



Arthur J. Gallagher & Co.
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Healthcare Analytics Consulting

Sarasota County Schools

Onsite Medical Center Feasibility Study

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Executive Summary

Scope

Sarasota County Schools ("SCS") engaged Healthcare Analytics, a Division of Gallagher Benefit Services ("HCA") to conduct a study of the feasibility of operating a primary care medical center for the benefit of employees and their eligible dependents covered under the SCS self-funded health insurance plan. The plan is administered by Florida Blue ("FB"). There are approximately 5360 employees and retirees and approximately 7,300 total members covered. Of those, approximately 4750 are active employees, with approximately 5800 active members. Annual claim costs under the plan are approximately \$38 million.

Methodology

The GBS study consisted of the following 3 main components.

We estimated the cost of operating the center(s), consisting primarily of administrative fees charged by a vendor to manage the center and professional fees paid for the medical professionals that would staff the center. Because of the range of costs relating to the administrative fees that we have seen from different vendors, we estimate the cost using high and low administrative cost assumptions. We based the projected professional services fees on the capacity needed to provide the volume of care under two distinct center utilization assumptions.

We estimated the potential reduction in claims paid under the health plan due to a combination of services provided directly at the center and a reduction in unnecessary services attributable to the "gatekeeper" function played by the center. As we did for the professional fee component above, we developed the savings estimates using two distinct assumptions about the % of primary care physician (PCP) office visits that are redirected to the center. We termed the assumptions "moderate" and "high" utilization.

We estimated the potential for savings related to improved health of covered members as a result of wellness and disease management initiatives supported by the center and for savings related to improved productivity related to the center. This is the most subjective component of the study.

Results

The projected first year results of the study are summarized in the following table. The savings associated with an improvement in population health are not included in this table as they are projected to emerge over a longer period of time. Potential productivity savings are also not included in the table.



Administrative Fee Assumption	Moderate Utilization		High Utilization	
	Low	High	Low	High
Estimated Direct Claim Savings	\$1,226,038	\$1,226,038	\$2,050,777	\$2,050,777
Projected Clinic Expense	\$1,603,707	\$2,059,983	\$2,175,679	\$2,631,955
Total First Year Savings/(Cost)	(\$377,669)	(\$833,945)	(\$124,902)	(\$581,178)

In addition to these hard dollar savings, it is possible that SCS would see savings related to a reduction in absenteeism. Employees would have to take less time off to visit the center than they would need to see their doctor. The value of those savings is beyond our ability to estimate with any precision without knowing more about SCS's costs for substitute teachers and other employees. Based on assumed center utilization and assumptions regarding average time saved and the average replacement cost of \$30 / hour, we estimate that the savings related to reduced absenteeism range from \$145,000 under moderate utilization to \$260,000 under the high utilization assumption.

As center usage increases, the financial results will improve and we certainly expect some increase in the use of the center over time. We have assumed a healthcare delivery model that is based on an onsite MD, with support from an RN or Physician Assistant, and a Medical Assistant. Delivery models based more on the RN or PA as the primary caregiver, with oversight from an MD, will have lower professional costs but may also be met with more resistance from employees who perceive an MD to be a higher level of care. We also assumed that center will include a dispensary to dispense generic drugs.

Conclusions

SCS has a large and concentrated enough population that it is a reasonable candidate for operating a medical center.

The historical utilization of services likely to be replaced by a center is higher, at least for specialist services, than our normative data suggests, and that increases the opportunity for savings somewhat.

We estimate that if approximately 1/3 of the PCP visits can be redirected to the center setting, a center would break even based only on hard dollar savings, assuming administrative expenses at the lower end of our assumed range. This ignores other sources of savings such as reduced absenteeism. While getting to breakeven is certainly possible, we think it would be difficult to get center utilization high enough that the pure redirection of services from physician offices to the center would generate significant savings to SCS. Even if 50% of primary care visits are redirected to the center, we project an operating gain of approximately \$200,000 on the cost of medical care.



We also point out that even the 20% of PCP visits that we assumed in the moderate utilization scenario will take extensive communication and education efforts by SCS to attain in year one.

