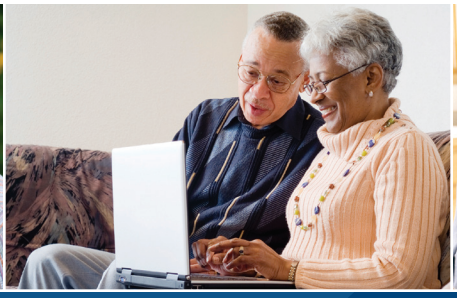
Center for State & Local Government Excellence

Issue Brief

State Health Plans During Times of Fiscal Austerity: The Challenge of Improving Benefits While Moderating Costs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State and local governments are giving greater attention to controlling health care costs and improving the quality of care. Why? As AonHewitt Senior Vice President Jim Winkler points out, the overall cost of employer-provided health insurance has risen by 52 percent in the past six years and is projected to increase at a rate of 8 to 9 percent a year unless changes are made.

Controlling costs is only part of the story. State and local governments also recognize the need to attract and retain talented employees, for which a competitive benefit package is required.

The Center for State and Local Government Excellence collaborated with North Carolina State University to hold a symposium that examined innovative benefit practices in eight states that have not only reduced costs, but also showed promise in improving employees' health.

With leadership from North Carolina State Treasurer Janet Cowell and a North Carolina State University research team led by Robert L. Clark, the symposium addressed both national trends and a rich variety of state innovations. Sessions featured pharmaceutical benefit strategies for active and retired public employees that have contained costs through audits and purchasing alliances; wellness programs that reduced costs and improved employee health; a program that pays providers for performance; and a revamped bariatric surgery program that cut costs and improved employee health.

Since public sector workers are older than their private sector counterparts, there could be a growing number of employees and retirees with chronic health conditions. Finding ways to promote better employee health has become an economic priority.

The Center gratefully acknowledges the financial support from ICMA-RC to carry out this important project.

Elizabeth K. Kellar
President and CEO
Center for State and Local Government Excellence

One of my top priorities as State Treasurer has been to discover and apply best practices in my areas of oversight. In early 2011, I began exploring the opportunities and benefits of moving the State Health Plan for Employees and Retirees to the Department of State Treasurer. In May of that year, the General Assembly passed legislation that did just that, centralizing retirement and health benefits in one agency and providing accountability for the Plan. Since that time my staff and I have been learning as much as we can about the public health insurance landscape and how to most effectively provide health insurance for 665,000 members. When Robert Clark called me in the fall of 2011 to discuss the idea for the symposium, it was perfect timing.

The event provided an opportunity to learn about how other state plans were addressing common issues and how nationally recognized economists view the healthcare landscape. The symposium also provided distinctive opportunities to speak with administrators from other states and begin thinking through ways that we might collaborate and share data in the future. My colleagues from North Carolina and I left the event engaged and eager to find ways to apply lessons learned from other states and to move towards best practices.

I hope that this is the first of a series of such meetings. While the symposium offered a great deal of information, there is much more to share. State health plans across the country are experiencing many of the same challenges and trying to balance the same elements. The challenge of improving benefits while moderating costs is a national challenge but one that is more easily undertaken as a collective. I look forward to building on this exchange of ideas and to continue the symposium dialog in the future.

Janet Cowell
North Carolina State Treasurer

State Health Plans During Times of Fiscal Austerity: The Challenge of Improving Benefits While Moderating Costs

By Robert L. Clark, Melinda Sandler Morrill, Emma Hanson, and Jennifer Maki*

Over the past four years, state and local governments have found it increasingly difficult to finance their employee health plans while maintaining the quality of health insurance. The steady rise in the cost of health care, in conjunction with declining revenues associated with the adverse economic environment, has caused most public employers to consider ways to amend the health insurance plans they offer employees. The challenge confronting plan administrators and public policy makers is how to continue to provide adequate health insurance plans to their employees at reasonable prices, while not unduly burdening taxpayers.

These important issues were examined in a one-day symposium organized by Robert Clark and Melinda Morrill of the Poole College of Management, North Carolina State University, and Janet Cowell, State Treasurer of North Carolina, through a grant provided by the Center for State and Local Government Excellence. The symposium featured representatives of eight state health plans, two prominent academic health economists, and a senior vice president of a large consulting firm. The program featured presentations of innovative policies that have been adopted by individual states, an assessment of the national landscape of public sector health plans, and a discussion of how national economic and health care policies are affecting public employers.

