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Greater Milwaukee Business Foundation on Health, Inc. GMBFH

Study of Southeast Wisconsin Community Healthcare Premium Costs

Greater Milwaukee Business Foundation on Health, Inc.

November 3, 2009

Uses of this Study

- This report is intended for use in collaborative quality and cost improvement initiatives. We ask that it not be used for public relations or general media purposes.

- Please review the full report (including Appendices) and use the information in its entirety. Market comparisons using only one measure or even a limited number of comparisons can be misleading.

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Study Overview

Study Background

- Greater Milwaukee Business Foundation on Health, Inc. (GMBFH, Inc.) commissioned two previous studies comparing Southeast Wisconsin average commercial healthcare premium costs to Midwest average commercial healthcare premium costs.

  – The initial calendar year 2000 study suggested Southeast Wisconsin's per-employee, per-year (PEPY) healthcare premium costs were approximately 55% higher than the Midwest average.

  – The subsequent 2003 study suggested Southeast Wisconsin's average PEPY healthcare premium costs were approximately 39% higher than the Midwest average.

Study Purpose

- GMBFH Inc. commissioned Mercer and Milliman to update the previous comparisons of Southeast Wisconsin healthcare premium costs to the Midwest average through 2007 using the most recent available data.

- The primary objectives of the study are to:

  – Compare 2007 healthcare premium costs in Southeast Wisconsin to Midwest and National benchmarks

  – Determine causes of 2007 Southeast Wisconsin healthcare premium cost variation from the Midwest average

  – Evaluate how 2007 Southeast Wisconsin healthcare premium costs have changed relative to the Midwest average since 2003

Summary of Results

Summary of Results

Southeast Wisconsin healthcare premium costs were approximately 9% above the Midwest average in 2007, a significant decrease from the 39% variance in the 2003 study

Summary of Results *(continued)*

- We examined the following components to determine how Southeast Wisconsin healthcare premium costs compare to the Midwest average:
  - Demographics
    - The 2007 demographics of the Southeast Wisconsin population resulted in approximately 4% higher costs than the Midwest average, primarily as a result of a higher average age (43 vs. 41)
    - Demographic differences resulted in 5% higher costs than the Midwest average in 2003
  - Plan Design
    - Southeast Wisconsin employers have historically offered richer plan designs than the Midwest average, though the impact has narrowed from 5% in 2003 to 2% in 2007

Summary of Results *(continued)*

- Utilization / Service Mix
  - Southeast Wisconsin utilization and service mix was 6% ***below*** the Midwest average in 2007. This represents a significant change since 2003 when utilization and service mix impacts were estimated to be 2% ***above*** the Midwest average.
- Provider Payment Levels
  - Southeast Wisconsin 2007 provider payment levels were approximately 9% higher than the Midwest average, which is a significant decline from the 27% difference reported in 2003.

Study Approach and Methods

Study Approach and Methods

- Milliman and Mercer collaborated on this study
  - Methods are consistent with previous studies
  - All significant analysis and key assumptions were reviewed by each firm
- The study includes an analysis of 2006 and 2007 employer healthcare premium cost
  - The study population includes commercial members under age 65
  - Premium cost includes employer cost plus employee contributions
  - Data from 2006 were primarily used to validate 2007 findings
- Southeast Wisconsin average costs are compared to the Midwest average
  - Southeast Wisconsin included residents of Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha counties

