White Paper on Healthcare Costs

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New Parameters for Partnerships in Correctional Healthcare

EXECUTIVE SUMMARY

The ongoing dramatic rise in healthcare costs impacts correctional facilities and their contracted healthcare providers just as it does all private and public employers who provide healthcare coverage to employees. This translates into increased costs for correctional healthcare contracts that have typically contained high levels of provider-managed risk and multi-year terms with limited renegotiation provisions.

In recent years, these factors have created an imbalance in the contracting relationship that must be addressed to insure that productive and viable client-vendor partnerships continue. These changes to business-as-usual contracts are required to advance the substantial savings and other benefits that correctional facilities can realize through contracted healthcare services.

Innovative new contracting arrangements are required to maintain partnership relationships that provide clients with 'best value' and a win-win for both parties. Several alternatives exist to correctional administrators seeking ways to reduce healthcare costs and limit risk including innovative risk/cost-sharing provisions, alternative pricing structures and mutual provisions for renegotiation based on predefined changes in costs or operating assumptions.

PERSPECTIVE

In response to healthcare cost increases in the 1980's, the market developed the now-familiar elements of managed care that today permeate virtually all private and public healthcare delivery and financing systems.[1] Such mechanisms as utilization review and case management, provider networks and contracted payment terms were successful in dramatically lowering the rate of growth in healthcare spending during this period. Indeed, during much of the 1990's, the rate of increase in healthcare costs slowed to a range of 3-4% annually, though still outpacing the overall inflation rate.

The slowing trend ended with the turn of the century, and costs were on the rise again until 2005 when costs declined and showed an increase of only 9%, compared to 12-15% in recent prior years.[2] However, even though the rates of increase fell, healthcare costs continued to rise at rates of up to two times the base rate of inflation and healthcare spending as a percent of gross domestic product continued to grow. In fact, the slowdown in healthcare costs may have been short-lived as it is now projected to increase 12% in 2008, approaching 16% of the GDP.[3,4] It is predicted that by 2016, the U.S. government will spend approximately $4 trillion dollars on healthcare, approximating 20% of the gross domestic product.[5]

The decision to contract correctional healthcare is fundamentally the search for contractual accountability to consistently deliver an acceptable standard of healthcare at an acceptable price over a defined time period. The contracting solutions that provide the best value to clients are those that demonstrate long-term viability by balancing cost containment and risk/liability provisions with adequate provider payments. Clients clearly should not overpay on pricing; neither is it in their interests to buy healthcare 'on the cheap' and face incremental liability, contract non-performance and costly operational problems resulting from vendor failure. The old adage that "lowest bid does not necessarily mean lowest cost" remains true.

CURRENT TRENDS

Following a decade-long period where healthcare costs had been under relative restraint, during the early millennium several market-based factors converged to exert sustained, system-wide upward pressure on costs.

Health plans in the private sector are seeing relentless pressures on their medical cost ratios (the percentage of premium revenues going directly to provision of care) leading to average rate increases of more than 10.5% for employer-sponsored medical plans.[6] In this environment, it becomes immediately apparent that multi-year correctional healthcare contracts with substantial risk and annual increases in the 3-5% range are untenable to the provider or not cost effective for the purchaser. The same major cost drivers contributing to the private sector increases also directly impact correctional healthcare providers as summarized below.

Physician and Nursing Shortages

The economics of supply and demand are being felt throughout the country as fewer people enter the nursing profession at the same time that many existing nurses are either retiring or leaving the field for quality-of-work reasons. About 41% of registered nurses in the United States are at least 50 years old, and nearing retirement. To complicate the matter, recruitment and promotion of the nursing field hits a brick wall due to lack of faculty to teach eager students. Qualified nursing faculty are choosing hospital jobs, where they can make an up to 38% higher salary than teaching. Nationally, about 30,000 applicants are turned away each year due to lack of faculty and/or space.[7]

These dynamics will compound dramatically as the baby boomer generation enters the period of life when they begin to consume more healthcare services creating an unprecedented demand on resources. The U.S. Census Bureau indicates that the U.S. population will grow by almost 54 million people from 2005 to 2025.[8] Yet by 2020, the number of RN's needed to meet our healthcare needs is predicted to fall short by at least 34%.[9]

The shortage is not limited to nurses. While the shortage of physicians has not been as thoroughly explored, numerous signs point to a growing deficit of doctors in the United States.

