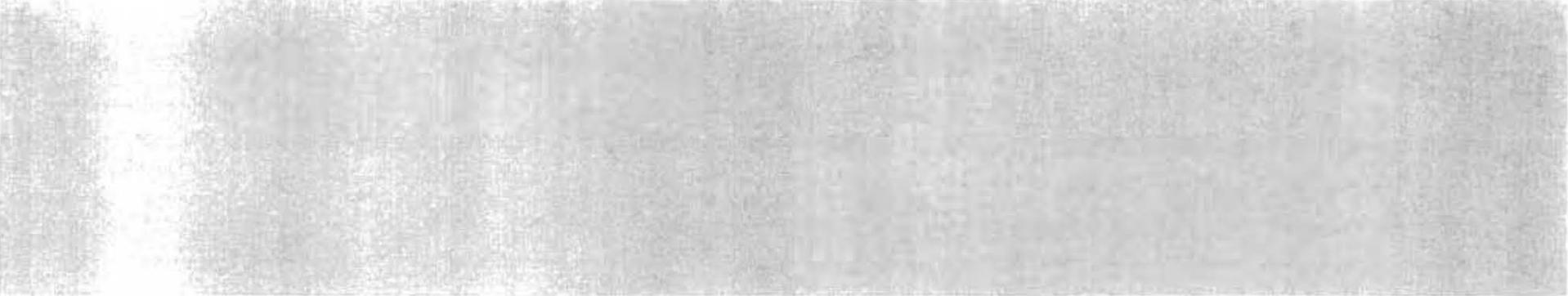
None

**Documentation (if any):** *(Include relevant documents/research/information that support the recommendation and rationale)*

# Montgomery County Agencies Doing business with Kaiser Permanente

•THE KAISER PERMANENTE ADVANTAGE





**Want to Save \$27.4 Million Dollars  
in Health Care Costs with no  
Reduction in Benefits?**

# Montgomery County Agencies 2011-2013 Best and Final Offer



Agency	Scenario I	Scenario V *
MCPS	6.0%	-2.04%
MCG	9.9%	1.45%
MC	0.3%	-7.67%
WSSC	2.6%	-5.24%
M-NCPPC	Prospective Business	

**\* \$27.4 Million  
Annual  
Savings  
as  
Exclusive  
HMO  
Carrier**

Based on estimated incumbent renewal action (includes EPO coverage)

Scenario I: Each agency is rated on an individual experience basis,  
Yr 2 cap of 10%, Yr 3 cap of 14%

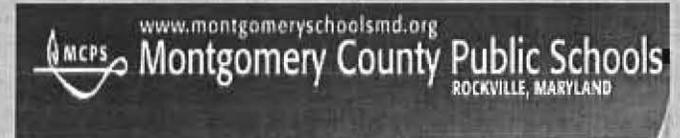
Scenario V: KP offered as Exclusive HMO to all agencies,  
Yr 2 cap of 8%, Yr 3 cap of 16%



# Montgomery County Public Schools

## 2011 Renewal Cost Drivers

**BAFO 6% Scenario I OR -2.04% Scenario V**



- **Decreased Enrollment yields worsening demographics**
- **Medical cost pmpm increased 8.6% from 2008 to 2009**
- **Increase in Inpatient and Outpatient cost**
- **Maternity and MHSA are key drivers**
- **Higher prevalence of depression, CAD, and asthma**
- **Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013**
- **Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013**

# Montgomery County Government 2011 Renewal Cost Drivers



**BAFO 9.9% Scenario I OR 1.45% Scenario V**

- **Increased enrollment w/ age > 60 erodes demographics**
- **Medical cost pmpm increased 13.6% from 2008 to 2009**
- **5 High cost claimants > \$125,000**
- **Increase in Inpatient and Outpatient costs**
- **High prevalence of diabetes, depression and asthma**
- **Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013**
- **Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013**

# Montgomery College

## 2011 Renewal Cost Drivers



**BAFO 0.3% Scenario I OR -7.67% Scenario V**

- **Medical costs decreased 2.4% from 2008 to 2009**
- **One High Cost Claimant exceeded \$125K Pooling point**
- **Growth yields favorable demographic change of 0.3%**
- **Favorable Risk score compared Kaiser Permanente average**
- **Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013**
- **Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013**

# WSSC

## 2011 Renewal Cost Drivers

BAFO 0.3% Scenario I OR -7.67% Scenario V



- Medical costs increased 9.0% from 2008 to 2009
- Four claimants > \$75K pooling point, 20.5% of claims
- Favorable demographic change of 2.2%
- Risk score slightly higher than Kaiser Permanente average
- Scenario I offers 10% & 14% Renewal Caps for 2012 & 2013
- Scenario V offers 8% & 16% Renewal Caps for 2012 & 2013

# The Maryland-National Capital Parks and Planning Commission



**\* \$1.7 Million  
Annual Savings  
as  
Exclusive HMO Offering**

**Scenario V  
offers  
8% & 16% Renewal Caps  
for 2012 & 2013**

**\* Based on estimated incumbent renewal action  
If not exclusive HMO for Scenario I rates will be increased by 5%**

 KAISER PERMANENTE®

**Follow-up Information from Kaiser Permanent to Task Force –  
Questions/Information Requests forwarded by Linda McMillan based on  
October 25, 2011 Task Force Discussion.**

**Responses from: Dawn Audia, Executive Director of Account Management for the  
Kaiser Foundation**

1. Please provide information on access to mental health services in terms of how quickly an appointment can be made with different levels of mental health professionals. This question came after the part of the presentation that discussed access to specialists and how appointments can be made while the patient is in the office with the primary care physician.

Response - Kaiser Permanente (KP) has a goal to provide non urgent appointments within 2 weeks and urgent appointments within one day. This spans all provider types (Psychiatrist MDs, Therapists, etc.). Patients are allowed to self-refer to mental health. They are triaged to find the right type of care provider for them. Currently, our overall results are relatively dependent on the speed at which non-KP providers can offer visits (we externalize roughly 1/3 of care at present). Please note that Kaiser is in the process of expanding our behavioral health capacity. We are accelerating plans to hire >30 FTEs in behavioral health region wide so that we can bring most of the care inside and take our own responsibility for ensuring we completely meet our access targets (and offer the best care).

2. What is the cost share (employee/employer premium split) for Kaiser employees? (Information for the mid-Atlantic region that would be fine.)

Response - Kaiser Permanente funds benefit costs for our own employees with Flex Credits. Flex Credits are calculated based on a Flat \$ plus a % of salary. If the benefits chosen cost more than the flex credits, the employee will pay the difference through pre-tax or after-tax payroll deductions (depending on the benefit selected). If the benefits cost less than the credits, the employee will receive those credits in their paycheck as taxable income.

3. I need to clarify the response to the question, "What percent of Kaiser employees are represented?" The response was 90% - was this 90% of those in eligible job classes (which would mean an employee could chose or not chose to be in the union) or 90% of non-doctors.

Response - Kaiser Permanente currently has 80% of our 164,000 (or roughly 131,000) non-physician and non-executive employees in a union.