Study Approach and Methods *(continued)*

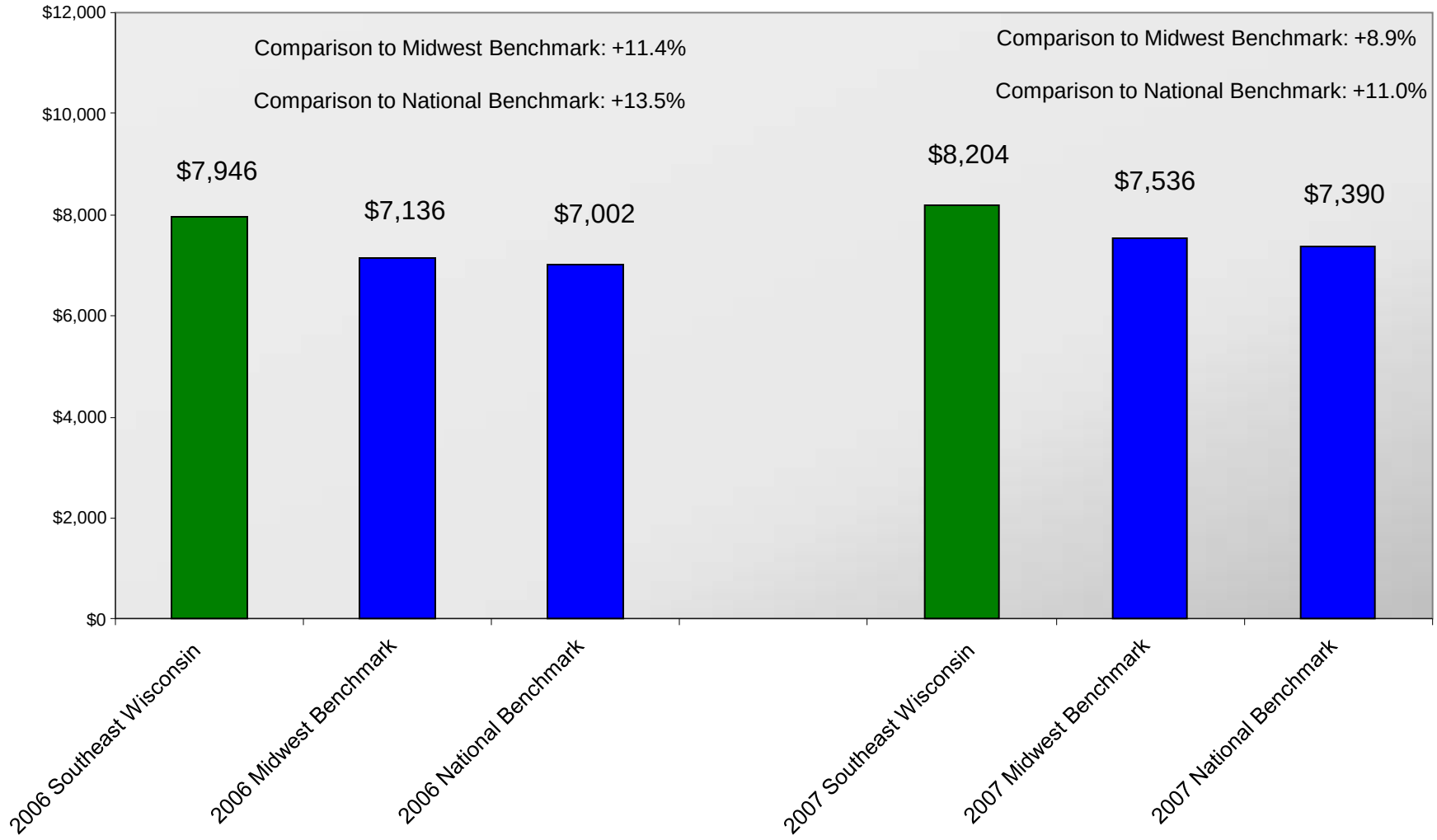
- Southeast Wisconsin PEPY cost estimates were based on 2007 medical and prescription drug claims and member data contributed by several area health plans.
  - Data represents more than $1.7 billion in healthcare costs from approximately 450,000 members (i.e., employees and dependents) for each year
  - Claims data included provider billed charges but did not include allowed provider payments
  - Provider payments were estimated using market average discount information provided by Southeast Wisconsin health plans or information from the Wisconsin Hospital Fiscal Survey obtained from the Wisconsin Hospital Association
  - Plan design factors were developed using median benefit levels submitted for the Milwaukee area and comparing them to Midwest median benefit levels. Both data points are from the Mercer Survey