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The symposium was organized around three panels that examined key elements of employer-provided health plans and three keynote presentations by leading policy analysts. This issue brief reviews and assesses the presentations made at the symposium with the hope that plan administrators across the country will join in the debate over how states can continue to provide adequate health insurance while moderating increases in the costs of these plans.

Overview

Treasurer Cowell opened the symposium by noting the importance of public health care administrators forming partnerships with researchers at academic institutions, like the one between the North Carolina Treasurer's Office and the Poole College of Management at North Carolina State University. These partnerships can provide useful analyses of plan data and provide guidance on how to reform public health plans.

Cowell briefly discussed the central role of health insurance in the wellbeing of public employees, but also recognized the need to protect the financial status of the government. In 2011, the North Carolina General Assembly transferred the management and oversight of the State Health Plan to the Department of the State Treasurer. In response, Cowell has been conducting a listening tour across the state in order to learn more about the concerns of state employees relating to the cost and benefits of the health plan. She reports that state employees had two primary concerns. First, employees express a desire to be rewarded for being healthy and, thus, reducing the cost of the plan. Second, employees would like to see their out-of-pocket costs reduced.

Based on her findings to date and her initial assessment of the current state health plan, Treasurer Cowell joined with North Carolina State University researchers to organize this symposium. The objectives were to learn more about innovative practices other states have adopted to address similar concerns of their own employees and to understand how the issues North Carolina faces relate to the provision of health care nationally.

Keynote Speakers

Challenges for the Future

Jim Winkler, Senior Vice President and Large Market Segment Leader, U.S. Health & Benefits, AonHewitt

Winkler gave his assessment of the health insurance landscape in both the public and private sectors of the economy. He stated that in the presence of continued rapid increases in the cost of health insurance, employers have been shifting costs to employees. In the past six years, the overall cost of employer-provided health insurance has risen by 52 percent, but there has been an 82 percent increase in the cost paid by employees. Given that annual earnings have increased little or not at all during this period, health care has been growing as a share of worker compensation. Winkler projected that health care costs will continue to increase 8 to 9 percent per year. With the aging of the public labor force and the increased number of retirees, there will be a greater number of participants suffering from chronic conditions, another factor that will push up the cost of providing health insurance.

Drawing from his experiences in the private sector, Winkler discussed the importance of providing incentives for workers to engage in healthy behavior. "The healthier the workforce, the better it is for the company and the economy," he said. Winkler discussed the need for employers to set appropriate rules and policies governing their health plans to keep down costs. He also speculated that greater use of health saving accounts and other consumer-driven spending incentives will help contain the cost of providing employee health insurance.

Public Health Plans in a National Health Market

Mark Duggan, Professor of Business and Public Policy and Health Care Management at the Wharton School, University of Pennsylvania

Duggan discussed the development of the Affordable Care Act (ACA), based on his experience at the Council of Economic Advisers (CEA) to the president. He began his remarks by comparing state governments to private sector employers, noting that most public sector workers are insured, the average premiums are higher due to lower deductibles, and that employees pay a much lower share of the premiums. Retiree health insurance is also far more common in the public sector. Because of this, the rising cost of health care is even more of a financial burden on public sector than private sector employers.

He provided an overview of the importance of health care in the U.S. economy. In 2009, health care accounted for 17 percent of the nation's Gross Domestic Product (GDP) and it is projected to increase to one third of GDP by 2040. Population change accounts for about one-quarter of this growth, with the remainder due to cost increases. Much of the growth is associated with Medicare and Medicaid. In addition, the fraction of workers covered by employer-provided health insurance has been steadily decreasing. Although public sector employers are unlikely to stop offering health insurance as a benefit for employees, many are considering eliminating retiree health insurance or requiring employees to pay higher premiums.

The future of health care and its cost are expected to be influenced significantly by various provisions of the ACA. The key provisions of the act are aimed at expanding health insurance coverage and containing cost growth through insurance market reforms. The reform also changes how Medicaid is financed at a national level. To achieve more complete health insurance coverage, the ACA expands Medicaid and creates state-based health insurance exchanges. Although the Medicaid expansion itself is expensive, the CEA reports that states will be better off given the reduction in uncompensated care, which is very costly. The reform also institutes tax credits, mandates employer-provided coverage for large firms, and includes a mandate that individuals must have coverage or pay a penalty. The latter two requirements have been controversial, but Duggan argues that both are necessary.