4. Do you have data on client retention for the mid-Atlantic region?

Response - Our client retention in the Mid-Atlantic region is very good. For 2011, in our large group segment Kaiser only lost two customers. One was due

to a consolidation - the group was purchased by a national organization, and the other loss was due to political issues (a new, competing organization was added to the region). Year-to-date for Kaiser for all of our segments (small group, mid-market, large group, federal government and national accounts), we are at a 92% group retention, but a 98% member retention (we are growing in the groups we are retaining). In 2010 and 2011, our region has seen significant overall growth in Kaiser members and we anticipate this trend to continue based on our high quality, customer satisfaction scores and the opening of our new Medical Centers.

5. Do you have demographic information on age and gender for Kaiser members in county agencies (broken out by agency) so that it can be compared to the entire pool of agency employees?

Response - Demographic information by agency is attached.

6. Are you able to provide any more detail on your proposal to Montgomery County that would have resulted in \$27 million in savings if the County agencies only used Kaiser as their HMO? Did the savings come from a reduction in the premium you would charge from serving a larger population or from the difference in the cost between United Healthcare/CareFirst/CIGNA HMOs + Caremark compared to the Kaiser premium that will be charged in 2012?

Response - The \$27.4 million in savings assumed that Kaiser Permanente would still sit along side CareFirst and UHC, however, Kaiser would be the only HMO offering. The savings came from a reduction in administrative expenses due to economies of scale on the additional members, but more importantly, it came from an overall reduction in estimated claims costs based on our ability to control costs. I have attached the high level information we presented during the finalist presentation from the RFP in June of 2010. The assumptions that were made for the calculation were shared with AON at the time. We would be happy to provide an updated projection for you based on current information, but we anticipate very similar, if not greater savings.

We again, appreciate the opportunity to speak with the Task Force and welcome the opportunity to answer any additional questions or provide a tour of our Capitol Hill Medical Center.

Monglomey County Agencies  
 Scenario 5 - Kaiser as exclusive HMO  
 Competitors monthly HMD enrollment and premium

Agency	UHC EPO Subscribers	UHC EPO Rates	Monthly Premium	CareFirst EPO Subscribers	CareFirst EPO Rates	Monthly Premium	Replace Competitor HMO Subscribers	Kaiser HMO Scenario 5 Rates	Competitor Monthly Premium @ KP Rates	Kaiser HMO Subscribers	Kaiser Scenario 1 Rates	Kaiser HMO Scenario 5 Rates	Difference In rates	Kaiser savings moving to Scenario 5
<b>MCPS</b>														
Single	1,880	\$ 519.61	\$ 976,867	1,105	\$ 464.45	\$ 513,217	2,985	\$ 419.89	\$ 1,253,372	1,242	\$ 454.56	\$ 419.89	\$ 34.67	\$ 43,060
2 - Person	1,945	\$ 993.04	\$ 1,931,463	693	\$ 890.77	\$ 617,304	2,638	\$ 837.97	\$ 2,210,565	995	\$ 907.17	\$ 837.97	\$ 69.20	\$ 68,654
Family	2,585	\$ 1,606.88	\$ 4,158,955	1,273	\$ 1,340.52	\$ 1,706,482	3,858	\$ 1,214.22	\$ 4,684,481	1,470	\$ 1,314.50	\$ 1,214.22	\$ 100.28	\$ 147,412
subtotal	6,410		\$ 7,067,284	3,071		\$ 2,837,003	9,481		\$ 8,148,397	3,707				\$ 259,326
							<b>MCPs SAVINGS</b>		\$ 1,756,890					
<b>MC GOVERNMENT</b>						4,227								
Single	659	\$ 493.86	\$ 325,454				659	\$ 431.98	\$ 284,675	539	\$ 467.97	\$ 431.98	\$ 35.99	\$ 19,397
2 - Person	614	\$ 926.46	\$ 570,074				614	\$ 838.54	\$ 513,638	322	\$ 879.77	\$ 636.54	\$ 43.23	\$ 13,920
Family	889	\$ 1,461.83	\$ 1,270,330				889	\$ 1,278.65	\$ 1,111,147	454	\$ 1,385.17	\$ 1,278.65	\$ 106.52	\$ 48,360
subtotal	2,142		\$ 2,165,858				2,142		\$ 1,909,457	1,316				\$ 81,677
							<b>MCG SAVINGS</b>		\$ 256,401					
<b>Mont. College</b>														
	No existing competitor HMO's													
Single										225	\$ 363.94	\$ 338.54	\$ 25.40	\$ 5,715
2 - Person										223	\$ 982.59	\$ 914.01	\$ 68.56	\$ 15,293
Family														
subtotal										448				\$ 21,008
							<b>MC SAVINGS</b>							
<b>WSSC</b>														
Single	152	\$ 621.00	\$ 94,392	262	\$ 553.32	\$ 144,970	414	\$ 428.98	\$ 177,598	127	\$ 464.63	\$ 428.98	\$ 35.65	\$ 4,528
2 - Person	151	\$ 1,242.00	\$ 187,542	214	\$ 1,106.64	\$ 236,821	365	\$ 857.95	\$ 313,152	81	\$ 929.27	\$ 857.95	\$ 71.32	\$ 5,777
Family	122	\$ 1,834.25	\$ 223,779	269	\$ 1,333.48	\$ 358,706	391	\$ 1,299.79	\$ 508,218	104	\$ 1,407.84	\$ 1,299.79	\$ 108.05	\$ 11,237
subtotal	425		\$ 506,713	745		\$ 740,497	1,170		\$ 998,967	312				\$ 21,542
							<b>WSSC SAVINGS</b>		\$ 247,242					
<b>M-NCPPC</b>														
Single	220	\$ 409.59	\$ 90,110	135	\$ 442.03	\$ 59,674	355	\$ 359.14	\$ 127,495	Currently does not offer Kaiser				
2 - Person	185	\$ 824.10	\$ 152,459	132	\$ 901.37	\$ 118,981	317	\$ 718.27	\$ 227,692					
Family	204	\$ 1,241.14	\$ 253,193	134	\$ 1,328.90	\$ 178,073	338	\$ 1,037.90	\$ 350,810					
subtotal	609		\$ 495,761	401		\$ 356,727	1,010		\$ 705,996					
							<b>NCCPC SAVINGS</b>		\$ 146,492					

Assumes competitor rates increased 5%

Total Monthly Savings for all Agencies	\$ 2,406,026
Total Annual Savings for all Agencies	\$ 28,872,301

Kaiser Member Savings	\$ 383,563
	\$ 4,602,632

SUMMARY	Competitor HMO Savings	Kaiser HMO Savings	Total Potential Savings
MCPS	21,070,679	\$ 3,111,909	\$ 24,182,588
MCG	3,076,615	\$ 980,123	\$ 4,056,737
MC		\$ 252,100	\$ 252,100
WSSC	2,966,905	\$ 268,600	\$ 3,235,505
NCPPC	1,757,902	\$ 1,757,902	\$ 3,515,804
<b>Total</b>	<b>28,872,301</b>	<b>4,602,632</b>	<b>33,474,933</b>





## Memo

**To:** Linda McMillan, Senior Legislative Analyst, Montgomery County Council  
**From:** Kathleen McAuliffe, Senior Vice President, Aon Hewitt  
**Date:** January 23, 2012  
**Re:** Review of Kaiser Proposal

### Requested Task

Aon Hewitt was asked to review and analyze the Kaiser proposal (as part of its 2011-2013 Best and Final Offer to a joint RFP issued by the five county-funded agencies for health benefits) that indicated \$27.4 million annual savings if Kaiser was selected as the exclusive HMO provider for all five county-funded agencies.

