2017 MASBO SUMMER CONFERENCE

- The WHY Behind Rising Costs of Health Care
- Keeping Personal Health Information Secure
MUST Mission and Commitment

**OUR MISSION** is to serve the public education community of Montana by providing high-quality, cost-effective health benefit plans and services through the Montana Unified School Trust.

**YOUR MUST TEAM** is committed to:

- **Exceptional Service.** Serving members every day, not just the day they enroll.
- **Integrity.** Being honest in all that we do.
- **Innovation.** Using technology and creativity to deliver solutions.
- **Continuous Improvement.** Always getting better at what we do.
- **Wellness.** Improving the health and well-being of our members and employees.

**OUR VISION** is to be the most trusted benefits provider in Montana.

MUST was started on July 1, 1987, for the purpose of ensuring that Montana’s public schools had options available when it came to providing health benefits for their employees. We are a multi-employer, self-funded, non-federal government plan, federally regulated by the Public Health Service Act.
The WHY Behind Rising Costs of Health Care
The Cost of Care

- 2 major components driving the cost of care:
  - Amount paid for each type of service
  - Utilization (number and type of services used)

- Components of cost
  - 5 categories of health care services
    - Inpatient facility care
    - Outpatient facility care
    - Professional/Physician services
    - Pharmacy
    - Other services
Rising Health Care Costs

The 2017 average cost for a family of 4 covered by an average employer-sponsored PPO plan is $26,944.

Understanding forces behind rising health care costs can help you better understand strategies you need to contain the cost of your employer-provided health benefit.
• The cost of care by component* has steadily increased over the last 5 years

Source: 2017 Milliman Medical Index

*Dollars based on the cost of a family of 4 covered by employer-sponsored PPO plan ($26,944)
Health Care Trends

Medical and Prescription Drug Trends (< age 65)

- Open Access PPO/POS Plans: 7.80% (2016) vs. 7.60% (2017*)
- HDHPs: 8% (2016) vs. 7.70% (2017*)
- Prescription Drug: 11.30% (2016) vs. 11.60% (2017*)
- Specialty: 18.90% (2016) vs. 18.70% (2017*)

* Projected Trends

Source: 2017 Segal Health Plan Cost Trend Survey
2017 regional projected health plan trend rates

Possible drivers of regional differences: number of competitors, mergers, regional competition (insurers and health care providers)

Source: 2017 Segal Health Plan Cost Trend Survey
The Health Care Dollar

*includes ambulance services, durable medical equipment, supplies, prosthetics, and home health care

Source: 2017 Milliman Medical Index
The WHY Behind the Numbers

COST DRIVERS

• Prescription drugs remain in the top 3 cost growth categories, along with hospital usage and physician services. Causes:
  › Purchasing habits or the propensity of patients to select brand-name drugs over generic equivalents
  › Type of drugs being consumed
  › Over-prescribing in an effort to avoid litigation or to appease demanding patients

• Redundant, inappropriate, or unnecessary tests and procedures that are recommended by physicians (and also frequently requested by patients)

• Advances in medical technologies; there is no requirement that effectiveness be demonstrated before a technology is adopted in the U.S. health-care market
  › The average patient wants the most modern care available, often regardless of price

WHAT WE AS CONSUMERS CAN DO

• Understand your pharmacy benefit and applicable tiering (i.e., generic, preferred, preferred brand, specialty)
• Where possible, take advantage of generic-equivalents
• Use mail-order or retail at pharmacy services if available
• Utilize available transparency/pricing tools and understand member vs. plan responsibility

• Be an informed consumer; do your research — determine if procedure/test is covered under your plan (e.g., certain procedures or rapid response testing may be considered “investigational or experimental”)

• Be an informed consumer; do your research
• In certain instances, technologies that offer only marginal improvement over existing treatments — but with dramatically higher price tags — are adopted broadly and rapidly (e.g., certain procedures may be considered “investigational or experimental”)
COST DRIVERS