Clearly, the most critical factor in the financial success of the center is the level of utilization. To the extent employees use the facilities as a substitute for seeing their PCP and the center more successfully manages referrals and testing than is currently the case, the direct savings will cover the operating costs of the centers. If the levels assumed in the study are not reached (and they are by no means easy targets), the center will produce a net loss prior to any savings realized outside the health plan such as reduced absenteeism.

In order for a center to have a more significant favorable impact on health care costs, it is imperative that it includes or enhances programs that favorably affect the health of the covered population in a way that reduces future medical trend.

Wellness Savings

In addition to the “hard dollar” analysis above, we considered the potential for the centers to support programs aimed at improving the health of plan members. The following table shows a normative mix of claimants sorted by 4 different types of clinical categories and the health risk index (HRI) for each category, followed by two columns assuming a slightly improved mix. The HRI is based on the Clinical Risk Group (“CRG”) logic developed by 3M. It is a measure of the health status of a population and can be used as a proxy for a measure of expected relative cost. What the chart shows is that even a relatively small shift in mix between chronic claimants and healthy claimants (in this case, 2% of members) can generate a significant improvement in the overall HRI and in the expected cost (in this case, a 3.3% improvement). Each 1% shift from chronic to healthy translates to an expected reduction of approximately \$600,000 in annual claim costs.

Clinical Category	% of Claimants	Health Risk Index	Illustrative % of Claimants	Illustrative Health Risk Index
Non Claimants	11.1%	0.000	11.1%	0.000
Healthy Claimants	36.7%	0.273	38.7%	0.273
Acute Claimants	5.3%	0.752	5.3%	0.752
Chronic Claimants	47.0%	2.370	45.0%	2.370
Total	100.0%	1.253	100.0%	1.211



In addition to moving members from chronic to healthy status, it is also possible to lower the HRI score associated with the chronic and acute categories. So while replacing external medical services with medical center services is unlikely to generate any large savings, the center's ability to improve the health of the population may have the potential to flatten the medical trend and generate much more significant long term savings.

In summary, if close to 1/3 of the active members covered by the SCS plan can be encouraged to use a center for primary care and preventive services we expect a center can breakeven based on only hard dollar savings. Moderate savings are possible if as many as 45% to 50% of PCP visits can be redirected to the center, and more significant savings are possible if the members that do use the center are more actively engaged in wellness and disease management programs and as a result the center can successfully reduce medical trend.

The ability of a center to impact population health will depend on the incentives offered by the employer for employees to use the center, and on the types of wellness and disease management services offered at the center. Many larger employers employ a wellness coordinator and the center serves as a logical setting for that individual to meet with and engage employees in the appropriate wellness programs.

The following sections document the assumptions and methods used to derive the values presented in the table above, and address in more detail the potential savings related to wellness and disease management initiatives that could be obtained through the center.

Data and Assumptions

The study uses data from the following sources:

Claims data and certain key utilization and unit cost measures are based on the SCS reports provided by FB for the period from January 1, 2012 through March 31, 2017. This included office visit and radiology services per 1000 members. We also received Key Indicator and pharmacy experience reports produced by FB for the years from 2013 to 2016. SCS provided information about plan designs and the use and cost of drug testing and employment physicals over the same 2013 to 2016 period. These reports were supplemented with normative data from HCA's data warehouse as appropriate.

Data regarding the cost of operating centers is taken from HCA experience with clients who have implemented centers and from RFPs and RFIs we have been involved with on behalf of clients considering a center model.



Assumptions regarding potential improvements in the health risk index level and resulting cost are based on HCA experience with other clients.

The study is based on key assumptions regarding what portion of primary medical services can be redirected to the center, how effectively the center will serve as a “gatekeeper” for specialist referrals and diagnostic testing, and what impact the center will have on future medical trends. We have used data from our own clients to develop a starting point for these assumptions, but we expect to see variation between clients in the results. In prior RFPs and RFIs, we have asked vendors for input on these assumptions as well, and although the vendors tend to be (in our opinion) somewhat optimistic in setting utilization and effectiveness assumptions, their feedback is valuable as a reasonableness test of our assumptions. Finally, in order to recognize the range of possible results depending on how a center is received by plan members, we prepared results using two separate sets of utilization assumptions.