Study Approach and Methods *(continued)*

- Midwest averages in this study are based upon the 2007 Mercer Survey of Employer Sponsored Health Plans average healthcare plan cost per active employee
  - Per Employee Per Year (PEPY) costs include medical, prescription drug, administrative costs, mental health, vision and hearing. Dental is not included.
  - PEPY costs is a blend of PPO, POS, HMO and CDHP plans, weighted by survey-reported participation percentages
  - Administrative costs are based on Mercer ASO fee survey results

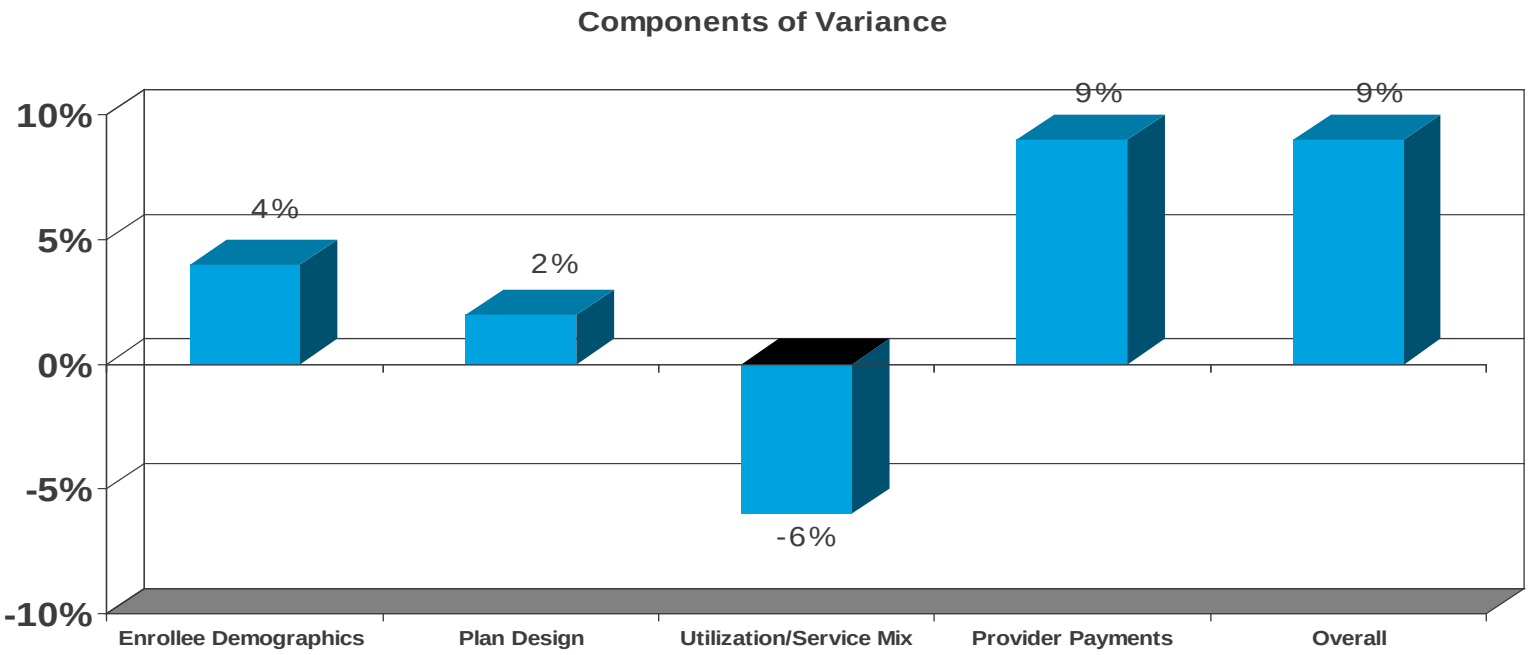
Healthcare Premium Cost Analysis

Total Per Employee Per Year (PEPY) Healthcare Premium Costs



Comparison of PEPY Healthcare Premium Costs to Midwest Benchmark

Comparison of Healthcare Premium Costs to Midwest Benchmark - 2007	
Southeast Wisconsin	$8,204
Midwest Benchmark	$7,536
Variance	***9%***