Because state workers tend to have higher health insurance premiums than their counterparts in the

private sector, Duggan argues that public employers should consider how the excise tax on high cost plans will affect the health insurance they provide to active and retired employees. The excise tax is projected to raise revenue by shifting compensation from non-taxable benefits towards salaries subject to income tax.

Duggan raised several issues that state government employers should consider. He thinks that financial incentives should be put in place to help workers make efficient plan choices. He encouraged states to experiment by varying plan parameters and financial incentives. Public sector employers reap the benefits from long-term health investments because state workforces have far lower turnover rates than found in the private sector, so they have even more of an incentive to uncover the factors that affect worker behavior.

Observations on Public Sector Health Plans

Joseph Newhouse, John D. MacArthur Professor of Health Policy and Management, Harvard University; Director at Aetna; and member of the Employer Health Insurance Committee at Harvard University

Newhouse discussed the reasons for growth in health care costs and discussed ways for controlling the rate of growth. He emphasized the need to change the health care delivery system in a manner that transfers risks to providers. Doing so would aid in efforts to manage health care costs for both active and retired workers.

It is well known that the United States is an outlier in terms of per capita health care spending, but it is of greater concern that these costs are growing at such high rates. This latter phenomenon is not just confined to the U.S., and the growth rate of these costs has been steadily increasing for decades. Patient centered medical homes (PCMH) and accountable care organizations (ACO) move in the direction of "bending the cost curve"; in other words, reducing the growth rate of these costs.

PCMHs provide a first step in the process of shifting some of the risk to providers. Within this setting, physicians receive capitated reimbursements based on diagnosis, which would ultimately lead to more integrated care and a focus on case management. The Center for Medicare and Medicaid Services (CMS) supports the Comprehensive Primary Care Initiative and has proposed a joint initiative in which they would pay a set fee per member per month for members who provide medical-home-like functions. Demonstration projects are being run across the country that should provide new evidence on how to develop this type of health care system. Newhouse described a program by Community Care of North Carolina, represented at the symposium by a speaker in the first panel, which is cited by CMS as supporting the PCMH model. Community Care of North Carolina was able to successfully reduce preventable hospitalizations and emergency room visits, which led to a reduction in costs.

Accountable Care Organizations (ACOs) are the next step in shifting risk to providers. Newhouse notes that ACOs "change the economic incentives of providers." Existing economic incentives may lead to over-utilization, as found in a recent study by Douglas, *et al.* The authors looked at coronary angiography and found that there were "between 12% to 24% too many" of these procedures performed. This provides some evidence on cost reductions that can be achieved by shifting some of the risk to the provider. If the provider can save money by avoiding a procedure rather than being paid for completing it, fewer unneeded medical procedures would be conducted.

He related these findings to managed care initiatives. Medicare Managed Care has been found to reduce the likelihood of Ambulatory Care Sensitive Condition admissions; the reduction is more pronounced among the sickest individuals. Another study looking at Medicare Advantage Special Needs Plans for diabetics found the intervention resulted in more primary care but fewer hospitalizations. These efforts led to a reduction in health care costs. Although risk sharing is desirable, the optimal degree of risk sharing is not known. Newhouse suggested additional study on how much risk should be shifted to providers in an effort to reduce unnecessary medical interventions.

Panels of State Plan Administrators

Panel One: Controlling Costs Through Pharmacy Network Strategies

The first panel examined the provision of pharmaceutical benefits to active and retired public employees. The panel was chaired by an expert in public sector retiree health insurance, Richard Kearney, professor of political science and public administration and director of the School of Public and International Affairs, North Carolina State University. In his introductory remarks, Prof. Kearney contrasted his health insurance benefits as a public sector employee in North Carolina with those from his previous employment in Connecticut, setting the stage for understanding both the diversity in

state plans and the necessary changes that have been implemented in recent decades.

Kentucky Teachers' Retirement System (KTRS): Gary Harbin

The first panelist was Gary Harbin, executive secretary of Kentucky Teachers' Retirement System (KTRS). KTRS manages the retiree health plan for retired public school teachers in Kentucky. To control health care costs, KTRS focused on five areas: (1) Medicare Advantage, (2) employer group waiver prescription drug plan, (3) drug purchasing alliance and the Kentucky prescription coalition, (4) prescription claims auditing, and (5) shared responsibility funding. The thrust of KTRS's effort to contain costs has been focused on pharmaceuticals, although they have also implemented a sustainable funding change (described below). As is the concern for many public employers, the aging of the population of teachers is particularly troubling in Kentucky, where 25 percent of all public school teachers will be eligible to retire in the next 18 months.