- Under the “Moderate” utilization scenario, we assumed that 20% of primary care services would be redirected to the medical center.
- Under the “High” utilization scenario, we assumed that 35% of primary care services would be redirected to the medical center.

Under both scenarios, we assumed that the center would have some success in controlling unnecessary use of specialist referrals and diagnostic testing and to a lesser extent the emergency room, and that a portion of the generic prescription drugs would be dispensed through the center. We assumed a greater impact on these services under the High utilization scenario than under the Moderate scenario.

We included potential savings associated with drug testing and employment-related employee physicals. The potential savings for additional occupational health services depends on SCS Workers Comp experience but are generally relatively small compared to potential savings under the health insurance plan.

In our Return on Investment analysis, we did not make any assumptions about how health risk or medical trend will be affected and how those factors would affect future claim costs. Each employer needs to decide how aggressively it wants to pursue wellness and disease management initiatives through a center, and there is a wide range of available options. As a result, we have quantified the apparent opportunity but have not made any assumptions about how SCS would pursue the opportunity and what the impact of those efforts would be.

There is no standard medical delivery system for centers. We assumed that the center would use a medical delivery system based on an MD with support from an RN and a PA. Other models under which the primary practitioners are RNs or PAs will generally

have lower professional staffing fees, but may also have less ability to treat as many conditions or to successfully perform the gatekeeper function. Overall, we do not believe that one system has an inherent financial advantage over the other available systems and that the results of the study would be similar regardless of the delivery system we assumed.

The assumptions are set out in more detail in the following sections of this report.

The Cost of Operating a Medical Center

In order to estimate the cost of operating a medical center, we first have to understand the volume of services that are expected to be provided. The volume is a function of the number of eligible members and the assumed utilization rate for those members. SCS provided a census of active employees that included the zip code for each employee. We estimated the number of employees that would have high, medium, or low access to a medical center by assuming that 5-digit zip codes with a high number of employees would be most likely to have access to a single location due to the density of the enrollment. The results are summarized in the following table.

Access Area	Employees	% of Total	Estimated % Eligible	Estimated Eligible
High	3,223	60.2%	100%	3,223
Moderate	1,430	26.7%	75%	1,072
Low	100	1.9%	0%	0
Total	4,753	88.7%	90.4%	4,295

There are certainly other ways to estimate access, but we believe that for a Countywide school system with multiple locations, an estimate of 90% of employees with convenient access, particularly if we consider 2 center locations, is reasonable.

Based on the current member to employee ratio, we estimate that if 4,295 employees would have reasonable access to a center, then there would be an estimated 5,829 total members with access.

Professional Staffing Costs

Based on the historical frequency of primary care visits projected to the 2018 plan year, we expect the 5,829 eligible members to have a total of approximately 12,325 primary care and preventive care office visits. Under the Moderate utilization assumption, we assume 20% of these visits, or 2,465 visits, will go through the center. Under the High utilization scenarios, 35% of the visits, or 4,314 visits, are assumed to go through the center.



In addition to PCP visits, we expect a small % of specialist visits will be replaced by visits to the center. We assumed 5% of specialist visits under Moderate center utilization and 10% of specialist visits under High center utilization will be redirected to the center. Under our assumed specialist utilization (approximately 17,300 per year), this will result in additional center visits of 864 under the Moderate and 1,728 under the High utilization assumption.

We use the expected number of visits to develop an estimate of the number of hours the center needs to operate in order to provide the expected services. Key assumptions in this step are set out below.

- There will be 3 office visits per hour.
- Only 50% of the appointments at a center actually replace an office visit. The other 50% are a combination of services for which the member would not have sought treatment in the absence of a center and visits related to health risk assessments or other wellness programs that also do not replace a visit. This assumption is based on GBS experience, but will vary by employer.
- The optimal utilization of available appointments is 90%. Vendors generally tell us that centers that operate at 100% capacity will experience problems for employees in getting appointments or walk in treatment and that will eventually hurt utilization. The vendors generally suggest that a center should have between 80% and 90% of the available appointment time scheduled with the remainder of the time available for unscheduled appointments.