Demographics

- Southeast Wisconsin age / gender differences contributed 3% additional cost in 2007 compared to Midwest averages
- Southeast Wisconsin's slightly higher average contract size than Midwest averages contributed an additional 1% to total PEPY costs in 2007

	Southeast Wisconsin	Midwest Average
Description	**2007**	**2007**
Average Age (employee)	43.3	41.0
Demographic Cost Factor		
▪ Male	0.92	0.90
▪ Female	1.17	1.19
TOTAL	**1.05**	**1.02**
Average Contract Size	**2.30**	**2.27**

2007 Plan Design Provisions

- Southeast Wisconsin plan design provisions (primarily lower deductibles and copayments) resulted in 2% higher costs than the Midwest average in 2007

Plan Design Comparison	Southeast Wisconsin	Midwest Average
In-network Deductible (PPO)		
Individual	$300	$400
Family	$650	$800
Physician Visit and Hospital Cost-Sharing (PPO)		
Physician copayments – PCP	$20	$20
Physician copayments – Specialist	$30	$35
Hospital coinsurance	15%	20%
Out-of-Pocket Maximums for Individuals (PPO)		
Out-of-pocket maximum	$1,500	$1,500
HMO		
PCP copayments	$15	$15
Hospital deductible	$370	$250
Retail Rx copayments	$7 / $21 / $39	$10 / $25 / $42

Utilization / Service Mix

- Southeast Wisconsin utilization and service mix patterns in 2007 were significantly different than the Midwest average
  - Hospital inpatient utilization (14 -16% lower)
  - Physician office visits (15% lower)
  - Emergency room visits (16% lower)

	Southeast Wisconsin	Midwest Average
Utilization	2007	2007
▪ Inpatient admissions per 1,000 members	56	67
▪ Inpatient days per 1,000 members	220	255
▪ Physician office visits per 1,000 members	2,414	2,837
▪ ER visits per 1,000 members	174	207
▪ Rx per 1,000 members	9,065	9,044

Provider Reimbursement

- Southeast Wisconsin hospital payment levels were slightly higher than Midwest averages in 2007
- Southeast Wisconsin physician payment levels were 24% higher than Midwest averages in 2007

	Southeast Wisconsin	Midwest Average
Reimbursement	2007	2007
Hospital		
▪ Average cost per inpatient day	$3,486	$3,400
▪ Average cost per inpatient admission	$13,758	$13,600
Physician		
▪ As a percentage of the 2007 Medicare RBRVS Fee Schedule	180%	145%

2007 PMPM Allowed Claim Costs

- In general, higher Southeast Wisconsin outpatient facility utilization and physician payment levels are partially offset by lower physician and hospital inpatient utilization, resulting in 2007 PMPM allowed costs 6% higher than the Midwest average (approximately 2/3 of total cost difference)

	Southeast Wisconsin	Midwest Average
Type of Service		
▪ Professional	$101	$93
▪ Inpatient Hospital	$62	$72
▪ Outpatient Facility	$70	$51
▪ Mental Health / Chemical Dependency	$9	$8
▪ Radiology / Pathology	$42	$38
▪ Prescription Drugs	$56	$58
Total	**$340**	**$320**

Summary – 2007 vs. 2003

- The Southeast Wisconsin 2007 healthcare premium costs have moved significantly closer to the Midwest average since the last study was completed in 2003

