

Tribal Council Workshop  
THE STATE OF TRIBAL HEALTH CARE COSTS  
July 24, 2009 9:00 am  
Tribal Administration Building

Facilitator: Gary Leva, Gary Leva Consulting Group

Objective: To gather information and raise awareness about the growth of Tribal health care costs and discuss concerns about future sustainability.

Present: Gary Leva, Mike Arnold (Conover Benefits), Ron Saltau (Health Comp Administrator), Robert Weeks (Health Comp Legal), Drew Adams, Trudy Simpson, Lynette Turner, Pat Dudas, Dr. Roger Willis, Kelle Little, Jeff Wasson, Brady Scott, Brett Kenney, Larry Scarborough, Mark Gagnon, Lynn Sandberg, Sue Thornton, Kathy Henry, Jack Lenox, Don Garrett, Michelle Ramey, Don Ivy, Denise Stuntzer-Gibson, Rod Cook, Tom Younker, Judy Rocha, Ken Tanner, Ed Metcalf, Toni Ann Brend, Cassie Ross, George Smith, Joan Metcalf, and Patrick Metcalf.

#### **A. Review the Council's Vision for Tribal Health Care**

(Power Point presentation handout)

- ❖ Rod Cook reviewed the vision of Nasomah and why it was created
  - ❖ Kelle Little reviewed Contract Health Services' vision
  - ❖ Mark Gagnon reviewed Health Care Trust Fund
- The health care trust fund was established in 2001 to provide for deferred Contract Health Services. The original fund target was \$800,000 and the annual need was estimated at \$40,000.
- ◆ Most of the services on the deferred list were orthodontia and when the orthodontia program was established in 2006, most of the list was cleared. There were a few deferred services remaining on the list, but they were considered cosmetic procedures that are excluded.
  - ◆ A new vision for the Health Care Trust Fund needs to be defined. Is the purpose to off-set the Tribal General Fund expenditures for member's health care? If so, then the need is about \$1.5 million per year, and it's growing every year. The fund target would have to be in excess of \$30 million, and growing every year. Perhaps a follow up action would be to determine what piece of Tribal health care do we hope this health care trust fund to attack, it's not deferred services anymore, but what should it be?
  - ◆ \$6 million dollars have been contributed into the fund, but because of losses in the investment, today's market value is \$5 million.
  - ◆ The trust funds are capitalized and maintained with gaming revenues. A new MOU with CEDCO was negotiated to determine how much of gaming revenue is distributed to the Tribe. The MOU went into effect on January 1, 2007 and will expire on December 31, 2011. The MOU gives consideration to CEDCO's operating cash needs, if CEDCO doesn't have enough cash to fund its business operations, then the

agreement allows delaying the Tribe's distribution. In 2007, about half the distribution was delayed. Last year, CEDCO was able to pay the full distribution and repay a portion of what was deferred. At the end of 2008, there is still about \$3 million left in the deferred distribution loan balance.

QUESTION: What percent is the \$3 million of what they are obligated to pay?

- ◆ Distributions owed for 2007 and 2008 totaled about \$14 million, so the \$3 million deferred loan balance is less than half – about 25%
- ◆ The deferred payments are a factor of business and the economy. Under the MOU, payments can be deferred up until the end of 2011. Beginning 2012 – 2016, any amounts deferred, need to be paid to the Tribe.

QUESTION: The distributions with CEDCO, is that formula driven or a flat rate negotiated deal?

- ◆ It is formula driver, 19% of gaming revenues, which is a 2% increase from the previous formula, so the agreement allows CEDCO to defer the 2% and any other amounts that it need to maintain operating cash.

## B. Review Nasomah's Costs and Trends

(Power Point presentation handout – presented by Rod Cook)

### ❖ Cost Growth

➤ In 1999 the cost was \$1,444,867 (audited) for 220 employee plan members – for 2009 the cost is are at \$7,098,910 (unaudited) for 622 plan members

### ➤ Factors Contributing to Cost Growths

- Large Claim expense – in 2003 - 04, three plan members cost's were \$212,819 – in 2004-05, four plan members cost's were \$412,316 – 2005-06, the cost was \$1,048,833 for 15 plan members and 2008-09, it was \$2,120,051 for 15 members. In six years, the costs have increased from \$200,000 to \$2,000,000 for less than 2% of the plan's population.

❖ ISL – Individual Stop Loss is at \$100,000 – for 2008-09 there were 15 people at \$50,000 or more, and 1 individual was over \$600,000.

❖ Laser – is a situation where a person is going into the new plan year and the carrier foresees that they will be incurring a large claim, the risk level will be set at some amount higher than the standard individual group deductible of \$100,000.