Based on these assumptions, the recommended number of available appointment hours is developed as follows for the Moderate and High utilization assumptions.

	Moderate	High
% of PCP Visits Directed Through Clinic	20%	35%
Target Physician Visits in Clinic	2,465	4,314
% SCP Physician Visits Avoided	5%	10%
Target Specialist Visits Redirected to Clinic	864	1,728
Total Visits Redirected to Clinic	3,329	6,042
% of Visits in Clinic Replacing a PCP Visit	50%	50%
Total Available Visits Needed to Meet Target PCP Utilization	6,659	12,085
Visits per Hour	3	3
Required Physician Hours	2,220	4,028
Target Utilization of Available Appointment Time	90%	90%
Target Available Appointment Hours	2,466	4,476
Required Hours per Week (50 weeks per year)	49	90



Under the Moderate utilization scenario, we project a total of 2,466 appointment hours will be needed, while under the High utilization scenario we project 4,476 hours will be needed. Assuming 50 weeks per year, this equates to 49 hours per week for the Moderate scenario and 90 hours per week for the High scenario. Note that it is possible to have available hours per week exceed the hours the center is open by having multiple providers available.

We have assumed that each location would have an MD, an RN or PA, and a Medical Assistant (MA). We have estimated hourly rates based on current RFP and RFI responses from a range of center vendors. The following table summarizes the resulting projected professional staffing costs.

	Hourly Rate	Moderate Utilization		High Utilization	
		Hours/Week	Annual Cost	Hours/Week	Annual Cost
MD	\$120	49	\$295,941	90	\$537,099
RN/PA	\$50	49	\$123,309	90	\$223,791
Medical Assistant	\$20	49	\$49,323	90	\$89,516
Total Staffing Cost			\$468,573		\$850,406

We project an annual professional services cost of \$469,000 for the Moderate utilization assumption and \$850,000 for the High utilization assumption.

Administrative Expenses

Vendors who administer medical centers will also charge an administrative fee for their services. The fee covers a variety of services such as hiring professional staff, obtaining insurance, communication services, reporting, maintaining systems, integrating data with the plan's TPA, and other services that vary by provider. Some vendors charge a separately identified administrative fee, while others combine their administrative fees with provider staffing and supplies in a single fee. We felt that for purposes of this study it made more sense to separately identify the administrative expenses. Because of the range we see in the market, we present both Low and High cost scenarios.

Per Capita Fees (PEPM)	Low	\$15
	High	\$23
Annual Fees	Low	\$855,518
	High	\$1,311,795

For a population of 4,753 eligible employees, we project the annual administrative fees will be somewhere between \$855,000 and \$1.3 million. It is possible to negotiate lower fees, but for a full service center we think this is a reasonable estimate, and our expectation is that the fees available in the market will be closer to the high end of this range for a full service facility.



Drugs and Supplies

We assumed that the center would include a generic drug dispensary to take advantage of unit costs savings available on generic drug purchasing and to promote generic utilization in general. We estimated drug utilization based on current patterns and assumptions about how many drugs would be dispensed through the center. Those assumptions are described in more detail in the Cost Savings section. We also estimated the cost of supplies (latex gloves, syringes, and other medical supplies) based on responses to other RFPs and RFIs. The estimated cost of drugs and supplies is shown in the following table.

	Utilization	# of Drugs/Supplies	Cost Per Drug/Supply	Annual Cost
Generic drugs	Moderate	7,588	\$15	\$113,822
	High	11,455	\$15	\$171,830
Supplies	Moderate	6,659	\$5	\$33,293
	High	12,085	\$5	\$60,424

Rent

Following is our estimate of the cost of renting center space. We based the annual cost of renting space on an estimate of approximately \$2 per month per square foot based on current information about commercial retail leasing rates in Sarasota County.