Comparison of Southeast Wisconsin PEPY Healthcare Premium Costs to Midwest Benchmark		
Components of Variance	**2003**	**2007**
Enrollee Demographics	5%	4%
Plan Design	5%	2%
Utilization / Service Mix	2%	-6%
Provider Payment Levels	27%	9%
Total Variance from Midwest Average	**39%**	**9%**

Summary – 2007 vs. 2003 *(continued)*

- The relative improvement appears to be the result of:
  - Lower percentage increases in provider payment levels
  - Employer shifts to networks with higher provider discounts
  - Changes in utilization and service mix to lower cost alternatives
  - Benefit design changes to bring plan designs closer to the Midwest average

- In 2007, Southeast Wisconsin commercial premium costs were higher than the Midwest average and were higher than most other large Midwest cities.

Interpretation Considerations (Caveats)

Interpretation Considerations (Caveats)

- In preparing this information, we relied on information provided by Southeast Wisconsin commercial payers and the Wisconsin Hospital Association. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

- This report was developed to provide comparisons of market average commercial PEPY health plan costs and may not represent the actual PEPY cost experience of individual employers.

- Our report does not reflect changes to medical costs in Southeast Wisconsin or other Midwest cities subsequent to 2007.

Contact Information

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Appendices

Greater Milwaukee Business Foundation on Health
Study of Southeast Wisconsin Community Healthcare Premium Costs

Appendix A
Southeast Wisconsin Healthcare Cost Development

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TABLE OF CONTENTS

This appendix describes the methods we used to extract, process, and summarize Southeast Wisconsin healthcare claims data for actively employed people (i.e., non-Medicare, non-Medicaid) from calendar years 2006 and 2007. Measuring healthcare costs is complicated and often controversial. Therefore, the descriptions in this appendix are crucial to the effective use of the comparisons provided throughout this report. The information included in the report should only be considered in its entirety including the information in the attached appendices.

I. OVERVIEW

The Greater Milwaukee Business Foundation on Health (the Foundation) commissioned Milliman and Mercer to update previous comparisons of Southeast Wisconsin healthcare costs to the Midwest average through 2007 using the most recent available data.

The Foundation's goals for this analysis are to:

- Compare 2007 healthcare premium costs in the Southeast Wisconsin to Midwest and National benchmarks.
- Determine current causes of 2007 Southeast Wisconsin healthcare premium cost variation from the Midwest average.
- Evaluate how 2007 Southeast Wisconsin healthcare premium costs have changed relative to the Midwest average since 2003.

Milliman's role in this analysis was to:

- Gather Southeast Wisconsin healthcare claims from local health plans at the billed charge level along with de-identified enrollment information.
- Convert the Southeast Wisconsin billed charges to allowed provider payment levels.
- Provide summarized Southeast Wisconsin healthcare costs and utilization metrics to Mercer who adjusted the Southeast Wisconsin data for member cost sharing and administrative fees to develop premium cost estimates.
- Review Mercer's Southeast Wisconsin premium estimates and benchmark comparisons for reasonableness.

II. DEFINITION OF SOUTHEAST WISCONSIN

We isolated Southeast Wisconsin healthcare claims from local health plan data based on whether a given claim was incurred by a person who is a resident of one of the following counties:

- Milwaukee
- Kenosha
- Ozaukee
- Racine
- Walworth
- Washington
- Waukesha

III. DATA SOURCES AND TIME PERIOD

Milliman used information from local health plans along with financial data included in the Wisconsin Hospital Fiscal Survey as reported by each hospital obtained from the Wisconsin Hospital Association (WHA) Information Center as the basis for our analysis.

The data provided by the health plans included:

- Billed medical and pharmacy claims from their claims administrative systems for services incurred in calendar years 2006 and 2007 with payments through March 31, 2008. The data was blinded such that no health plan specific information was included. As such, we were not able to differentiate a claim from one health plan carrier versus another.

- Monthly enrollment data (de-identified to protect individuals' privacy) from administrative systems.