The Council on Graduate Medical Education (COGME) a group of healthcare experts charged by the federal government with monitoring physician supply, projects a deficit of some 90,000 physicians by 2020.[10] Other analysts and academics project that the deficit of physicians could reach 200,000 by 2025.[11]

With over 120,000 unfilled hospital positions, a vacancy rate exceeding 8.5% of capacity the economic and clinical delivery impacts have become acute in virtually all markets.[9,12] The net effect is a dramatic and continuing rise in the compensation package required for healthcare providers to attract and retain a sufficient number of qualified nursing personnel.

Correctional healthcare providers are competing with private, community and teaching hospitals, physicians' offices, skilled nursing facilities and other organizations in the same local and regional labor pools for these staff. The depth and scope of the healthcare provider shortage is already forcing a re-engineering of current

clinical/staffing models that allows nurses and doctors to focus more exclusively on clinical care while other tasks are handled by other personnel.

Pharmaceuticals

It has long been touted that a significant source of escalating health care costs is rising medication expenditures. Spending on prescription drugs in the U.S. has grown to $216.7 billion, which is more than 5 times the $40.3 billion spent in 1990.[4] The annual rate of increase in prescription spending declined from a high of 18% in 1999 to 6% in 2005. This is due to the slowdown in Medicaid drug spending, the increased use of generic drugs, changes in the types of drugs used, and a decrease in the number of new drugs introduced.[13] In fact, generic drugs accounted for 63% of all drugs dispensed in 2006.[4]

Correctional systems experience an even greater increase in overall pharmaceutical treatment costs due to three major influences:

1) increased prevalence of HIV and other chronic conditions,

2) more advanced technology being used in the daily practice of medicine, and

3) increased cost of care for the mentally ill.

HIV and Other Chronic Conditions

The incarcerated population brings a much higher prevalence of many clinical conditions (mental health and suicide risk, HIV/AIDS, chronic illnesses, sexually transmitted diseases, drug and alcohol abuse and hepatitis.) These conditions escalate the cost of healthcare. At yearend 2005, the estimated rate of confirmed AIDS in State and Federal prisons was more than 2½ times higher than in the general population.[14] The cost for treatment of HIV alone can range from $1200 - $2500 per inmate per month.

Technology

Healthcare experts point to the development and diffusion of medical technology as primary factors in explaining the persistent difference between health spending and overall economic growth, with some arguing that new medical technology may account for about one-half or more of real long-term spending growth.

Broadly speaking, the term "medical technology" can be used to refer to the procedures, equipment, and processes by which medical care is delivered.

- Development of new treatments for previously untreatable terminal conditions, including long-term maintenance therapy for treatment of such diseases as diabetes, end-stage renal disease, and AIDS;

- Major advances in clinical ability to treat previously untreatable acute conditions, such as coronary artery bypass graft;

- Development of new procedures for discovering and treating secondary diseases within a disease, such as erythropoietin to treat anemia in dialysis patients;

- Expansion of the indications for a treatment over time, increasing the patient population to which the pharmacologic treatment is applied.[15]

Caring for the Mentally Ill

In the last few decades, the number of inmates with severe mental illness has grown so significantly that prisons may now be the largest mental health providers in the United States. There are three times as many mentally ill people in prisons as in mental health hospitals, and the rate of mental illness in prisons is two to four times greater than in the general public.[16] It is estimated that 49% of state prisoners and 60 percent of inmates in jail custody have "symptoms of a mental disorder based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)."[17] Although prescriptive costs for treating mental illness have flattened, the substantial growth in utilization has caused greater costs due to the sheer number of patients in treatment. While there are cost

savings achieved through use of medications in such areas as reduced hospitalization and more effective disease management strategies, the annual increase in medication expenditures is expected to continue for the next decade, particularly with the aging of the inmate population.

