Durham County Government
FY 2017-18 Benefits Plan Budget Adjustment Overview

All funds are monitored throughout the year to ensure expenditures do not exceed the authorized budget levels. This evaluation occurs based on monthly and historical annual trend analysis. For most funds, prior monthly and annual trends are the best gauge for year-end projections due to the predictable and cyclical nature of funding streams. However, certain budget activities are less predictable due to the non-cyclical nature of the transactions and/or policy changes that make historical patterns less predictable. For Durham County, two funds fall into the latter category, benefits and risk management. In both cases, claims can fluctuate due to usage patterns, changes in allowable expenses and/or payouts that may occur due to case settlements. Self-insurance funds are required to carry fund balances to ensure funding is available for such cost fluctuations.

Durham County's benefit plan fund is partially self-funded. This plan allows for more effective and efficient management of health care costs for both the County and its employees. The County retains profits that would normally accrue to the administrator (i.e. Aetna) of a fully-insured plan. As such, the County is able to provide a benefit package for all employees that includes health, dental, vision and one time salary life insurance coverage for all employees and offers dependent coverage, more employees can afford. Many jurisdictions are fully insured, not partially self-insured, which results in higher overall costs and often less budgetary control. However, assuming the approach of partially self-insured also means there may be times that expenditure projections may pace higher than original budget projections. To mitigate for these occurrences, several years ago the Fund Balance Policy was revised so that unspent funds for the self-insured benefits (i.e. Health and Dental) can only be used as funding for these benefits and is committed in the County's fund balance for this purpose. By committing these unspent funds in the County's fund balance and establishing this process in amending the County's Fund Balance Policy, the Board added stronger internal controls to further ensure compliance.

Benefit expenditures can fluctuate month-to-month based on several factors including the types of claims, increase in number of claims, number of employees diagnosed and being treated for serious illnesses, changes in benefits structures that impact the number of allowable expenses, etc. In FY 15-16, a budget amendment was taken to the BOCC due to projected expenditures. It was determined, after monitoring the expenditure activities over the year that additional funds were needed to support the FY 2015-16 benefits budget to ensure cost overruns did not occur. A budget amendment was approved for $3 million based on annualized spending trends. The amount required totaled $2.56 million.

Consistent with FY 15-16 BOCC action, a $3,350,000 budget amendment is required in FY 17-18 to appropriate fund balance and recognize additional revenues for the benefits plan. Three factors necessitate the budget adjustment including: 1.) increase in the original budget amount to recognize revenue received from employees (*e.g., for their out-of-pocket contributions for their coverage*) $264,000; 2.) increase in the original budget to recognize the transfer of funds from the General Fund into the benefits fund $255,000; and 3.) a one-time County contribution transfer of $2,831,000. The County contributes a fixed amount per employee per pay period into

the Benefits Plan. This funding takes place for the governmental funds as a transfer from the fund the employee resides in to the Benefits Plan Fund. Please note that to date, these contributions have exceeded the current budget amount. As such, this amendment is needed to continue the funding source committed to by the County for the fiscal year.

County staff does not anticipate the need for the entire amount; however, the Local Government Commission will not allow amendments to the budget after June 30, for the current fiscal year. Therefore, staff is requesting this conservative amount to ensure that we do not exceed budget appropriations for the expenditures as well as to ensure that sufficient budget is there for the amount of County contributions required as funding sources for the partially self-insured benefits per the County Benefits Plan; hence avoiding any audit findings.

The largest factor contributing to the budget adjustment is the higher expenditure trend pattern. This is resultant from the types of claims incurred; employees reaching out of pocket maximum in June, employees that have already met their deductible will try to get in additional services before year end, there may be new hires with large claims that are not reflected in the trend and stop loss report activity. All of these scenarios can contribute to the County incurring more costs. Stop loss activity happens when the employer's liability is capped at a specified amount. Once the specified amount has been paid, the stop loss insurance pays for the rest of the employee's medical expenses. This protects the County against high claims by any one employee or family member.

Upon reviewing our healthcare claims data, our medical claims increased by 137% for the month of August 2017 ($1,336,168) over the previous fiscal year ($562,634). Specifically, we saw a total of 1,308 claims for 73 members that amounted to a cost of $752,871.68 for health services related to chemotherapy, severe obesity and liver disease. The 'year over year' increased trend continued until claims leveled off December 2017 and peaked again in February 2018.