This estimate of savings was also made by Kaiser representatives during a presentation to the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs on October 25, 2011.

For this analysis, Aon Hewitt reviewed the materials submitted by Kaiser in response to the joint RFP as well as the materials Kaiser provided to the Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs.

The review and analysis has been completed in two components:

#### Component #1

- Aon Hewitt detailed and clarified the assumptions that were used by Kaiser to calculate the projected savings of \$27.4 million; and
- Aon Hewitt assessed the validity of the assumptions used by Kaiser to develop the projected savings.

#### Component #2

Aon Hewitt assessed the feasibility and reasonableness of achieving \$27.4 million in annual savings as detailed in the Kaiser presentation. Aon focused on the calculation of savings for MCPS which accounted for almost 75% of the projected savings. This included:

- Utilizing the applicable 2012 premium rates and rate equivalents
- Valuing the impact on Employer cost
- Separating retirees and active employees and utilizing the appropriate rates and cost share factors
- Valuing plan design differentials
- Including only individuals with access to Kaiser facilities in the analysis
- Including estimates for enrollment shifts to non-HMO plans

## Component #1

### Kaiser Process and Assumptions

The calculation done by Kaiser attempted to compare competitor rates to the proposed Kaiser rates. The calculation took the difference in rates and multiplied by enrollment to come up with a savings number. The rates included the cost of medical and prescription coverage.

Kaiser stated that they utilized competitor 2010 rates and assumed that competitor rates would increase by 5% in 2011. This assumption was reasonable and was close to the actual increase for most of the HMO plans for 2011. Kaiser also assumed that all employees and retirees who currently have HMO coverage would choose the Kaiser plan. Retirees eligible for Medicare were not included in the analysis. Only active employees and early retirees were included.

### Validity of Assumptions

The first major area of concern involved the rates utilized in the comparison. Incorrect competitor rates were used in many instances in the calculations. Where Aon found discrepancies, the rates used were much higher than the actual competitor rates. The chart below shows inaccuracies for the two MCPS HMO plans. The MCPS plans are being highlighted since the MCPS HMOs have the greatest enrollment and accounted for almost 75% of the projected savings.

To maintain consistency with Kaiser's methodology, Aon utilized the correct 2010 competitor rates and increased them by 5% to estimate 2011 cost

MCPS	UHC HMO 2010 + 5%	Rate Kaiser Used	Difference	CareFirst HMO 2010 + 5%	Rate Kaiser Used	Difference
Ind.	\$519.61	\$519.61	N/A	\$424.19	\$464.45	\$40.26
Ind. + 1	\$993.04	\$993.04	N/A	\$813.26	\$890.77	\$77.51
Family	\$1,517.79	\$1,608.88	\$91.09	\$1,223.23	\$1,340.52	\$117.29

Utilizing the enrollment that Kaiser assumed, these discrepancies reduce the estimated savings for these two plans alone by \$5.8 million.

When Kaiser calculated savings, they utilized active employee rates for the <65 retirees and ignored the cross subsidy issue where most of the active plan rates for competitors subsidize retiree rates.

Kaiser's \$27.4 million savings result also did not take into account the Agency share of the cost. Their calculation results in a gross estimate that does not represent true savings to the Agencies since it ignores the amounts that participants pay in premiums.

Kaiser also neglected to apply assumptions for plan design differentials among the plans –in particular the Kaiser prescription benefit is less generous than some of the other Agency plans. A reduction in benefit would produce savings even if other HMOs were not eliminated. This portion of the savings could be achieved within the current vendor plans by reducing benefits down to the Kaiser plan level.

A major additional area of concern is the assumption that all current active and retired employees would select the Kaiser HMO if the UHC and CareFirst HMOs were eliminated. There was no assumption made for those employees and retirees who would stay with their current vendor, but select the POS or PPO plan rather than moving to the Kaiser HMO.

This is significant since a change to Kaiser would require all HMO participants to change their physician relationships. It is extremely unlikely that all employees and early retirees would make this change when there are other plan options that would allow them to maintain their physician relationships. The POS and PPO plan options have a greater employer cost than the current HMOs, so employees electing these plans would significantly increase overall employer cost and significantly reduce the savings projected by Kaiser.

In the RFP response Kaiser provided geo-access information that showed that about 7% of the Agency employees did not have access to their facilities. Access was defined as having a provider within 10 miles of the employee's home address. This segment of the population should not have been included in the Kaiser analysis.

## Other Issues

### **Funding Methodology**

The current non-Kaiser HMO plans for all the Agencies are self-funded. This allows the Agencies to pay the actual cost of health insurance claims and an administrative fee for the HMOs to administer the plan. The Agencies also purchase stop loss coverage to protect from the risk of high cost claims. Self insurance allows the Agencies to manage both the funding and plan design of their benefit programs most effectively without the constraints of state mandated provisions and additional charges included in fully insured programs.

Under a fully insured arrangement, a 2% premium tax would become applicable. This amounts to about \$2 million annually in additional expense for MCPS alone. The Agencies also would be subject to state mandates which increase cost as benefits are improved or mandated. In addition, the Agencies would not have the cash flow advantage that self insurance provides. When claims experience is better than expected, as has been the case in recent years, the Agencies only pay actual claims. Under a fully insured arrangement any positive claim experience results in profit for the insurer.

Kaiser guaranteed rate caps of 8% for 2012 and 16% for 2013. The actual increases in HMO costs for 2012 for MCG United HMO was 3.2% and Kaiser was 3.5% while the MCPS HMO increases were about 7.0% for Kaiser and 0% for CareFirst and about 1% for United.

### **Capacity of Kaiser Facilities**

An additional item of concern that Kaiser neglected to address is the capacity for their facilities to handle the significant increase in membership that would occur should Kaiser gain all of the Agency HMO membership (approximately 30,000 new members). It is likely that Kaiser's current staffing would have to be increased significantly to accommodate this many new members. Kaiser's plan for growth in staff should have been shared with the Agencies as part of the Kaiser proposal to ensure that plan participants would not experience long wait times for appointments and to outline new staff experience requirements.

## Component #2

### **Aon Hewitt Assessment**

#### **Analysis Revisions and Validation**

***The following Aon Hewitt analysis is based on MCPS data:***

*Step 1* – Aon updated the preliminary savings estimate with 2012 MCPS premium rates for the CareFirst HMO plan plus Caremark and the United HMO plan plus Caremark compared to the Kaiser premiums. The actual Kaiser premiums were discounted by about 7.7% to reflect the discount Kaiser proposed in the RFP response should all Agencies elect Kaiser as full HMO replacement. Aon also utilized the correct early retiree rates that are different from active employee rates.