Utilization	Square Feet Per Location	Total Square Feet	Annual Cost/ Square Foot	Total Annual Cost
Moderate	3,000	3,000	\$25	\$75,000
High	2,500	5,000	\$25	\$125,000

Other Expense

We also estimated the cost of other expenses such as obtaining necessary licenses, insurance, and cleaning services. We estimated these as a % of the cost of rent. This will be a relatively minor expense, as shown below.

Licenses, Insurance, Cleaning, etc.	Assumed % of Rent	10%
	Moderate Utilization - Annual	\$7,500
	High Utilization - Annual	\$12,500

Start Up Expenses

Finally, we estimated the cost of starting the center. These expenses would be incurred in the first year of operation, although some may be amortized. The start up expenses will depend on whether a facility needs to be built out or if SCS is able to rent space



that is already compatible with use as a center. It is important to note that building out a medical facility requires adherence to codes and requirements that may be stricter than a regular build out.

Based on other RFP submissions and the required size of the SCS facilities, we estimate the build out costs for a space not currently used as a medical facility to be \$50,000. For a facility that is currently in use as a medical facility, the build out expense will be nominal.

Summary of Expenses

The total of all estimated expenses is summarized in the following table.

Administrative Fee Assumption	Moderate Utilization		High Utilization	
	Low	High	Low	High
Professional Salaries	\$468,573	\$468,573	\$850,406	\$850,406
Administrative Fees	\$855,518	\$1,311,795	\$855,518	\$1,311,795
Equipment and Supplies	\$147,116	\$147,116	\$232,254	\$232,254
Rent	\$75,000	\$75,000	\$125,000	\$125,000
X-Ray Machine	\$0	\$0	\$0	\$0
Other	\$7,500	\$7,500	\$12,500	\$12,500
Total Annual Expense	\$1,553,707	\$2,009,983	\$2,075,679	\$2,531,955
Start Up Expense	\$50,000	\$50,000	\$100,000	\$100,000
Total First Year Expense	\$1,603,707	\$2,059,983	\$2,175,679	\$2,631,955

Under Moderate utilization, we project annual expenses before start-up costs and assuming a single location, to be between \$1.5 million and \$2 million. Under High Utilization, we project annual expenses before start-up costs and assuming 2 locations, to be between \$2.1 million and \$2.5 million. The build out cost is estimated to be \$50,000 for Moderate utilization and \$100,000 for High utilization. These results are consistent with a rule of thumb that a full time center operating at 40 hours per week will cost roughly \$1 million a year to operate.

The key conclusion from this section is that operating a center is a significant investment and will only make financial sense if there are significant potential savings.

Potential Claim Savings

Hard Dollar Savings

Center vendors tout savings that can be classified as direct, or hard dollar, savings, and indirect, or soft dollar, savings. This analysis focuses on the hard dollar savings. We will comment on soft dollar savings at the conclusion of this section.

A medical center offers the opportunity to save costs on two broad types of services:

- Services that are provided directly in the center, such as primary and preventive care visits and generic drugs, and
- Services that are often over utilized for which the center can serve as a gatekeeper that reduces unnecessary utilization, such as specialist visits, diagnostic tests and brand name drugs.

Vendor estimates of the potential for these savings vary depending on their model and steps taken to encourage center utilization. The higher the utilization, the greater the potential for generating both types of savings. In order to promote center utilization, employers often waive all or most employee cost sharing for services performed in the center. As cost sharing in general has increased in recent years, this has become a more meaningful incentive. Some employers who offer HRA/HSA programs increase funding of spending or reimbursement accounts for using the center. Some employers use the center as a focal point for wellness activities in an attempt to engage employees.

Based on our experience with employers who have implemented centers, and on information provided in responses to RFPs and RFIs, we prepared the following Moderate and High utilization assumptions.

% of Services in Center	Moderate	High
Primary Care/Preventive Care Visits	20%	35%
Generic Drugs	10%	15%

% of Services Avoided	Moderate	High
Specialist Visits	5%	10%
Outpatient Diagnostic Services	5%	10%
Brand Drugs	3%	5%

Vendors believe it is possible to see even higher center utilization over time, but we feel that there are practical limits that cannot be ignored. For example, centers do not normally offer pediatric services, so children visits may not be directed to a center. Covered spouses who do not work for SCS may not find the center location to be convenient.