QUESTION: What was the average age of the 15 individuals?

- ◆ They were all employees and spouses, but did not have the average age.

❖ Changes in Benefits and Services – Rod reviewed Power Point slide.

QUESTION: Is the Healthy Tradition Program included in the information provided?

- ◆ It was not included – it was the incentive to draw people into the preventive services of the plan. Less than 10% were going in for preventive checks, now it is 70%. Healthy Traditions will be covered at the end of presentation.

❖ Comparison of Benefits to other Health Insurance Options

QUESTION: Why did Blue Cross decrease by 11% between 2008 -09?

- ◆ Possibly due to elimination of benefit plans

❖ Cost Projections

- Last 9 yrs.(2000 – 2009) shows an average annual increase of 4.6% increase
- Last 4 years (2005 -2009) shows an increase of 9%
- National trend – 11.5%

❖ Cost Control Measures

QUESTION: With Healthy Traditions and early detection, have they been able to catch high costing illnesses early on?

- ◆ Early detection of colon cancer
- ◆ Early diabetes & hypertension

QUESTION: Follow up question: Do you see this as a change in the health system vs. our discussion which is mostly dominated by the change in how we pay – I see it as two different To have a Healthy Tradition that is change in the health system vs. a discussion about how we pay for that, which is another discussion.

- ◆ Tribe leaning toward preventative health care
- ◆ People thinking more of their health due to Healthy Traditions
- ◆ Focus on Preventable & treatable
- ◆ Gathering data to see health costs due to Healthy Traditions
- Large Case Management
  - RN Case Management - help to contact members with high risk factors – and follow up with them to understand resources.
  - Start next month to help treat and lessen large case exposure

QUESTION: Disease management and Case management are they the same thing?

- ◆ Not quite, but almost the same thing
- ◆ Disease management – try to head off before a large case
- ◆ Case management – have a large case make sure the patient is doing the proper things to manage their care so they don't have another large case.

QUESTION: For the out of service area -How do you manage the cost for people you don't have good contacts with?

- ◆ Programs will be developed
- ◆ There are programs across the Northwest that we will be able to access and monitor.
- ◆ Health Comp is already doing large case management

### C. Review Contract Health Service's Costs and Trends

(Power Point handout - presented by Kelle Little)

❖ Cost Growth

- The Northwest, which includes Oregon, Washington and Idaho is a unique area and whereas the Contract Health is a solely CHS dependent area for any hospital care and any specialty medical care – we have to purchase all services, MRI, CT scans etc. We have to go into the community to purchase these services; there are no Indian Health Service hospitals or regional outpatient facilities.

- Patient Care Costs – 1996-2008
  - 1996 - \$ 300,000 to 2009 - \$1,390,000
  - 1996-1999 – 16% increase
  - Receive 1 to 2% increase in funds from I.H.S. each year
  - Possible increase of 10% from I.H.S. – first time in about 10 years
  - CIT Contract Health receives only 50% of what is needed from I.H.S., fortunately the Tribe supplements the rest
- Factors Contributing to Cost Growth
  - 1995 change service level from 2 to 3
  - Added travel benefit
  - Added orthodontia in 2006
  - Expanded eligibility in 2002 to Tribal Spouses
  - Added Non-Tribal, adopted children

QUESTION: How were non-Tribal adopted children added when the Tribe doesn't recognize adopted children?

- ◆ It was added under the same Indian Health Service provision that spouses were added: Tribal Contract Health can “choose” to cover those that show close socio economic ties to the Tribe.
- ◆ All changes were revised by the Health Advisory Board and Tribal Council.
- ◆ 2001 Pharmacy closed – lost access to discounted cost of drugs

QUESTION: When the Pharmacy closed, spouses were added, it was suppose to be a wash, is it not anymore?

- ◆ At the time it was a wash, but with the increases in medical inflation, it is not anymore.

QUESTION: Are we still going to Chemawa?

- ◆ Since we added orthodontia in 2006, we have contracted with orthodontists in the service area.

QUESTION: Regarding the pharmacy, can we get together with other Tribes?

- ◆ Working with other Tribes at looking at a consortium – a lot to work out

QUESTION: If there was a program with other Tribes, could the prescriptions be mailed out?

- ◆ Yes they could, but it changes the way they would get their medications, and it has not been before the Health Board yet.

QUESTION: Would it help, as a Case Manager, to control the amount of drugs people are taking?

- ◆ Yes, one of the things that we are working on with the Contract Health Services Case Manager, use of medications, use of generics, and amount of medications.