This calculation results in a “savings” amount of \$16.4 million compared to Kaiser’s calculation amount of \$24.2 million (for MCPS portion only). Kaiser did not incorporate any other adjustments to their savings calculation for MCPS of \$24.2 million.

*Step II* – Aon looked at the employer share of the \$16.4 million, recognizing that MCPS active employees pay 5% of the HMO premium and 10% of the prescription premium while early retirees pay 36% of the medical and prescription plan cost. The net result was a “savings” to MCPS of \$13.7 million.

*Step III* – Aon reviewed the geo-access information provided by Kaiser in their 2010 RFP response. They identify about 7% of MCPS employees and retirees who do not have access to their facilities. Access is defined as having a facility within 10 miles of their home address. Aon reduced savings to reflect that not all current HMO participants would have access to Kaiser. This adjustment reduces the savings number to \$13.0 million.

*Step IV* - Aon valued the difference in plan design between the Kaiser plan and the other HMO plans. The most significant design difference is that the Kaiser Prescription copay is \$15 at non-Kaiser facilities. This reduced savings by an additional \$1 million to \$12.0 million.

*Step V* - Aon next looked at the assumption that 100% of HMO participants would move to Kaiser if that were the only HMO option. Since this would require changing physician relationships for all participants it is very unlikely that this would occur. Many employees and retirees would elect one of the CareFirst or United POS plans in order to maintain their physician relationships. All the United and CareFirst HMO physicians also participate in the POS plans. Assuming 50% do not switch to Kaiser but elect a POS plan; savings are significantly reduced to about \$3.9 million. This is because the employer cost for the POS plans is much greater than for the HMO plans and dilutes most of any anticipated savings.

The \$3.9 million final validated savings estimate is composed of \$1 million from other HMO participants and \$2.9 million from the discounted Kaiser rates that would be applicable to current Kaiser participants. Under this scenario – the effect of eliminating all other HMO plans and requiring participants who want to maintain HMO coverage to change providers and select Kaiser is \$1 million in savings for MCPS. The \$2.9 million is savings for participants who already have Kaiser coverage and are not being required to change plans and physicians.

**Attachments:**

Summary of Kaiser Analysis for MCPS

MCPS 2012 Active and Early Retiree Rates Used in the Analysis



Summary of Kaiser Analysis for MCPS - Annual Savings (in millions)

Steps	Savings for Moving to Kaiser	Actives Additional Savings for Current Kaiser	Total Savings	Savings for Moving to Kaiser	< 65 Retirees Additional Savings for Current Kaiser	Total Savings	Savings for Moving to Kaiser	Total Additional Savings for Current Kaiser	Total Savings
Kaiser Analysis	\$21.1	\$3.1	\$24.2	\$0.0	\$0.0	\$0.0	\$21.1	\$3.1	\$24.2
(1) - Update with 2012 Enrollments and Premiums	\$10.1	\$3.0	\$13.1	\$3.1	\$0.2	\$3.3	\$13.2	\$3.2	\$16.4
(2) - Same as (1), but value only the employer share of premiums	\$8.8	\$2.8	\$11.6	\$2.0	\$0.1	\$2.1	\$10.8	\$2.9	\$13.7
(3) - Same as (2), but exclude employees without access	\$8.2	\$2.8	\$11.0	\$1.9	\$0.1	\$2.0	\$10.1	\$2.9	\$13.0
(4) - Same as (3), but adjust for a difference in plan design	\$7.3	\$2.8	\$10.1	\$1.8	\$0.1	\$1.9	\$9.1	\$2.9	\$12.0
(5) - Same as (4), but assume 50% elect POS plan rather than move to Kaiser	\$0.3	\$2.8	\$3.1	\$0.7	\$0.1	\$0.8	\$1.0	\$2.9	\$3.9

**2012 Active Rates - MCPS**

Plan	2012 Rates	EE %	EE Contributions	ER Contributions
<b>UHC Select HMO</b>				
Single	\$388.70	5%	\$19.44	\$369.26
Employee + One	\$730.59	5%	\$36.53	\$694.06
Family	\$1,196.95	5%	\$59.85	\$1,137.10
<b>CareFirst BlueChoice HMO</b>				
Single	\$293.24	5%	\$14.66	\$278.58
Employee + One	\$551.14	5%	\$27.56	\$523.58
Family	\$902.95	5%	\$45.15	\$857.80
<b>Kaiser HMO</b>				
Single	\$422.08	5%	\$21.10	\$400.98
Employee + One	\$841.05	5%	\$42.05	\$799.00
Family	\$1,218.11	5%	\$60.91	\$1,157.20
<b>UHC Open POS</b>				
Single	\$450.77	10%	\$45.08	\$405.69
Employee + One	\$901.51	10%	\$90.15	\$811.36
Family	\$1,226.63	10%	\$122.66	\$1,103.97
<b>Caremark Prescription Drug</b>				
Single	\$141.07	10%	\$14.11	\$126.96
Employee + One	\$281.84	10%	\$28.18	\$253.66
Family	\$347.81	10%	\$34.78	\$313.03
<b>Kaiser Prescription Drug</b>				
Single	\$65.55	10%	\$6.56	\$59.00
Employee + One	\$130.87	10%	\$13.09	\$117.78
Family	\$189.66	10%	\$18.97	\$170.69

2012 <65 Retiree Rates - MCPS

Plan	2012 Rates	EE %	EE Contributions	ER Contributions
<b>UHC Select HMO</b>				
Single	\$648.05	36%	\$233.30	\$414.75
Employee + One	\$1,226.39	36%	\$441.50	\$784.89
Family	\$2,003.19	36%	\$721.15	\$1,282.04
<b>CareFirst BlueChoice HMO</b>				
Single	\$418.75	36%	\$150.75	\$268.00
Employee + One	\$787.06	36%	\$283.34	\$503.72
Family	\$1,289.45	36%	\$464.20	\$825.25
<b>Kaiser HMO*</b>				
Single	\$468.20	36%	\$168.55	\$299.65
Employee + One	\$934.39	36%	\$336.38	\$598.01
Family	\$1,354.52	36%	\$487.63	\$866.89
<b>UHC Open POS</b>				
Single	\$657.90	36%	\$236.84	\$421.06
Employee + One	\$1,315.82	36%	\$473.70	\$842.12
Family	\$1,790.17	36%	\$644.46	\$1,145.71
<b>Caremark Prescription Drug B</b>				
Single	\$165.57	36%	\$59.60	\$105.97
Employee + One	\$331.12	36%	\$119.20	\$211.92
Family	\$413.91	36%	\$149.01	\$264.90

\* Includes prescription drugs

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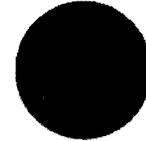
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December 9, 2011

George Leventhal  
Chair, Health and Human Services Committee  
Montgomery County Council  
100 Maryland Avenue  
Rockville, Maryland 20850

065977



**RE: Task Force on Employee Wellness and Consolidation of Agency Group Insurance Programs**

Dear Councilmember Leventhal,

In follow-up to this week's presentation of the Task Force's Report, I wanted to share some thoughts and observations. I believe the Task Force and its Report have laid an important foundation for future work on the issues surrounding employee healthcare. From our end, MCEA remains committed to doing all we can to respond to the cost challenges and to continue to advance health care for school system employees and their dependents that is both affordable and of high quality.