- Average professional and ancillary allowed provider payments (either stated as a percentage discount off billed charges or as a percentage of Medicare RBRVS).

The data from the Wisconsin Hospital Fiscal Survey is based on 2007 financial report data from each health system's fiscal year as reported to WHA. Southeast Wisconsin health systems have different fiscal years ending from June 30 through December 31 of each year. Milliman does not believe the differences in health system fiscal years are likely to have a material impact on the billed charge discounts used in our comparisons. Hospital reimbursement levels (i.e., discounts) may change over time. The results of this comparison may be different if the analysis was performed on more recent data.

IV. HEALTH INSURANCE COSTS FORM THE BASIS OF COMPARISON

The focus of this analysis is on the health insurance premium levels for actively employed people under the age of 65 living in Southeast Wisconsin. The analysis does not include cost or premium analysis of other market segments such as Medicare, Medicaid or the uninsured population that may influence these costs. In addition, the analysis is focused on costs related to health insurance (i.e. medical and prescription drug coverage) and excludes other costs related to services such as dental services.

The reader of this report should consider all elements of healthcare costs before drawing conclusions from this report.

V. QUALITY COMPARISONS ARE NOT INCLUDED IN ANALYSIS

Milliman's analysis did not include any quality or outcomes information because such data was outside the scope of this analysis. Quality information is a critical component of provider evaluation and should be considered when evaluating healthcare costs.

VI. METHODOLOGY AND ASSUMPTIONS

A general description of our approach for analyzing and preparing the Southeast Wisconsin data summarized in the report is as follows:

a) We identified all commercial members under the age of 65 with enrollment records indicating residence in the Southeast Wisconsin counties.

b) We extracted all claims associated with the members identified in (a).

c) For claims identified in (b), we developed allowed provider payment levels using methods described in the following section.

d) Finally, we summarized key metrics using commonly accepted calculations (i.e. per member per month, inpatient days per 1,000, etc.) for inclusion in the final report.

CONVERTING BILLED CHARGES TO ALLOWED PROVIDER PAYMENTS

The claims information provided to Milliman included billed charge information (but not allowed amounts) which required Milliman to develop estimates of allowed provider payment levels for each claim. A description of our methods for estimating allowed provider payment levels is included below.

For purposes of this discussion, we are defining billed charges and allowed provider payments as follows:

- **Billed Charges:** Charges billed for a medical service or drug prior to any negotiated discounts. Billed charges omit any duplicate claims or claims that are not covered by a health plan due to exclusions.

- **Allowed Provider Payments:** The amount commercial health plans pay for a medical service or drug after negotiated discounts are applied, but before member cost sharing (i.e., deductibles, coinsurance, copays) and third party liability credits (i.e., coordination of benefits or subrogation) are applied. In its simplest form, the following formula describes allowed provider payments.

  ALLOWED PROVIDER PAYMENTS = BILLED CHARGES x (1 - NEGOTIATED DISCOUNTS)

We used the following sources and methods to convert billed charges to allowed provider payments for each healthcare service category.

Hospital Inpatient and Outpatient

We adjusted the billed charges included in the health plan data using 2006 and 2007 average inpatient and outpatient commercial discounts (as a percentage of billed charges) reported by each hospital in the Wisconsin Hospital Association Information Center's (WHA) Wisconsin Hospital Fiscal Survey. Average Southeast Wisconsin Allowed to Billed Charge Ratios are found in Table 1 below.

Table 1 Average Southeast Wisconsin Hospital Allowed to Billed Commercial Charge Ratios		
Year	**Hospital Inpatient**	**Hospital Outpatient**
2006	0.66	0.66
2007	0.65	0.64

Professional Services

Our approach for estimating allowed provider payments for professional services was limited to applying market average payment levels to all professional service claims. The reasons for using this market average approach stem from:

1. The inability to distinguish the carrier or provider network for a given claim.

2. The inability of health plans to divulge provider specific fee schedules due to confidentiality agreements

To address this issue, several of the major health plans doing business in Southeast Wisconsin agreed to share their commercial reimbursement levels (typically as a percentage of Medicare RBRVS fee schedules) with us for professional services (across all their provider networks). In addition, the plans provided their average enrollment levels for 2006 and 2007 so that we could develop a market average professional services reimbursement level.