In addition, individuals with chronic conditions are likely to have established physician relationships and may be more reluctant to use a medical center. Since those with chronic illnesses have the highest frequency of visits, this means that the people responsible for the largest share of visits may be least likely to use a center. All of these

factors suggest that reaching levels such as 50% or more of Primary Care visits going through a center is difficult and even over a period of years may not be possible.

We developed the current utilization and unit costs for services that could be affected by the center using SCS data as reported by FB, supplemented as appropriate with our normative data. We adjusted the data to an assumed starting point of January 1, 2018 using normative utilization and unit cost trend assumptions. We also assumed that for services such as diagnostic services and brand drugs, the services eliminated would be less expensive than the average service in that category. The logic for that is that the most serious visits and tests are less likely to be eliminated.

The baseline utilization for services that can reasonably be expected to be affected by a center is summarized below.

Type of Service	Service	# of Services	Unit Cost	Annual Claims
Preventative	Preventive Visit	3,187	\$108.89	\$347,010
	Immunizations	6,026	\$53.02	\$319,525
Other Physician	PCP	9,139	\$115.39	\$1,054,587
	Specialist	16,300	\$119.78	\$1,952,338
	Consultation	982	\$206.57	\$202,913
	Lab/Pathology	26,980	\$31.10	\$839,195
	Radiology	7,471	\$85.22	\$636,664
	Physical Therapy	8,879	\$38.22	\$339,310
	Subtotal			\$5,025,006
	Outpatient Facility	Diagnostic	6,224	\$975.15
Emergency Room		978	\$1,960.18	\$1,916,391
Subtotal				\$7,985,430
Pharmacy	Generic	71,494	\$39.37	\$2,814,955
	Brand	14,626	\$689.35	\$10,082,418
	Subtotal			\$12,897,372
Miscellaneous	Drug Testing	798	\$33.08	\$26,383
	Physicals	256	\$77.18	\$19,742
	Subtotal			\$46,125
Total for These Services				\$26,300,943

We project the total claim cost that might be affected by the center, assuming current plan design and enrollment, for members eligible to use the center based on their location, to be \$26.3 million. The following table shows the projected annual claims for



each of the indicated service categories, and in total, as well as the total projected savings for both the Moderate and High utilization scenarios.

Type of Service	Service	Baseline	Moderate Utilization	High Utilization
Preventative	Preventive Visit	\$347,010	\$277,608	\$225,556
	Immunizations	\$319,525	\$255,620	\$207,691
Other Physician	PCP	\$1,054,587	\$843,669	\$685,481
	Specialist	\$1,952,338	\$1,864,483	\$1,776,628
	Consultation	\$202,913	\$194,796	\$186,680
	Lab/Pathology	\$839,195	\$805,627	\$772,059
	Radiology	\$636,664	\$611,198	\$585,731
	Physical			
	Therapy	\$339,310	\$339,310	\$339,310
	Subtotal	\$5,025,006	\$4,659,083	\$4,345,889
Outpatient Facility	Diagnostic	\$6,069,039	\$5,905,175	\$5,795,932
	Emergency Room	\$1,916,391	\$1,864,648	\$1,830,153
	Subtotal	\$7,985,430	\$7,769,823	\$7,626,085
Pharmacy	Generic	\$2,814,955	\$2,561,609	\$2,434,936
	Brand	\$10,082,418	\$9,870,687	\$9,729,533
	Subtotal	\$12,897,372	\$12,432,296	\$12,164,469
Miscellaneous	Drug Testing	\$26,383	\$0	\$0
	Physicals	\$19,742	\$0	\$0
	Subtotal	\$46,125	\$0	\$0
Total for These Services		\$26,620,468	\$25,394,430	\$24,569,691
Estimated Annual Savings			\$1,226,038	\$2,050,777

The projected savings for each service type are shown below.