Allow me to also complement the high quality of the work done by the OLO staff in supporting the work of the Task Force. They were thoughtful, skilled and very hardworking in supporting and guiding the work of the Task Force members. This project would not have been nearly as productive as it has been, were it not for their efforts.

Many observers may read into the Task Force Report whatever assumptions they bring to the issue in the first place. This should come as little surprise on a topic as complex and multifaceted as reforming our health care system. However I believe there are a number of clear lessons from the Report that should not be lost – and which were not all clarified in the presentation. Specifically:

1. There are no quick fixes
2. "Consolidation" means different things to different people
3. Improving the health of plan participants is the central means of controlling health care costs
4. The MCPS wellness program appears to be the most comprehensive of all the agencies
5. There is little savings to be had in administrative costs
6. The current fee-for-service model of health care delivery is ill-suited for improving health care
7. The projected cost savings from the "Kaiser-only-HMO" option are faulty
8. The cost comparisons between agencies are incomplete
9. It is possible to "bend the cost curve"

## 1. There are no quick fixes

I believe the Task Force Chair and Subcommittee Chairs made clear in their presentations that there are no quick fixes. As Councilmember Elrich observed during the discussion, this is a national problem facing every private sector as well as public sector employer. At best, the return on investment (for actual investments in wellness programs) is three years. Even at that point, it can be difficult to draw a direct connection between a declining rate of growth in claims and specific wellness initiatives. A consensus conclusion of the Task Force was that

*“...there are no simple solutions to bending the health care cost curve downward... improvements will take time, may require upfront investment and will likely be incremental” (p. i)*

Anyone who had hoped for easy solutions to save millions of dollars in one year has unrealistic expectations.

## 2. “Consolidation” means different things to different people

To some, consolidation means consolidation of administration. The federal government has been held up as an example. One agency, the Office of Personnel Management, administers all insurance plans across all federal agencies. However what OPM administers is literally hundreds of different plan options that are available to federal employees. Yet the Task Force saw no data indicating that the average cost of health care for federal government employees was any less than it is for Montgomery County employees.

To others, consolidation means consolidation of plan options. For them, the existence of 17 different plan options across agencies suggests inefficiencies; leading to a conclusion that the county should consolidate and offer fewer plan options. This perspective underlies a suggestion that there are savings to be had if there were only one HMO plan option. Yet this contradicts the federal government/OPM model, where there are literally hundreds of plan options.

Additionally, I must say that I believe the Task Force chairs overstated the extent of agreement amongst Task Force members on the potential advantages of consolidation. It was my impression from the discussions that there were many Task Force members who were not and are not ready to recommend consolidation to the Council. While there have been assertions that it is “logical” that there would be savings from consolidation, there was no substantive information presented to the Task Force to support that assertion. And given that there are contradictory interpretations of what consolidation actually means (see above) – I, among others, remain unconvinced that there are meaningful savings to be had.

### **3. Improving the health of plan participants is the central means of controlling health care costs**

The strongest consensus, not only among Task Force participants but among the policy experts and practitioners who met with and supported the Task Force, is that improving the health of plan participants is the single most important driver in controlling health care costs. If we want to focus on what matters, we must continue to seek new and innovative ways of encouraging both plan participants and health care providers to take greater responsibility for improving the health of plan participants.

### **4. The MCPS wellness program appears to be the most comprehensive of all the agencies**

I believe both OLO staff and Task Force participants recognize that the wellness initiatives that have been developed within the Montgomery County Public Schools are a model. (*An overview of the MCPS cost containment efforts can be found in Appendix H of the Task Force Report*). From the new smoking cessation program, to the recent "MCPS on the Move" partnership with Kaiser Permanente, to the plan design changes to discourage use of emergency rooms, there is much that can be learned from MCPS's efforts. However we cannot rest on our laurels, so to speak, but rather must continue to see innovative ways to increase participation in wellness efforts and increase the incentives for both participants and providers to take responsibility for improving participants' health.

### **5. There is little savings to be had in administrative costs**

The Task Force Report was very clear in saying that *"Consolidation per se does not guarantee lower costs, particularly in a self-insured environment. The savings from administrative consolidation alone would not be material"* (p. iv).

To understand why this is true, one need only examine the chart on page 12 of the Task Force Report. As that chart indicates, 94% to 96% of county health insurance costs are due to claims: not to either administration or stop loss coverage. Any possible savings in administrative costs due to consolidation represent only the smallest share of county health costs. This further illustrates why it is controlling claims costs that is the real challenge facing all of us who are concerned about the high cost of health care. Simply moving around the chairs of those administering the plans is insignificant in comparison.

Further, I believe those who are convinced there are savings to be had from consolidating administration grossly underestimate the information technology (IT) costs involved in doing so.

### **6. The current fee-for-service model of health care delivery is ill-suited for improving health care**

The work of the Task Force only deepened my understanding of why the current health care delivery model is so inadequate to the task. Both Task Force members and the policy experts and practitioners who were consulted clearly saw the shortcomings of a health care delivery system that reimburses providers based on number of visits – or services provided - rather than on health outcomes.

**8. The cost comparisons between agencies are incomplete**

Much has been made of the comparative cost of health care between MCPS and the Montgomery County Government. Therefore I must point out that the comparisons done by AON, and highlighted in the Task Force Report, only speak to a comparison of active employee costs. AON states that the primary reason behind the differences in ACTIVE employee costs is the fact that the County Government blends its active and retiree rates.

This leaves unanswered the comparison between RETIREE costs between MCPS and the County Government. As it is, MCPS pays a lower percentage of retiree premiums than the county government or most of the other agencies:

	<b>Percent of Retiree Premium Paid by Employer/Agency</b>
M-NCPPC	85%
WSSC	80%
Montgomery County Government	> 70% <sup>1</sup>
Montgomery College	60%
MCPS	64% - 40% <sup>2</sup>

<sup>1</sup> – as AON has explained, the County Government “pools” its active and retiree costs to establish its premiums. As a result, the retiree “rate” is artificially low, as it is subsidized by the active rate. If one were to account for the pooling, the County Government is actually paying more than the listed “70%” of the cost of retiree health premiums.