QUESTION: Changes of eligibility, in the Pacific Northwest, how many other tribes acknowledge what we have, spouses, domestic spouses?

- ◆ None

QUESTION: If you are a Tribal member and live outside the service area and you're Nasomah, would you be able to access the pharmacy?

- ◆ Not known

QUESTION: We have had several changes in eligibility, changes in levels of care, like orthodontia, that contribute to the cost of the growth, when you look at the exact numbers, some are small, some are astronomical, like the 15 people on Nasomah that are using a tremendous percentage, and sure they need it, look at different areas, like eligibility, different covered services, and what impacts it percentage wise.

- ◆ Have the information, but did not bring today, includes a breakdown of costs, levels of care, comparison of level 2 vs. level 3 costs.
- The Nasomah high cost cases would have fallen into a level 2, necessary service.
- CHS Enrollment - in 1993 there were 290, 2002 there were 518, and in 2009 there are 597(1 is adopted, no domestic and there are 116 spouses).
- Oregon Health Plan – lack of funding – aggressive with helping in keeping members on OHP and filling out paper work.
- Reduction in Employer Health Insurance – not just Nasomah – premium for member, through employer, is not considered an alternate resource.
- CHEF (Catastrophic Health Emergency Fund) cases – the fund is available to all CHS programs in the country – once it's gone, that's it. It's lasting longer, ran out in August last year. Looked into Stop Loss Insurance for members, premiums would have been over a million dollars

QUESTION: When it was looked into for Stop Loss Insurance, with the possible scenario of running out of CHEF funds, was there no levels of stop loss self coverage that made any sense at all, tribe pays a million dollars, even though that's a huge amount of money, stop loss kicks in, at lease at the end of a million, there's something.

- ◆ Risk carrier can set up the liability, ask if they will agree to set at whatever amount.
- ◆ There were a couple of options, when presented to Tribal Council, the decision was, when looked at year to year basis, the amt of premium that was going to be paid in for that coverage, why not take the money that was going into paying the premiums, and not having to pay it each year, and put it into a fund and draw interest ourselves.

QUESTION: Out of all the cases that we have been submitted to CHEF, it's never been a time that the fund had been depleted, the Tribe has never had to pay beyond the cap, CHEF has covered?

- ◆ One case, in 1999
- Modifications
  1. Dental – cap of \$1500, no cosmetic, more people are using it
  2. Medical – Level 3 since 1993 compared to Level 2 (Preventative Care services) other Tribes are at Level 1.

QUESTION: Other tribes at level 1, which don't have the same privileges as that we do, what happens to those people that are in morbidity and mortality?

- ◆ Deferred until more funding comes in.

They don't have any funding, so it becomes mortality then, so that's the biggest complaint of Indian Tribes today, because they are only at Level 1.

3. Vision – cap of \$450
4. Orthodontia – added 2006, from deferred list - \$45,000 per year
5. Travel – provide transportation for outside their local area – started at \$5000, now at \$17,000. Cap at \$1000 per year.

QUESTION: When does a non-Tribal adopted child age out at?

- ◆ At 18 yrs. and out of High school.

6. Tribal spouses – 82 added in 2002, cost was \$87,000 out of total patient care costs of \$586,000 – in 2008 it was just over \$208,000 with 113 spouses.

QUESTION: Wasn't the pharmacy costs at that time (2002) \$150,000?

- ◆ Yes

- Cost Containment

1. Medicare Like Rates – saved over \$400,000 last year.

QUESTION: Explain Medicare Like Rates, what happens to enjoy these savings.

- ◆ Medicare Like Rates is the legislation that prohibited hospitals exemptions from charging Indian health program more than what they were charging Medicare.

QUESTION: Is it possible for Bay Area Hospital to receive an exemption?

- ◆ NO, I don't think so - it has to be a critical access hospital or designated by CMS. Believe the only critical access hospital on the coast is in Lincoln City.

2. Negotiated Discounts – negotiations with Preferred Provider discounts – North Bend Medical Center, Bay Clinic, optical labs, pathology consultants, orthodontia and others.
3. Implementation of Primary Care Providers - implemented in 2007, those that only have Contract Health Services only and live in Coos County, have to use the Community Health Center as their Primary Health Provider, unless they were an Elder. In Douglas county, they are to use Cow Creek – other counties, they are to use Health Care Direct providers, which were negotiated.
4. Maximizing Alternate Resources – any other insurance that is available , Medicaid, Medicare, OHP.

- Comparison to other CHS Programs – I.H.S. Medical Priority – Dental Priority Annual Dental Maximum – Orthodontia.
- Cost Projection – chart does not factor in Medicare Like Rates - \$2 million by 2012
- Northwest Portland Indian Health Board advocating for health reform
- There is an increase in funding for 2010-2011. Not sure for future, haven't seen increase in the last 10 years.