We blended each health plan's average RBRVS multiplier for each year using Southeast Wisconsin membership counts provided by each plan to arrive at a weighted average Southeast Wisconsin RBRVS multiplier that was used as the basis for estimating reimbursement for each professional service claim. We found that the multipliers were virtually identical in 2006 and 2007, coming out to approximately 180% of Medicare RBRVS fee schedules for each year.

We used the market average RBRVS multiplier to re-price all professional claims to allowed provider payment levels. In instances where no CPT code was assigned to a claim, we applied the market average discount from billed charges to these services. The market average discount in 2006 and 2007 was estimated to be 41% of billed charges.

Ancillary Services

Ancillary services include private duty nursing, home health, ambulance, Durable Medical Equipment (DME), prosthetics, vision hardware, and hearing aids. We were able to obtain average ancillary discounts from a subset of health plans, and it appeared that the average discount for these services was very close to the average implied discount from professional billed charges (after applying the RBRVS multiplier mentioned earlier). Based on this analysis, we assumed the market average discount of 41% for professional services was the same as the market average discount for ancillary services.

Prescription Drugs

Prescription drug information provided by the health plans did not include fully populated billed charge information. Instead, we approximated ingredient costs by using average wholesale price (AWP) by National Drug Code (NDC) and applying average discounts from various surveys that Milliman performs and / or purchases. We also included an estimate for dispensing fees and rebates based on prescription drug survey information and our experience with such matters to arrive at the allowed payment level estimates.

ANALYSIS FOR REASONABLENESS

We analyzed the final data developed as a basis for the comparisons by reviewing the following metrics:

- Per employee per year allowed costs
- Per member per month (PMPM) allowed costs by service category
  - Hospital Inpatient
  - Outpatient Facility
  - Professional Services
  - Ancillary Services
  - Mental Health / Chemical Dependency Services
  - Prescription Drugs
- PMPM costs by gender and quin-quennial age segments
- Claim probability distribution based on each member's annual claim amounts
- Utilization metrics such as days / 1,000, admits / 1,000, average length of stay, and office visits / 1,000
- Payment level metrics such as payment/day, payment / visit, and percentage of RBRVS
- Average employee and member age
- Distribution of members by age and gender
- Drug costs and utilization by generic vs. brand and retail vs. mail order

We also reviewed Mercer's independently developed benchmarks for reasonableness relative to other data sources available to us.

VII. USES OF INFORMATION

The Greater Milwaukee Business Foundation on Health, Milliman and Mercer encourage the business, healthcare provider, and government communities to use this information to collaborate on quality and cost improvement initiatives. We did not create this information for, and we ask that it not be used in, any organization-specific public relations efforts or for general media purposes. We also ask that this information be reviewed and used in its entirety. Market comparisons using only one measure or even a limited number of measures can be misleading. An informed comparison of healthcare market characteristics should also incorporate other information, particularly additional quality measures, not included in this report. This information is designed for use by the business, healthcare provider, and government communities, not individual consumers of healthcare services.

VIII. CAVEATS AND LIMITATIONS ON USE

Milliman relied, without audit, on health plan information and public data sources. To the extent this information is not accurate; the results of Milliman's analyses may not be accurate.

This report is designed to measure changes in Southeast Wisconsin health costs relative to other regional and national averages. This information may not be appropriate, and should not be used, for other purposes.

IX. FOR FURTHER INFORMATION

Please contact Keith Kieffer, CPA, RPh, or Scott Weltz, FSA, MAAA in the Milwaukee office of Milliman (Phone: (262) 784-2250, email: keith.kieffer@milliman.com or scott.weltz@milliman.com) with questions and comments about the information in this report.