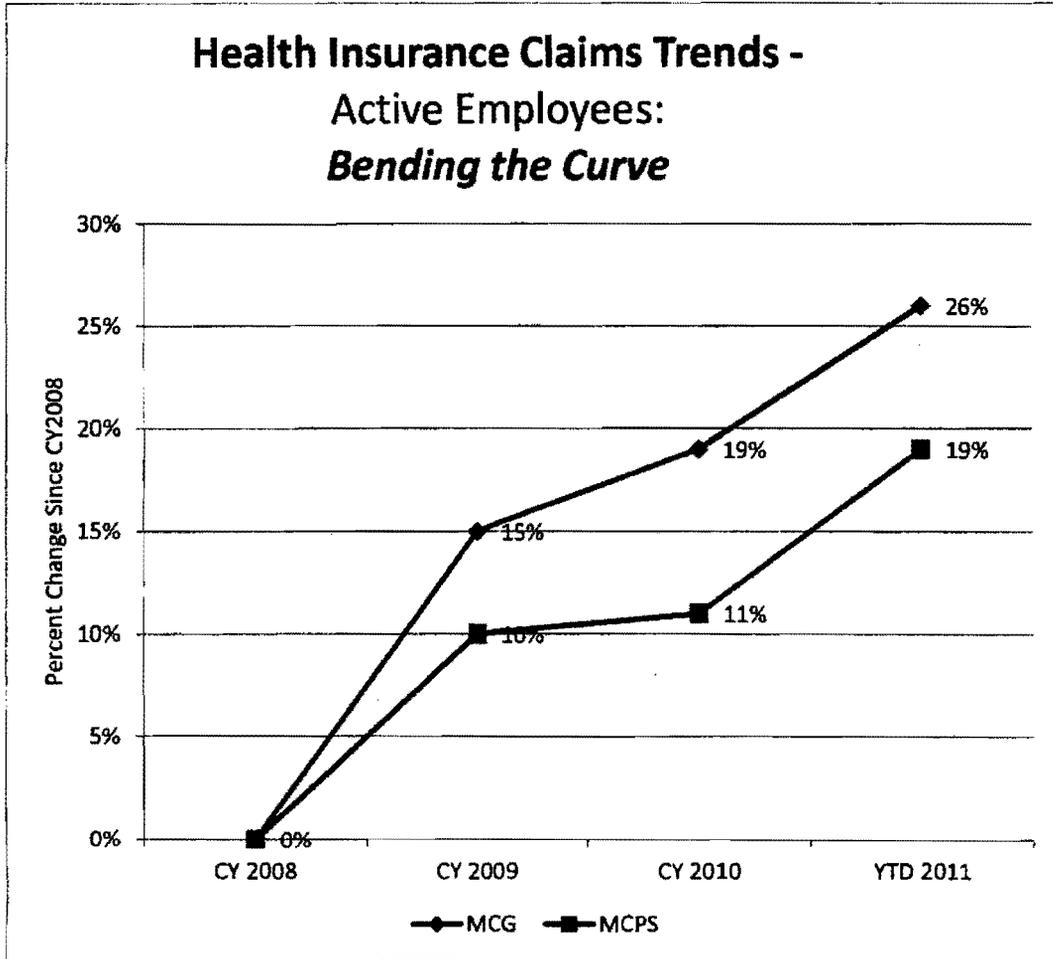
<sup>2</sup> – MCPS pays no more than 64% of its retirees’ health insurance premiums. As a result of action in the spring of 2011, MCPS has reduced its’ share to 50% for those who retire with 15-20 years of service and to just 40% of the premium for those who retire with 10-15 years of service. (Those retiring with less than 10 years of service are not eligible for retiree health care).

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The Task Force rightly focused on how to control the escalating cost of health care – for both the county and its employees – and not on simplistic cost shifting. However given the time and energy that has been spent on the issue of premium cost sharing formulas for active employees – and the attention given to AON’s complicated analysis attempting to compare MCPS and MCG costs for active employees by ‘backing out’ the value of the County Government’s pooling of active and retiree rates – it is important to not ignore the impact that pooling has on the differences in premium cost sharing formulas among retirees. Retirees represent 25% of health plan participants – and a significantly higher percentage of actual health care claims.

9. It is possible to “bend the cost curve”

The good news is that it is possible to “bend the cost curve” and slow the rapid rise in health care costs. The Task Force reports on several concrete, documented examples; for example in King County Washington and the Johnson & Johnson company. However even here in Montgomery County, the Task Force reports an encouraging trend in health care costs. The Report includes the following chart illustrating the health insurance claims trend in MCPS and MCG:



Source: Task Force Report, p. 4

**MCPS is experience a measurable slower rate of growth in health care expenses than the County Government.** Given the significant focus on wellness within MCPS, this data suggests that these wellness and cost containment efforts are indeed having a positive impact on overall health costs.

And this data precedes any real impact from MCPS’ fall 2010 “MCPS On The Move” wellness partnership with Kaiser, which saw:

- 5,300 of 10,000 eligible elementary school staff participating (53%)

- 16,490 pounds of documented weight loss
- Reduction in average Body Mass Index (BMI) from 26.2 to 22.4, moving the group from the obese category to the normal weight category

- Task Force Report, p. 14.

### Conclusion

The Task Force has done a great deal of valuable work, and has laid a foundation for future progress. MCEA remains committed to working collaboratively to address these challenges in ways that control the escalating cost of health insurance for both the agencies and their employees. We look forward to continuing to work with you on this.

Sincerely,



Tom Israel  
Executive Director

c: — Montgomery County Council  
Montgomery County Board of Education  
Dr. Joshua Starr, Superintendent of Education  
William Mooney, Task Force Chair



## February 2012 Well Aware eNews

Welcome to the February issue of the Well Aware eNews!

Read on to learn about—

- How a wellness champion transformed a tough year into endless possibilities,
- The new fitness challenge designed to get you walking,
- Staff accomplishments through *MCPS on the Move* and *Work It Circuit*,
- How even a little exercise can help your heart, and more!

### Wellness Champion Makes Major Changes



**Meet Coree Ogden:**  
School Secretary, John Poole Middle School

Coree Ogden had a rough year in 2011. After suffering some losses in her family and undergoing major surgery, Coree was feeling tired and run-down. But an invitation to join *MCPS on the Move* turned her life around! Coree has been a motivator for the staff at John Poole Middle School since the first day of *MCPS on the Move*. Coree faithfully exercised for one hour every day of the challenge. Her husband—and favorite walking partner—thinks she looks eight years younger. She was even able to put her wedding ring back onto her finger after ten years of being unable to wear it. Most important, Coree now enjoys playing with her two young grandchildren at the park. Says Coree, “They love their ‘new’ grandmother and I am beginning to love her too!”

Coree’s enthusiasm and ability to inspire those around her have even earned her an *MCPS on the Move* Spirit Award. Congrats, Coree! Read more about her inspiring story in an upcoming issue of *The Bulletin*!

### MCPS on the Move and Work It Circuit Challenges End on a High Note

An awards ceremony was held on January 24, 2012, to celebrate the successes of *MCPS on the Move* and *Work It Circuit*.



Don’t miss it!