- Changing demographics
  - Workers who are 55+ will likely make up approximately 26% of the labor force by 2022, compared to 21% in 2012 and just 14% in 2002

- Increases in addictions, obesity rates, and inactivity are all linked to chronic health conditions that cause some of the heaviest use of medical services
  - People who have three or more chronic diseases fall into the top 1 percent of patients who account for 20 percent of all health care spending in the United States

WHAT WE AS CONSUMERS CAN DO

- Wellness programs/clinics may be able to reduce the likelihood of catastrophic medical events through early detection and increased preventive care

- Again taking advantage of Wellness programs/clinics, which may help reduce the likelihood of catastrophic medical events through early detection and increased preventive care

- Employers making a difference by supporting healthy lifestyles among employees; employees taking advantage of available programs and resources

It is important for consumers to be conscientious, wise and informed about their health care and understand how their health care dollars are spent.
Questions
Keeping Personal Health Information Secure – Working with Individual’s Health Information
Health plans/insurers (covered entities) are subject to the HIPAA Privacy and Security Rules

› **Privacy Rule** sets the standard for who may access PHI
  - Medical records numbers
  - Email addresses
  - Photographs
  - Call notes
  - Participation in programs
  - Account numbers
  - Dates of birth
  - Telephone numbers
  - Amounts billed for services
  - Physical/Mailing Address
  - Drivers license
  - Treatment dates
  - Financial information
  - Biometrics
  - IP address

› Covered entities can only use or disclose protected health information (PHI) as required or permitted under the Rule

› **Security Rule** sets the standard for ensuring only those who have access to electronic PHI will have access
HIPAA and Schools

• Schools (elementary or secondary) are generally not subject to the **HIPAA Privacy Rule** because the school either:
  › is not a HIPAA covered entity; or
  › is a HIPAA covered entity but maintains health information only on students in records that are by definition “education records” under FERPA and, therefore not subject to the HIPAA Privacy Rule.

• Schools (elementary or secondary) may be subject to the **HIPAA Security Rule** if they employ a health care provider that conducts 1 or more covered transactions electronically (i.e., electronically transmitting health care claims to a health plan or Medicaid for payment).
  › School would be considered a HIPAA covered entity and would need to comply with the HIPAA Security Rule’s Transactions & Code Sets & Identifier Rules with respect to those transactions.
• Clerks and business managers are key school resources for district health insurance-related matters
  › Assist with insurer/health plan selection
  › Coordinate staff enrollment/disenrollment
  › Assist with eligibility and enrollment during open and special enrollment periods and leaves of absence
  › Initial contact resource for questions
  › Assist with retiree coverage eligibility
  › COBRA
  › Billing
• Members ask Clerks specific information regarding claims or how types of services will process (i.e., visit to a dermatologist that turned into skin cancer).

  • Clerks should refer member to your health insurer carrier’s customer service
  • For MUST schools, members can call MUST at 800-845-7283 or Blue Cross/Blue Shield customer service (MUST’s third party administrator (TPA)) at 855-322-4953

• Members bringing their Explanation of Benefits (EOB) to the Clerks and ask questions (i.e., why did the claim deny).

  • Clerks should refer member to your health insurer carrier’s customer service
  • For MUST schools, members can call MUST at 800-845-7283 or Blue Cross/Blue Shield customer service (MUST’s third party administrator (TPA)) at 855-322-4953
• Clerks need to send a member’s personal or health information to insurance carrier (i.e., enrollment forms) and do not have email encryption technology available.

  • MUST Enrollment and Eligibility team can send the clerk a blank Proofpoint secure/encrypted email that they can then ‘respond’ to allowing the information to be sent securely. The email will expire after 30 days, but a new blank secure email can be sent again.

• Clerks may be asked to assist in getting a member’s ID card (or replacement card).

  • MUST can receive ID card requests from the clerk. However, the ID card will need to be sent to the member’s mailing address or email address.
Questions
Thank you for joining us!