Appendix B

Comparisons to Midwest Average

Methodology and Assumptions

This appendix describes the data, methodology, assumptions and tools used by Mercer to develop Midwest averages for comparison to Southeast Wisconsin health care costs.

Study Purpose

GMBFH Inc. commissioned Mercer and Milliman to update the previous comparisons of Southeast Wisconsin medical costs to the Midwest average through 2007 using the most recent available data.

The primary objectives of the study are to:

- Compare 2007 healthcare costs in the Southeast Wisconsin to Midwest & National benchmarks
- Determine causes of 2007 Southeast Wisconsin healthcare cost variation from the Midwest average
- Evaluate how 2007 Southeast Wisconsin healthcare costs have changed relative to the Midwest average since 2003

Definitions

Premium Cost – Total gross annual cost (claims cost and administrative cost) for medical plan only, for active employees and dependents, divided by the number of active covered employees. Includes employee contributions (payroll deductions), if any, but not employee out-of-pocket expenses such as deductibles and copays. Prescription drug, mental health, vision and hearing benefits for all active employees and their covered dependents are included if part of the plan. Dental benefits, even if a part of the plan, are not included in these costs.

Allowed Cost - Represents the amount of submitted charges eligible for payment, for all services provided under medical coverage as well as any prescriptions filled. It is the amount eligible after applying pricing guidelines (discounts), but before deducting third party, copayment, coinsurance, or deductible amounts.

Provider Cost - The amount of charges submitted by the provider for facility and professional services provided under medical coverage as well as any prescriptions filled. It

represents the gross charge amount before applying pricing guidelines (discounts) or deducting third party, copayment, coinsurance, or deductible amounts.

Data Sources

Mercer Survey – The Mercer National Survey of Employer-Sponsored Health Plans is conducted using a national probability sample of public and private employers with at least 10 employees. Nearly 3,000 employers completed the survey in 2008. The survey was conducted during the late summer, when most employers have a good fix on their costs for the current year. Results represent about 600,000 employers and more than 90 million full- and part-time employees. States included in the Midwest are Illinois, Indiana, Ohio, Michigan, Minnesota, Iowa, North Dakota, South Dakota, Missouri, Kansas, Nebraska, and Wisconsin.

MarketScan Database – Produced by Thomson Reuters Healthcare reflect the health care experience of employees and dependents covered by the health benefit programs of large employers. These data are collected from approximately 100 different insurance companies, Blue Cross Blue Shield plans, and third party administrators. These data represent the medical experience of insured employees and their dependents for active employees, early retirees, COBRA beneficiaries and Medicare-eligible retirees with employer-provided Medicare Supplemental plans. No Medicaid or Workers Compensation data are included.

Report Category and Source

- Annual Premium Cost
  - Midwest averages in this study are based upon the Mercer 2007 Mercer Survey of Employer Sponsored Health Plans average medical plan cost per active employee
  - Per Employee Per Year (PEPY) costs include medical, prescription drug, administrative costs, mental health, vision and hearing. Dental is not included
  - PEPY costs is a blend of PPO, POS, HMO and CDHP plans, weighted by survey-reported participation percentages

- Administrative fees derived from Mercer Midwest ASO Survey

- Medical and Rx cost split developed using MarketScan Active claim cost distribution

- Allowed amounts are adjusted to net paid using MarketScan Active paid to allowed ratio, and then adjusted for plan design.

- Demographic age/gender factors developed using MarketScan Active database distribution, and Mercer morbidity factors
- Average age and average contract size developed using MarketScan Active database
- Monthly Costs by Service Category (PMPM) developed using MarketScan Active claim cost distribution by service category
- Utilization and provider reimbursement developed using MarketScan Active database

Contact Information

For further information or questions, please contact Rob Grant at 312 917 0679 or rob.grant@mercer.com.

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