The Aging Population Behind Bars

The graying of the nation's prisons is another factor in additional costs for medical care. The number of state and federal prisoners 50 years or older grew by an astounding 173% between 1992 and 2001, according to a 2004 report by the National Institute of Corrections. [1]

By 2010, older inmates are forecast to make up one third of the population in federal prisons. While aging decreases criminal activity, it brings a multitude of challenges in a prison setting, including visual impairments, incontinence, dietary intolerance depression, and early onset of chronic diseases. As a result, the average cost associated with an older prisoner is $70,000 – two to three times that of a younger prisoner.[18]

Physician and Hospital Charges

Payers today, no matter how large, no longer have the ability to unilaterally dictate terms and prices to hospitals. According to the American Hospital Association, the number of hospital beds has shrunk by 18% since 1985. Simultaneously, hospital admissions increased from 30.9 million in 1995 to over 35 million in 2005. Outpatient visits increased 30% during the same timeframe.[19] Many hospitals use their market position to force payers to renegotiate reimbursement rates upward or risk termination of their existing contracts. These new contracts have significant price escalators and over-all hospitals have found themselves in stronger market position while becoming more risk adverse.

According to the Health Affairs policy journal, hospital compensation costs were estimated to account for approximately 62 percent of operating expenses in 2004, and have continued to rise with inflation.[20] Hospitals are now paying more for nursing staff, pharmaceuticals, blood processing, new technology, regulatory compliance, patient safety initiatives and information system demands.

Physician reimbursement based on Medicare methodology represented 17.2% of national health spending in 2005.[21] In many cases, these payments still fail to meet the physicians' actual costs in providing care. The end result is that more physicians are unwilling to accept reimbursement based upon Medicare. Physicians who accept new patients generally are only willing to do so under a discount arrangement from the standard billed charges. Finally, the potential pool of physicians willing to practice medicine within the specialized environment of corrections is limited. This supply-side limitation can increase the rates necessary to secure physician services.

Utilization & Acuity

As described in the Institute of Medicine report "Crossing the Quality Chasm: A New Health System for the 21st Century", the health needs of the American population have been shifting from predominantly acute, episodic care to care for chronic conditions. "Chronic conditions […] are now the leading cause of illness, disability and death." Chronic illnesses affect almost half of the U.S. population and account for the majority of health-care expenditures.[22] Individuals admitted to correctional facilities today have a high rate of chronic physical and mental conditions, many of which have long gone untreated.

Additionally, correctional healthcare programs act as extensions of and in collaboration with local public health departments, performing communicable disease surveillance and disease management. Since individuals admitted to correctional facilities typically present multiple medical and mental health issues, they require intensive work-up and service upon admission. Since over 95% of incarcerated individuals are released back to the community, this presents a critical point at which to intervene in the

cycle of poor access to healthcare services and resulting chronic problems in this population, to create improvements to the public health of the community. The net result is an increased number of healthcare services and events that must be provided and resources allocated for this purpose.

The cost of providing healthcare services to incarcerated individuals has also been adversely affected by changes in reimbursement and contracting trends. In the past, many states provided Medicaid reimbursement for enrolled individuals until the time at which they were sentenced. Now, in many states eligibility stops once an individual is housed in a correctional setting. Likewise, Medicare benefits are not available to the incarcerated population, while the elderly population in correctional facilities continues to increase dramatically with attendant rise in healthcare needs/costs, mirroring the national trends.

In simplest terms, the overall cost of healthcare is equal to the number of events times the average cost per event. Within the nation's correctional settings, both elements of the equation continue to grow at increasing rates resulting in a cost multiplier effect.

Insurance

The United States is the most litigious country in the world, and prisoners are the nation's most litigious group. Inmates bring a disproportionately high percentage of all civil actions filed in federal district court. The rate and cost of medical litigation have increased dramatically over the past decades and the impact on corrections, both from private suits as well as court-ordered public actions, has been profound. Medical malpractice insurance premiums increased by 71% from 1991 to 2003.[23] The cost of this litigation in the area of corrections is not lost on insurance markets.