Type of Service	Service	Moderate Utilization	High Utilization
Preventative	Preventive Visit	\$69,402	\$121,453
	Immunizations	\$63,905	\$111,834
Other Physician	PCP	\$210,917	\$369,105
	Specialist	\$87,855	\$175,710
	Consultation	\$8,117	\$16,233
	Lab/Pathology	\$33,568	\$67,136
	Radiology	\$25,467	\$50,933
	Physical Therapy	\$0	\$0
	Subtotal	\$365,923	\$679,118
Outpatient Facility	Diagnostic	\$163,864	\$273,107
	Emergency Room	\$51,743	\$86,238
	Subtotal	\$215,607	\$359,344
Pharmacy	Generic	\$253,346	\$380,019
	Brand	\$211,731	\$352,885
	Subtotal	\$465,077	\$732,903
Miscellaneous	Drug Testing	\$26,383	\$26,383
	Physicals	\$19,742	\$19,742
	Subtotal	\$46,125	\$46,125
Total for These Services		\$1,226,038	\$2,050,777

Projected savings range from \$1.2 million to \$1.9 million depending on the utilization assumption. In the long term, utilization should increase over time resulting in increased plan savings.

It has also been our experience that some vendors will suggest that other types of direct claim savings are possible through a center. Some will suggest that a center can reduce inpatient admissions for example. Our experience with employers who have implemented a center does not support these claims, at least in the short term. The center will provide only primary care, so anything requiring more acute treatment should be referred to the proper setting. A successful center might affect inpatient admissions in the long run (as will be discussed in the next section), but that will depend entirely on how the center is integrated with the employer's wellness and disease management programs.

Soft Dollar Savings

Most medical center vendors promote the notion of soft dollar savings. Sources of soft dollar savings include the following:



- Reduced absenteeism since employees can receive medical treatment without being away from work for long periods of time.
- Enhanced productivity while at work (“presenteeism”)
- Reduced employee turnover and recruiting costs
- Increased compliance with treatment plans that will lower long term costs

We developed an estimate of potential savings due to reduced absenteeism. We estimate that the number of retail doctor visits avoided will be between 3,200 (moderate utilization) and 5,800 (high utilization). If the center saves 1.5 hours per visit, then between 4,900 and 8,800 hours are saved. If the average value per hour saved is \$15, then the savings would be \$73,000 assuming moderate utilization and \$131,000 assuming high utilization. We did not include these estimates in our analysis because we have no hard data to support some of our assumptions but we believe SCS should consider the possibility of savings associated with reduced absenteeism in its decision making process.

Although we agree that an employer may benefit to some degree from each of the other items listed above, we have not made any attempt to quantify these sources of savings. For the most part, we do not have any credible baseline against which to measure these items, and in some cases it is hard to measure them at all. We do not suggest that these items have no value, but we are reluctant to try to estimate their value without additional data.

Wellness and Disease Management Opportunities

In the prior section, we concluded that the potential for direct claims savings under reasonable center utilization assumptions was likely to be less than the cost of operating a center in the first year of operation. Despite that conclusion, better long term results are possible if the center can be used to improve the performance of other aspects of the health insurance program. Two likely candidates for improvement are wellness and disease management programs.

Wellness programs can be defined as initiatives aimed at preventing employees from moving down the health spectrum from healthy to less healthy. Most wellness programs focus on promoting exercise, healthy eating habits, smoking cessation, weight loss, and appropriate wellness visits and screenings. A number of published studies have suggested that 50% or more of health care costs can be linked to lifestyle issues. If those studies are accurate, even small improvements in the overall wellness of a population could have a material impact on health care claims.



Disease management programs can be defined as initiatives aimed at ensuring that individuals who already have health conditions that require treatment actively participate in treatment plans that provide efficient care leading to the best possible health outcomes. Some conditions, such as diabetes, asthma, heart disease, and cancer, are natural candidates for disease management. Disease management programs also exist for a number of other conditions that are less obvious, ranging from behavioral health to rehabilitation therapy.

A successful center can be used to promote employee participation in both wellness and disease management programs. Participation can be encouraged through plan design incentives, premium credits, and enhanced employer funding of healthcare reimbursement or savings accounts. While similar incentives can be developed in the absence of a center, the convenience of a center may make employees more likely to participate and remain engaged in these programs.