QUESTION: Contract Health dollars, how much is being consumed by service delivery as opposed to how much is the service that is being delivered when you look at the numbers?

- ◆ We'll have to get numbers – CHS has 3.5 staff – Manager – Billing Clerk – Case Manager and full time person that is shared with Business office.
- ◆ Direct Costs – Budget is 1.7 million
- ◆ \$350,000 from 3<sup>rd</sup> Party Revenue – money that clinic collects
- ◆ 532,000 from General Fund
- ◆ 800,000 from I.H.S.
- ◆ 1.5 mil comes from Patient care cost
- ◆ Service Delivery component is about \$250,000 a year for staff to administer the programs (salary, fringe, travel, training & supplies) that comes from I.H.S. money. CHS Case Manager is funded with General Fund dollars.

#### **D. Discussion, Questions and Comments – Gary Leva**

Gary Leva led the group in identifying major areas of concern regarding the Tribe's health care system and health care costs. Once the major areas of concern were identified, the group ranked each by importance. The numbers next to each item represent the number of votes received. The larger the number, the more votes the item received and the greater concern or importance it represented to the group.

The overall sustainability of the Tribe's health care system was the focus in developing the list. The group was concerned with maintaining health services at current levels, establishing health care priorities linked to funding and relating those priorities to the Tribe's strategic plan.

- ❖ (9) Impact from Health Care Reform on current system – Tribal Advocacy
- ❖ (11) Create a Tribal "CHEF" for CHS – safety net
- ❖ (16) Vision needed for HealthCare Trust Fund
- ❖ (19) Better grasp on prevention in both CHS & Nasomah – determine which programs are more effective/linking education to health
- ❖ (4) Establish health service priorities based on funding – approach to sustainability
- ❖ (16) Community involvement in health care
- ❖ (17) Pharmacy Cost
- ❖ (15) General Cost Savings
  - Pooling with other Tribes
  - Fully insured vs. self funded
  - CHS Medicare like rates for Nasomah
  - Pay to stay away vs. other options
- ❖ Medical Tourism option
- ❖ Long Term funding strategies vs. current status
- ❖ (17) Define current crisis
- ❖ (10) Enhance revenue strategy – create endowment like entity

- ❖ (14) Revisit original mission of whole Health Service in the context of sustainability - eligibility/service area/others
- ❖ (4) Establish needs based on ability to pay & various options related to service delivery
- ❖ (7) Health Care benefits to whom – eligible population
- ❖ (20) How to prioritize the balance of Tribal program priorities in relation to overall resources
- ❖ (7) Priority of medical services – individual responsibility and how to determine obligations to pay
- ❖ (16) 3 – 5 year revenue projection sustainability (from Tribe) closer scrutiny & review
- ❖ (16) Small percentage of health users consuming significant resources – look at population estimated trend ( using vs. consuming)

## **E. Follow-up / Next Steps – Gary - TOP PRIORITIES**

From the list above, the group identified the top priorities:

1. How to prioritize the balance of Tribal program priorities in relation to overall resources
2. Better grasp on Prevention in both CHS & Nasomah
3. Look into developing a pharmacy program – consortiums, partnerships, other options
4. Define current crisis
5. Community involvement in health care decision making – how to involve the entire Tribe in discussing any changes.
6. Vision of Health Care Trust Fund
7. 3 – 5 year revenue projection sustainability (from Tribe) closer scrutiny & review
8. Small percentage of health users consuming significant resources
9. General cost savings ideas: pay to stay away programs, pooling with other tribal groups, fully insured vs. self insured, Medicare-like rates for Nasomah, medical tourism

The group then created a follow-up action list:

- ❖ Creating a working group – Ad hoc Committee – bring it back with suggestions to Tribal Council

- ❖ Communicate to General Membership – through monthly newsletter, on the website and Nasomah quarterly newsletter let the members know what is being worked on and what is being planned as a result the meeting and invite their comments.
- ❖ Representatives: No more than 8 to 10 people - come back with recommendations
  - 2 people from Health Advisory Board
  - 2 from Nasomah
  - 2 from Finance
  - 2 from the Health Clinic
  - 1 General Tribal member at large – Advertise
  - Ad hoc Budget committee members – overlap of same people on Finance
- ❖ Put a flyer in with the newsletter
- ❖ Dates
  - Appoint George to coordinate
  - Towards the end of September, have a workshop with Tribal Council – discussion, then another workshop with recommendations around the end of October or November.

Meeting concluded at 3:00 pm