Few insurance industry leaders are interested in bidding on corrections business and those who do are pushing through significant rate increases. Insurers have increased rates for medical malpractice liability coverage from 30% to 100% and at the same time raising policyholders' co-pays and deductibles in an effort to restore profitability.[24,25] These insurers are experiencing deteriorating underwriting results and rising costs on medical malpractice lines which are caused largely by high jury verdicts against medical practitioners and the inability to raise rates in the previous soft market. One result is that the ability of healthcare providers to obtain performance and bid bonding coverage has been severely curtailed. These factors were pressing factors even before the events of September 11th, the losses of which have placed additional pressure from other lines of insurance and which the carriers are trying to spread over their entire portfolio.

Employee Healthcare Costs

As a consequence of the factors above, employers nationwide are experiencing on average a 10-12% increase in the annual renewal premiums charged by insurance companies to provide employee medical coverage and related plans.[6] As a result, employers have shifted away from traditional indemnity insurance plans and are passing on an increasing level of cost to employees for their medical coverage. These same fundamental dynamics affect the cost of providing and means of contracting for correctional healthcare.

No private insurance company in the marketplace provides the type of multi-year, fixed price contract once typical in the corrections field, due to the risk and inflationary factors described here. Healthcare providers and companies such as PHS, which employs over 4,000 personnel, are not immune from these cost increases, the result being the vast majority have shifted away from traditional indemnity insurance policies to administrative services contract reviewed and renewed on an annual basis. Ultimately, these fundamental costs of doing business must be reflected in the pricing of services to customers and restructuring of contract terms. Full-risk, multi-year correctional healthcare

contracts that contain fixed annual inflators and no provision for renegotiation have become an unsustainable and too costly a vehicle for purchasing correctional healthcare services with increasingly limited taxpayer resources.

IMPLICATIONS FOR CONTRACTING

Higher Risk = Higher Cost

The net effects of these sustained cost increases within what have typically been multi-year, fixed cost correctional healthcare contracts translates into significantly greater risk to the provider. Not surprisingly, there must be a pass through of these increased costs in the form of a substantial "risk premium" to the potential client as no provider, public or private, can continue to absorb cost increases at this rate. What was feasible in an environment of stable, predictable healthcare costs (if indeed such a time existed) becomes increasingly expensive and untenable as the premium needed to cover such risk rises.

Benefits of Contracting Remain

Correctional facilities have been choosing to contract their healthcare services for almost 30 years for the simple reason that it saves money while improving quality, limiting liability and freeing correctional administrators to focus their expertise on issues of custody, security and control. The current turbulence in healthcare costs combined with increasing budget shortages in the public sector only increase the potential benefits of contracting for these services.

At the same time, there will be situations where existing contracts become unsustainable in the face of rising costs and risks. Contracts with no provision for renegotiation, low fixed annual inflators and/or high levels of vendor risk (e.g. no catastrophic limits or carve-out of high cost treatments) set the stage for a lose-lose scenario. Contractors continue to incur financial losses, potentially to the point of insolvency and clients lose the assurance of a well-functioning contract and service delivery system capable of consistently meeting their original objectives.

Three basic options are open to clients in a situation where an existing contract structure is no longer tenable:

- Return to self-operation
- Re-bid the project
- Renegotiate contract terms

Self-operation

Return to self-operation is an option for the contracting authority at any time. This entails the assumption of all operational management, staff recruiting, direct and indirect costs, malpractice and other liabilities and the substantial administrative 'headaches' that lead to the original decision to contract the healthcare service. The high degree of incremental internal costs incurred in rebuilding an infrastructure to effectively manage these services renders a return to self-op an infrequent occurrence.

Re-bid

Re-bidding the project can provide both parties a chance to 'test the market' for the services and recalibrate the contract terms and pricing to reflect current realities with the current or newly selected provider. The ultimate impact on contract costs depends on the scope and risk parameters of the resulting RFP. Rebidding an existing contract "as is" has often resulted in substantial cost increases; but it can also present an opportunity to restructure the contract and risk terms into a more viable long-term solution for both parties by incorporating some of the risk-sharing alternatives discussed below.

Renegotiation

It is in neither party's interest for an existing contractor who is providing an otherwise responsive level of service to be forced, because of unsustainable and unforeseeable financial losses, to prematurely end an otherwise mutually beneficial contract. The issue is not one of increasing profits to the contractor (in many cases it is a matter of 'stopping the bleeding'), but rather of finding win-win solutions to the contracting process that appropriately

reflect the new environment. Renegotiation of key contract terms, to the extent permitted by applicable purchasing regulations, in the context of a collaborative working dialogue, utilizing some of the elements described below can provide such an outcome.