### Heart Smart Seminar

#### Thursday, February 9

4:00–5:00 p.m.  
Poolesville HS Cafeteria  
17501 Willard Road  
Poolesville, MD 20837

#### Monday, February 13

10:00–11:00 a.m.  
West Farm Bus Depot Training Room  
11920 Bournefield Way  
Silver Spring, MD 20904

#### Wednesday, February 15

10:00–11:00 a.m.  
Shady Grove Bus Depot Staff Lounge  
16651 Crabbs Branch Way  
Rockville, MD 20855

#### Thursday, February 16

4:30–5:30 p.m.  
CESC Cafeteria  
850 Hungerford Drive  
Rockville, MD 20850

#### Thursday, February 23

4:00–5:00 p.m.  
Sherwood HS Cafeteria  
300 Olney Sandy Spring Road  
Sandy Spring, MD 20860

Spread the word with a printable [flyer!](#)

Presented by:



*MCPS on the Move and Work It Circuit.* During the ceremony, winners claimed their prizes, including grants for physical education equipment or staff wellness programs, gift cards for sporting goods, and Wii Fit systems. Check out [this article](#) in *The Bulletin* for a complete list of grand prize winners!



"These prizes are just the tip of the iceberg," said Lisa Cooperstein, MCPS wellness coordinator. "They provided a little incentive to start making changes for the better, but the real prizes are the benefits that have come and will continue to come from the changes participants have made."

Payoffs from those changes have already begun to show. During the competitions, school system employees logged a total of 82,540 hours of exercise. Participants in the *MCPS on the Move* program, which was open to all secondary school and central services staff members, burned a total of 30,235,667 calories—the equivalent of burning 8,638 pounds. Coree Ogden, secretary at John Poole Middle School and this month's wellness champion, said, "I have lost 12 pounds and two sizes. I am thinking about being healthy on a daily basis. I am actually doing it!"

Although *MCPS on the Move* and *Work It Circuit* have spurred employees to take great strides toward health improvements, it doesn't end there. Staff members are encouraged to keep the momentum going with the next fitness challenge—*Walk This Way*. Read on to learn more about the new program!

In the above photo: Team Moving Along, from John Poole Middle School, was honored with the award for the greatest team change in Body Mass Index.

## Take Care of Your Heart and Your Sweetheart with *Quit for Good*

### Caring for Your Heart

February is American Heart Month. If you're wondering how to best care for your heart, experts say quitting smoking should be your first step. According to the Centers for Disease Control and Prevention (CDC), people who smoke are 2–4 times more likely to develop coronary heart disease than nonsmokers.

Quitting smoking can have positive effects on your health almost right away. Within one to two years of quitting, the CDC reports that your risk of developing coronary heart disease is substantially reduced.

Why wait? Well Aware wants to support you in your efforts to quit with the free *Quit for Good* program. The program is eight weeks long and consists of once-a-week classes led by a nurse practitioner with assistance from Kaiser Permanente clinicians and health experts. *Quit for Good* is free for all participants, regardless of whether or not you carry Kaiser Permanente health insurance. [Learn more about the program details.](#)



TOBACCO CESSATION PROGRAM  
**Quit for  
GOOD!**

The next session begins this month. If you are interested, e-mail Well Aware as soon as possible to register at [wellness@mcpsmd.org](mailto:wellness@mcpsmd.org).

### Caring for Your Sweetheart

You cannot quit in a vacuum—often, family members and loved ones also smoke and want to quit as well. Just in time for Valentine's Day, upcoming sessions of *Quit for Good* will welcome all staff members **and** their spouses. Well Aware wants to help you and your spouse quit together—register as a couple to receive the tools you need to support one another in your joint efforts to quit!

## New! Prepare to Make Strides with *Walk This Way*

Building on the success of *MCPS on the Move* and *Work It Circuit*, Well Aware announces the next activity competition, *Walk This Way*, which challenges employees to reach the end goal of walking 10,000 steps a day.

10,000 STEPS A DAY  
**WALK**  
this way

10,000 steps roughly equates to 30 minutes of physical activity, the Surgeon General's recommended activity level for all Americans. The program will provide incentives and encouragement to spur employees to work their way up to this goal. "Walking is one of the simplest activities you can do, yet it benefits you in so many ways," says Lisa Cooperstein, MCPS wellness coordinator.

The competition will begin in March and will last eight weeks. Each participant will receive a pedometer to track daily steps. Watch for more information from Well Aware and the volunteer wellness coach(es) at your location!

## Even a Little Exercise Helps the Heart, Study Finds

Take the stairs instead of the elevator. Go for a walk after dinner. Play tag with your kids at the park.

New research shows that even small amounts of exercise—about 150 minutes, or 2.5 hours, of moderate activity a week—can reduce the risk of heart disease by about 14 percent.

Those who did more—about 300 minutes a week, or five hours—reduced their risk of heart disease, including heart attacks, angina and bypass surgeries, by 20 percent compared to people who did no exercise, the study found.



"Some physical activity is better than none, and more is better," said lead study author Jacob Sattelmair, who was a doctoral candidate at Harvard University School of Public Health, Boston, when he conducted the research.

The benefits of even more exercise continue to add up. People who reported exercising for 750 minutes a week, or 12.5 hours -- had a 25 percent reduced risk of heart disease. But that's many more hours of working out for only a small additional risk reduction, Sattelmair noted.

"The biggest bang for your buck is at the lower ends of physical activity," said Sattelmair, now director of research and strategy at Dossia, an organization in Cambridge, Mass., whose goal is to improve employee health and health care, while reducing health care costs. "If you went from none to 2.5 hours a week, the relative benefit is more than if you went from, say, 5 to 7.5 hours a week."

In the study, published online Aug. 1 in *Circulation*, Sattelmair and colleagues analyzed the results of 33 studies that assessed the health benefits of exercise.

For reasons researchers aren't sure of, women saw even more protective benefits from exercise than men, although this could have been a quirk of the statistics, they said.

While 150 minutes of moderate to vigorous exercise a week is the minimum goal based on current U.S. guidelines, they found even people who did less than that (75 minutes weekly) had a decreased risk of heart disease compared to total couch potatoes.

"If you are doing nothing, do something. And if you are doing something, say, walking 10 or 15 minutes, two to three times a week, do more," said Barry Franklin, director of the preventive cardiology program at William Beaumont Hospital in Royal Oak, Mich., and an American Heart Association spokesman.

Yet physical activity, of course, isn't the sole key to preventing heart disease, the leading cause of death in the United States. Eating a healthy diet, maintaining a normal body weight, avoiding high levels of stress, and keeping blood pressure and cholesterol levels in a healthy range all play a role, he added.

Just as important as an exercise program is getting physical activity while going about your day, Franklin said. Recent research has suggested that it's not only structured exercise classes or sessions, but the incidental exercise you get when you walk around the mall, go up and down the stairs, clean the house, or mow the lawn that matters for health.

"In addition to your structured exercise program, where you drive to the gym and walk on the treadmill, disguised exercise can also have a profound impact on your cardiovascular risk," Franklin said. "The take-home message is: Move more. Sit less."

Used with permission from CareFirst Blue Choice [http://carefirst.staywellsolutionsonline.com/RelatedItems/6\\_655381](http://carefirst.staywellsolutionsonline.com/RelatedItems/6_655381) (Jan. 10, 2012).

The employee wellness newsletter is brought to you by the Employee and Retiree Service Center (ERSC). To learn more about employee wellness, visit our [website](#). To view this email as a .pdf document, click [here](#).

Questions or comments about your employee wellness program? Contact ERSC at 301-517-8100 or [wellness@mcpsmd.org](mailto:wellness@mcpsmd.org).