In order to estimate the potential impact of improved wellness and disease management programs, it is necessary to understand the prevalence of manageable conditions and the general level of wellness in the population. The chart on page 5 suggests 47% of a normative population with SCS demographics have a diagnosis that we classify as chronic, while 37% of members are what we consider healthy claimants. The 47% of members falling into the chronic category make up 89% of the claim cost.

The ability to slow the growth of future healthcare costs by improving the health of the population is absolutely essential for a center to succeed. Even a small change in the underlying population, as measure by improvements in the HRI, can have a significant impact on claim costs. With chronic claimants accounting for nearly 90% of the total claim cost, and if we assume that each 1% change in the HRI corresponds to a 1% change in the health claim cost, then for each 1% by which a successful disease management program is able to reduce the HRI for chronic claimants, we estimate an annual claim savings of \$525,000. The ability to reduce medical trend by even 2% per year over a period of several years will generate very significant savings.

A successful wellness program will reduce key risk factors and that will also translate to lower HRI scores. Preventing members from moving from healthy claimants to chronic claimants will keep the overall HRI lower and will reduce claim costs over time. On average, each 1% shift from chronic to healthy claimant reduces the overall HRI by an estimated 1.65%, which we estimate would translate to annual claim savings of \$585,000.

These potential savings are likely to occur over a longer time period of perhaps 2 to 3 years at best. Also, estimating claim savings by looking at changes in the HRI is complicated by the fact that even in the absence of any disease management or



wellness program, there is often movement in the HRI from year to year. If one year has an unusually high frequency of serious illnesses, it is common that the next year is not as bad, as experience tends to move back to “normal” over time. In order to attribute savings to these programs, it is necessary to track experience for given conditions over time and compare the progression of risk scores before and after the programs are introduced, taking into consideration the progression of the scores in an environment with no such programs.

Finally, many employers are taking stronger steps in this area without using a center, so the real question is how much can the performance of these programs be improved by using a center. Disease management and wellness vendors will generally agree that the biggest barrier to success is that not enough employees are truly engaged in the programs. To the extent a center serves as a tool for increasing the engagement level of employees, the programs should be more effective. A discussion of strategies for promoting employee engagement through a center is beyond the scope of this report, but we recommend that if SCS analyzes center vendors, the approaches taken by vendors to engage employees be given a material weight in the evaluation process.

After all the caveats and unknowns, the question remains: How much can a well-designed center contribute to health plan savings by improving the health risk of the covered population? Based on the theoretical analysis, there is more potential for long term savings related to health improvement than for avoiding office visits and other medical procedures and prescriptions. Based on what we have seen, it is possible to slow the growth of healthcare costs through more effective wellness and disease management programs, and we certainly have examples of centers successfully engaging employees in health promotion activities. Therefore, we believe a center can play a role in slowing the growth of healthcare costs and that the magnitude of potential savings is at least as significant as the short term direct cost savings that can be achieved.

Other Considerations

As we prepared this report, there were other issues that presented themselves that we think are worth noting.

One key factor that drives center utilization is the location of the facility. If employees are spread out over several work locations it is often difficult to find a single location for a center that provides ready access to all employees. In our work, we assumed that at most 2 locations could provide reasonable access to the majority of SCS employees.

A second issue we think is important to note is that some employers who have implemented centers have been disappointed with the level of reporting about the



nature of services performed in the center and the inability to integrate that data with the medical TPA data. As centers mature, we expect some of the reporting issues will be resolved, but it remains an issue today with many vendors. The possible partnering of center vendors and medical TPAs might also prove to be one method of addressing this issue.

Finally, we think it is important to keep in mind that while employer sponsored centers have been around in some form for decades, the more recent explosion in this field has not been going on long enough to have a great deal of credible history. This analysis is based on a mix of our assumptions and hard data from clients we have worked with. While we believe our findings are reasonable and consistent with the experience that we do have, there is still an element of uncertainty regarding the long term results under center programs. SCS should keep this uncertainty in mind when evaluating its options regarding medical centers.