CONTRACT ALTERNATIVES

The following sections briefly describe several elements that can be utilized in the correctional healthcare contracting process to re-establish a workable balance in the cost vs. risk trade-off and provide benefits to both the client and provider. Some variation or combination of these factors will be most appropriate depending upon the unique circumstances of each contract and client operating characteristics (e.g. prison vs. jail, facility capacity and annual intakes, detainee health status profile, etc.).

Cost-Based or Fixed Management Fee

In contrast to more traditional capitation or per diem-driven pricing models, an alternative long-favored by many federal and other agencies utilizes a structure based upon actual operating costs plus a percentage or fixed management fee component. Not only does this approach mitigate criticism leveled at capitated contracts regarding implied incentives to withhold services, but utilizing a fixed management fee (set amount) also takes away any supposed incentive of the contractor to drive up costs in order to realize a larger fee. In essence, clients retain the expertise and resources of an experienced healthcare manager to control costs and improve quality for a pre-determined management fee. Indeed such an approach most closely resembles the structure under which a majority of private and public sector employers purchased health plans services for their members under Administrative Service Only (ASO) contracts with little or no risk borne by the health plans.

For this approach to be successful it requires a clear definition of allowable costs, including a percentage or agreed-upon allocation of necessary corporate overhead expenses assigned to the contract (e.g. professional liability premiums, risk management, accounting, legal and other support functions). Regularly scheduled audits are used to verify the actual expenses and make whatever adjustments may be appropriate as agreed by both parties.

To address concerns about this model's ability to control costs, additional components may include a sliding fee scale that is determined, in part, by the actual costs incurred (lower costs mean higher fee), some element of risk-sharing by the provider (e.g. off-site costs) and review of the quality of care achieved or other operationally defined indicators of success. For example, in 2006 the State of Vermont Department of Corrections not only opted to change their contracting structure from full-risk to a cost-based model (with some risk-sharing by the provider) but also instituted a "pay for performance" component which provides modest financial incentives to the provider for meeting predefined measures of patient care process and outcome. Such a scenario provides for clear provider accountability for cost control and quality care while also avoiding the incrementally high costs that bidders must build into a full- or high-risk contract.

Risk Pools and Variations

Aggregate Limits

Currently utilized in many correctional healthcare contracts, this mechanism establishes predetermined cost levels for certain categories of service or expense. Usually calculated on an annual basis, cost categories typically included are off-site care (e.g. inpatient days, ER visits, outpatient surgery procedures, etc.), pharmaceuticals and specialized diagnostic tests. Cost thresholds are usually determined through an analysis of actual experience and comparisons to similarly sized sites/contracts. Often, there are cost-sharing provisions whereby savings achieved below the threshold are shared between client and vendor and costs incurred above the limit are also shared, but up to a certain predetermined point, beyond which the client is responsible.

This approach can save clients the significant up-front expense that results from having to price all potential aspects of healthcare costs into a bid, particularly in the highly volatile area of off-site services. Aggregate pools also provide a clear cost- and risk-sharing mechanism that focuses both parties on effective management and regular reporting on major cost drivers within the contract.

Carve-outs

Under this variation, certain high risk and/or high cost services are either paid for directly by the client (pass-through) or paid by the vendor for later reimbursement by the client. Typically this would be applied to procedures that are pre-existing, relatively infrequent and/or exceptionally expensive (e.g. organ transplants, Factor 8 treatment for hemophiliacs) or treatments that are still in a state of flux regarding clinical protocols, cost-effectiveness and outcome (e.g. Hepatitis C).

For example, ten years ago this exemption was frequently applied to the treatment of HIV/AIDS patients. However, as clinical protocols and standards of care have emerged, this has become a reasonably predictable cost given appropriate prevalence data, and it is not uncommon for HIV to now be included as a risk factor. In contrast, Hepatitis C is now the disease where such a carve-out methodology is best applied. Again, the client saves on the front-end of the bid process where potentially excessive and still unpredictable costs must be priced into an all-risk proposal.