Harbin provided details of the two plans within KTRS. The first plan pools retirees under age 65 with active employees, while the second groups older retirees into a separate plan, the Medicare Eligible Health Plan. Benefits for both groups have remained roughly the same for the past 10 years. However, while premiums have risen sharply for the active worker plan, the premium for Medicare-eligible workers has remained relatively stable due to the implementation of several cost controlling measures.

First, KTRS adopted the Medicare Advantage Plan, which reduced costs by around $10 million per year for 2007 and 2008. In addition to generous federal subsidies, the Medicare Advantage Plan reduced costs of disease and case management programs. Second, KTRS moved to a fully insured Employer Group Waiver Prescription Drug Plan which reduced the system's OPEB liability by $900 million. In addition, KTRS joined a drug purchasing coalition with several universities in the state. While the coalition allowed for deeper discounts and savings, there was some concern over the administrative burden of another RFP and worry over unknown consequences.

Harbin indicated that a major issue with the drug benefit is the cost of specialty drugs. Specialty drugs make up just 0.28 percent of total prescriptions, but account for 10.50 percent of drug costs. Through participation in the Public Sector Health Care Roundtable, a national coalition that includes retirement systems from several states, the KTRS is working to increase the availability of bio-similar drugs and implemented a prior authorization criterion to limit the use of specialty drugs where appropriate.

Harbin concluded by describing KTRS's new Shared Responsibility funding initiative, which increases the contribution rates to the health plans. Harbin noted that funding retiree health care has been a chronic problem since its inception as a pay-as-you-go system in 1964. The plan was seriously underfunded in 1998, so the state began redirecting funds from the pension plan. Because this was seen as undermining the financial integrity of the pension plan, in 2010 the state passed legislation aimed to reach full funding of the health plan. The contribution rates for employees and employers are set to increase every year until 2015 and then remain at the increased level until the benefit is sufficiently funded. Additionally, retired teachers began paying the equivalent of the Medicare Part B premium in 2010. Now, the health care benefit is on the path to being fully funded. By moving to a pre-funded system, they reduced liabilities from $8 billion to $3.7 billion. The additional cost controlling measures (discussed earlier) have further reduced liability to below $3 billion.

In response to an audience question, Harbin explained that KTRS has a goal of 100 percent funding but currently assets represent only 8 percent of liabilities. They project that they will have $1 billion of assets within the next seven years and that the system will be 80 percent funded after 20 years. Active teachers will contribute 3 percent of pay and there will be an employer matching contribution. Retirees under age 65 will pay the equivalent of the Medicare Part B premium into the fund and the state will contribute another 1.4 percent of pay, for a combined annual contribution of approximately 9 percent of compensation. Because of these recent changes in prescription drug plans and the Shared Responsibility legislation increasing the funding, the KTRS has successfully reduced its Actuarial Accrued Liability and is on a more sustainable path.

Community Care of North Carolina: Troy Trygstad

The second panelist was Troy Trygstad, director of the Network Pharmacist Program and Pharmacy Projects at Community Care of North Carolina. His firm works with state agencies to reduce costs and improve health outcomes through medication management. He discussed how the management of medication cost is a key element to slow the rise of health care costs. Trygstad stated that 75 percent of health care dollars are spent on chronic disease, and most chronic conditions

are treated with medications. Medicare beneficiaries with multiple chronic illnesses see an average of 13 different physicians and fill 50 different prescriptions every year. They are also 100 times more likely to have a preventable hospitalization than someone who is not chronically ill. Case management providers can reduce costs by intervening to avoid preventable hospitalizations and streamline prescription drug management for patients.

Trygstad echoed Harbin's concern over the cost of specialty drugs and he noted that spending on non-specialty drugs is expected to rise slowly, with an annual trend of less than 1 percent per year, while the utilization of specialty drugs is growing at an annual rate of approximately 17 percent. By reducing the usage of specialty drugs in favor of less expensive treatments, medication management can improve patient outcomes while reducing costs.