## Kaiser Permanente News Center

### Press Releases: Mid-Atlantic States

January 30, 2012

**Contact:**

Caitlin Ervin, Kaiser Permanente, 301-816-6264, @KPMidAtlantic  
 Dana Tofig, Montgomery County Public Schools, 301-279-3853, @MCPS

## Montgomery County Public Schools and Kaiser Permanente Celebrate Results of MCPS on the Move Fitness Competition

*Program promotes health and fitness among MCPS employees*

**ROCKVILLE, Md.** — Montgomery County Public Schools and Kaiser Permanente of the Mid-Atlantic States recently recognized MCPS employees for their outstanding accomplishments in phase two of the **MCPS on the Move Fitness Challenge**.

MCPS on the Move, a friendly nutrition and fitness competition, strives to create a culture of healthy eating habits and lifelong exercise among MCPS employees. More than 3,100 middle- and high-school employees and central services office staff signed up, joined a team, and participated in the 12-week fitness challenge, competing for \$50,000 in prizes for themselves, their teams and their schools.



**From Oct. 3 to Dec. 23, 2011, Montgomery County's engaged educators and administrators:**

- Recorded 3,169,029 minutes of activity on the **Fitness Journal website**
- Exercised a total of 52,819 hours
- Traveled 211,267 miles in support of this challenge — this is the same as traveling around the Earth 8.5 times

"I am so proud that thousands of our employees made a commitment to living a healthier lifestyle by participating in the MCPS on the Move program," said MCPS Superintendent of Schools Joshua P. Starr. "They not only took positive steps to improve their lives personally and professionally, but they served as outstanding role models to our students and our community. I want to thank Kaiser Permanente for their commitment to the health and well-being of our employees."

MCPS on the Move, an innovative and first-of-its-kind fitness competition, was established in 2010 to help create and promote a culture of healthy eating and active living among MCPS employees. The program was first introduced in the county's 131 elementary schools and due to the success of the pilot program, Kaiser Permanente and MCPS continued the partnership in 2011, expanding the program to secondary schools and central services office staff.

"Kaiser Permanente is invested in the total health of Montgomery County, Maryland," said Farzaneh Sabi, MD, assistant physician in chief for the District of Columbia and Suburban Maryland with the Mid-Atlantic Permanente Medical Group. "At Kaiser Permanente, we are committed to helping build healthy communities and educating the public about the importance of healthy lifestyles. We look forward to expanding our partnership with MCPS and continuing our investment in the health of Montgomery County."

MCPS on the Move is designed to motivate employees to make their health a priority while they have fun competing against their colleagues for prizes. Some of the 2011 grand prize winners include:

- **John Poole Middle School**, \$7,000 grant for physical-education equipment or to promote staff

wellness

- **Thomas Edison High School for Technology**, \$7,000 grant for physical-education equipment or to promote staff wellness
- **Team Biggest Winners**, \$2,000 grant for staff health and wellness
- **Team Awesome Accounting Auditors**, \$2,000 grant for staff health and wellness
- **Team Phat Winners**, \$2,000 grant for staff health and wellness

Through Kaiser Permanente's partnership with MCPS, the organizations have been able to set a positive example for staff and students while establishing the MCPS on the Move Fitness Challenge as a model for workplace wellness throughout the Mid-Atlantic region, and for the nation.

#### **About Montgomery County Public Schools**

Montgomery County Public Schools (MCPS) is the 16th largest school system in the nation, with 146,500 students. MCPS is one of the most successful large school districts in the country and has been recognized for its academic and operational excellence. In 2010, MCPS became just the sixth school district in the nation to receive the Malcolm Baldrige National Quality Award, the highest presidential award an organization can receive. MCPS was also a finalist for the 2010 Broad Prize for Urban Education, which recognizes large districts that are improving student achievement and narrowing the achievement gap. For more information on MCPS, visit [www.montgomeryschoolsmd.org](http://www.montgomeryschoolsmd.org) or follow the district on Twitter, [www.twitter.com/MCPS](http://www.twitter.com/MCPS).

#### **About Kaiser Permanente of the Mid-Atlantic States**

Kaiser Permanente of the Mid-Atlantic States region, headquartered in Rockville, Md., provides and coordinates complete health care services for almost 500,000 members through 30 medical centers in Maryland, Virginia, and Washington, D.C. Founded in 1980, Kaiser Permanente of the Mid-Atlantic States is a total health organization comprised of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that features approximately 900 physicians who provide or arrange care for patients throughout the area. Kaiser Permanente of the Mid-Atlantic States is considered one of Maryland's "Top HMOs," according to the Maryland Health Care Commission. The health plan was ranked in the nation's 50 top commercial health plans and 20 top Medicare health plans — and the No. 1 Medicare plan for Maryland, Virginia, and Washington, D.C. — by "NCQA Health Insurance Plan Rankings 2011-2012 Private." For more information about Kaiser Permanente of the Mid-Atlantic States, visit [www.kp.org](http://www.kp.org) or follow us on Twitter, [www.twitter.com/KPMidAtlantic](http://www.twitter.com/KPMidAtlantic).

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**American Academy of Family Physicians (AAFP)  
American Academy of Pediatrics (AAP)  
American College of Physicians (ACP)  
American Osteopathic Association (AOA)**

**Joint Principles of the Patient-Centered Medical Home  
February 2007**

***Introduction***

**The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.**

**The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.**

***Principles***

***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

***Quality and safety*** are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care

planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

### **Background of the Medical Home Concept**

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

### **For More Information:**

American Academy of Family Physicians  
<http://www.futurefamilymed.org>

American Academy of Pediatrics:  
[http://aappolicy.aappublications.org/policy\\_statement/index.dtl#M](http://aappolicy.aappublications.org/policy_statement/index.dtl#M)

American College of Physicians  
<http://www.acponline.org/advocacy/?hp>

American Osteopathic Association  
<http://www.osteopathic.org>

# ...And the number of hospitalizations have been reduced by this model.

## Reduction in hospitalizations

40% Community Care of North Carolina\*

24% HealthPartners Medical Group  
BestCare PCMH Model

15% Genesee health Plan HealthWorks PCMH Model

14% Geisinger Health System ProvenHealth  
Navigator PCMH Model

11% Group Health Cooperative of Puget Sound\*\*

\*Study of asthma cases only \*\*Study of ambulatory sensitive care admissions.

SOURCE: Patient-Centered Primary Care Collaborative. (Ed.). (2009). *Proof in practice: a compilation of patient centered medical home pilot and demonstration projects*

# Evidence shows medical homes reduce emergency room use.

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## Reduction in ER Visits

**50%** Genesee Health Plan HealthWorks PCMH Model

**39%** HealthPartners Medical Group  
BestCare PCMH Model

**29%** Group Health Cooperative  
of Puget Sound

**16%** Community Care of North Carolina

**15%** John Hopkins Guided Care PCMH Model

SOURCE: Patient-Centered Primary Care Collaborative. (Ed.). (2009). *Proof in practice: a compilation of patient centered medical home pilot and demonstration projects*