One of the drivers of these increases is the number of high cost claimant medical plan members who incurred claims of $25,000 or more. The data pictured below illustrates how the medical needs of our employees can fluctuate. In the month of December 2017, medical claims (greater than $25,000) for two members accounted for $75,305 while in April 2018, 39 members experienced high cost medical claims that accounted for more than $2.9 million alone.

Member's Claims greater than $25,000

FY 17-18	Number of Members	Medical Claims Paid
Oct. 2017	3	$360,647
Nov. 2017	2	$245,756
Dec. 2017	2	$75,305
Jan. 2018	2	$78,267
Feb. 2018	2	$332,427
Mar. 2018	20	$1,149,822
Apr. 2018	39	$2,914,322
Grand Total	**70**	**$5,156,546**

The data vividly illustrates the unpredictability of claim costs even from month to month. Medical claims paid for this subset of members amounted to $5,156,546 for approximately 3.5% of our member population.

In addition, pharmacy claims costs have increased from FY16-17 to the current fiscal year. From July 2016 to February 2017, specialty drugs comprised 31.5% of total net cost ($1,095,465), while the percentage of specialty drug

usage increased for July 2017-February 2018 to 39.5% ($1,626,891). Noticeably, 2.4% of our member population is driving the trend increase for specialty drugs.

Members with chronic conditions generally use more health care services, including physician visits, hospital care, and prescription drugs[1]. Currently, 40% of our member population have been diagnosed with one or more chronic disease. Of the 40%, 691 members (21%) have gaps in care. A "gap in care" is defined as the difference between recommended best practices and the care that is actually provided. Often, a physician will prescribe a treatment, medication, or lifestyle change, and the member may face obstacles that prevent him or her from implementing the physician's recommendations. Or, perhaps, the member may choose to not follow the physician's recommendations. All of these scenarios result in gaps in care.
One of the chronic diseases that affect many members on our plan is diabetes. Our health plan currently has 289 members who have been diagnosed with this disease, however, no member is 100% compliant with the best practice care recommended by their physician, which amounts to a projected savings of $673,809. When members do not follow the prescribed guidelines for managing their chronic diseases, complications tend to rise as a result and members produce more health claims. In the last 12 months, 44% of our total spending was used in providing healthcare coverage to members with gaps in care.

As a result of the aforementioned factors, the following measures could assist with making health claims more manageable and in increasing the member's overall health and well-being.

Benefits Integration - Implement *Balance Benefits*
A recent survey completed in March 2018, in collaboration with the Social Services Department, 66.7% of respondents stated that they understood our benefit choices but not the plan details or coverages they provide. To control health claims and get a return on investment for the County's benefit dollars, improved communication and education through benefit integration is needed.

Balance Benefits is a fully-integrated tool that brings all of an employee's benefit information directly to their mobile device. This platform is backed by a 24/7 Benefit Information Line staffed with highly qualified Certified Employee Benefits Specialists (CEBS) and Health Advocacy Care Guides to assist employees with benefit education and support. Employees can contact specialists at any time to learn about benefits that will support the life events they are experiencing, as well as request assistance navigating increasingly intricate healthcare plans.

Projected Cost: $42,014.80

Chronic Disease Management

[1] Partnership for Solutions (2002). Chronic Conditions: Making the Case for Ongoing Care (Baltimore, MD: Johns Hopkins University).

The most effective way to reduce overall health spending is to focus our efforts on employees with chronic conditions, specifically diabetes. Partnering with staff at the Employee Wellness Clinic to provide members with targeted personalized education, support and health coaching for their chronic diseases will arm employees with information that is actionable and easy to understand, leading to savings in time and resources. Providing support to employees in managing their chronic conditions not only leads to improved care outcomes, but also enables members and the plan to save money in the form of avoided readmissions and/or complications.

We will coordinate a marketing campaign to highlight our current Disease Management Programs and provide incentives for program completion of participants, if budget allows. If participants are willing, spotlighting their success stories on MyDCo (intranet) would increase awareness and engagement with other employees.

Enhanced Wellness Program

We will continue to collaborate with Public Health and the Employee Wellness Clinic to enhance our wellness initiatives and encourage healthy behaviors and lifestyles. We will create monthly themed wellness topics that relate to themes that affect our medical plan for awareness, education and prevention purposes.