Catastrophic Limits

By defining upper limits of provider responsibility for medical costs incurred on a per inmate basis, there are client savings in avoiding the incremental pricing for a 'worst case scenario' or actuarial pricing where the provider must bear full-risk for the occasional but exceptionally high-cost case.

These limits may be set on either an episode of care basis (e.g. a course of hospitalization or course of treatment for a disease state) or more commonly for an annual total per inmate. The amounts typically range from $5,000 to $20,000 annually with the degree of savings inversely related to the catastrophic limit. In rare instances where the amount may be set as high as $50,000, the savings effect is effectively nullified.

Defining Up- and Down-side Risks

Focusing directly on the financial structure of the contract, there are mechanisms that can more precisely define the risk and return to both the client and provider. For instance, a contract may be constructed such that the overall profit is capped at a certain percentage of the annual revenues. In return for limiting its upside return on the contract, the provider is guaranteed a 'floor' under which its operating results will not be allowed to fall (either a lower percentage or break-even when allocated indirect costs are included).

Similar to cost-based arrangements, this requires a clear definition of all costs, including an allocation of necessary overhead expenses assigned to the contract (e.g. professional liability premiums, accounting, legal and other support functions). Regularly scheduled audits (semi-annually) are used to "true-up" the numbers and make whatever adjustments are appropriate as approved by both parties. In essence, this approach allows the parties to define the risk-return balance of the contract under a "concept of reasonableness" that minimizes surprises and adds stability to the contract.

Contract Re-openers

These elements provide pre-determined points or events under which the parties may review and renegotiate key terms of the agreement. Examples may include:

- Market-based inflation or deflation of nursing rates over a defined threshold, after the provider has been at risk for certain amounts and verified through audit;

- Renewal years exercised at both parties' option, allowing for negotiation of annual increases or decreases based on actual costs and experience;

- Mutual notice of termination whereby either party may end the contract without cause by providing appropriate advance notice, typically of 90-120 days.

Again, the intent is not to relieve the provider of all risk, but to clearly define the risk and identify up-front those cost drivers that are either to a large degree outside of the provider's control and/or of such volatility that it is not in the client's best interest to price these risk premium costs into a bid for a multi-year, no-out contract. Mutual termination provisions become an option of last resort since triggering this clause implies that one of the parties is in a losing situation where continuation of the contract is not feasible. The inclusion of other contract provisions described here minimizes the possibility of this outcome.

OFF-LOADING RISK TO PROVIDERS

The desire of clients to off-load risk onto the healthcare provider is one of the fundamental needs driving the contracting decision. In response to potential criticism that these variations take the provider 'off the hook' for any risks and obviate the need to consider contracting, there remain several elements of substantial size and risk that the provider must successfully manage, including:

- Personnel costs – the single largest cost component of most correctional healthcare contracts, particularly for nursing staff in a chronic shortage across the country;

- Employee health and benefit costs – currently increasing at rates of 10-12%;[6]

- Staffing levels and service performance – often defined through staffing plans and clinical/operational performance indicators with attached financial penalties or liquidated damages;

- Professional liability (malpractice) insurance – these costs increased 96% between 1993 and 2003;[26] many liability, bonding and related risk management costs, are increasing at annual rates of 20-50%.

Beyond these specific risks, the client is retaining the expertise and resources of an experienced correctional healthcare management team to effectively control not only actual costs, but also the mechanics and effectiveness of the healthcare delivery process. This frees the administration to focus on issues of custody, security and control while an accountable partner manages this complex system reducing overall facility risk and liability.

SUMMARY

The market factors and client needs that created the private correctional healthcare field 30 years ago remain valid and vital today. This is especially true given chronically inflationary healthcare costs at rates higher than general inflation which are exacerbated by the incarcerated population's greater incidence of medical and mental health needs and aging population, all within a context of growing public sector budget shortfalls. Creatively adopting alternative contract terms and conditions to reflect the increased costs and risk that accompanies this environment is required to 'rebalance' the risk vs. cost trade-off that forms the basis for successful partnerships to manage these services.

Client objectives for off-loading risk while insuring cost-effective services that meet community standards of care are best met through contractual relationships that provide a continuity of care through long-term partnerships.

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