Currently, there are a variety of people involved in medication management in a relatively uncoordinated way, including specialty doctors, primary care doctors, pharmacists, and both pharmacy and medical benefit insurers. Trygstad argues that the system could be improved if pharmacy benefits were not managed separately from medical benefits. Still, case managers can focus on both drug cost minimization and drug use optimization by considering the full process of patient health care. In order to minimize drug costs, the pharmacy benefit manager is able to negotiate with the drug company to reduce the reimbursement amount. With drug use optimization, the reimbursement rate may be higher and there will be additional costs for adherence, coordination of care, and incentives for pharmacies and providers. However, the increase in the cure rate may justify the additional investment. The goal of the health plan should be to create a well-coordinated, goal-oriented, continually re-enforced drug use plan.

Community Care of North Carolina is an organization that is trying to create supports, contracts, and systems that focus on patient outcomes and delivering value. One successful example is the Pharmacy Home Project, created in 2007, which gathered drug use information from multiple sources into one place, improving both efficiency and patient outcomes by allowing prescribers to see the full set of treatments that a patient is currently undergoing, since often the patient is receiving medications from multiple sources. Community Care of North Carolina provides resources to coordinate care and assist the patient in understanding and navigating a sometimes complex medical care system.

Trystad said that reducing medical costs requires the right incentives, the right technology, and a willingness from all parties to work to make it happen. There should be a growing reliance on generic drugs, so that the cost to dispense will be driving the cost. To facilitate a new medication management process, there needs to be the erosion of the barrier between the drug benefit and the medical benefit and increased attention and investment in optimizing the use of medications, so that the focus is on global patient outcomes and the total cost of care. He said this requires "breaking out of our silos" and getting everyone interested in cure rates, reducing preventive admissions and readmissions, reducing emergency department visits, and reducing the use of specialty drugs.

Panel Two: Health Management Strategies

The second panel examined health management policies and strategies in three states. The panel was chaired by Elizabeth Kellar, president and CEO, Center for State and Local Government Excellence, and included discussion of policies in Rhode Island, Tennessee, and Virginia.

Kellar began the discussion by examining some key demographics associated with the public labor force, including the fact that state government employees are older and more educated than their private sector counterparts. As a result, they tend to have different attitudes toward health and retirement benefits. She reported that the annual poll of members of the National Association of State Personnel Executives and International Public Management Association for Human Resources found that in 2009, public sector workers were postponing retirement. Last year, however, the poll found that there had been an acceleration in retirement rates. This is due, in part, to the uncertain environment of public sector jobs. The public workforce is under considerable stress associated with the economic crisis, which has generated pay freezes, hiring freezes, and layoffs.

Rhode Island: Susan Rodriguez

The first panelist was Susan Rodriguez, deputy personnel administrator for the Rhode Island Department of Administration. Rodriguez stated that since Rhode Island is a small state, its size allows the state to introduce innovations that may be more difficult in larger states. In recent years, Rhode Island has implemented a number of health management strategies aimed at reducing costs.

Rodriguez began her remarks with an overview of the state's public sector and the benefits it provides to its employees. Including all branches of the state government, Rhode Island has 14,500 employees in 42 locations; 87 percent of state employees are members of unions. There are 22 bargaining agreements that are negotiated every three years. The public sector workforce is older than the general population with an average age of 48.2 years. There is low turnover among state workers and it is common to have several generations of a family working in state service.

As is typical of national health plans, much of the cost of the plan is due to a small fraction of covered employees who are in relatively poor health. Rodriguez said that half of premature deaths in America are associated with individual behavior and are therefore preventable. "As a health plan, and a nation, we need to focus on behavioral change," she said. In recognition of this need, in 2005 the governor of Rhode Island issued an executive order designating state employee wellness as a priority and created various committees to assist in implementing programs. Beginning in 2008, the state began to bargain with the public sector unions in the state. At the time, employees were paying eight percent of the cost of the plan, which was much less than the average in the private sector. The state and the unions reached an agreement that over four years the employee premium would be raised to an average of 20 percent of the plan cost. Participants were allowed to offset this increase by up to $500 per year if they participated in wellness activities; the average employee cost was $1,325 per year. The outcome was a "win-win situation," and the unions became one of the biggest advocates of the wellness initiative.

Rodriguez warned that in order for wellness programs to succeed, unions and employee organizations must support the changes. She argued that wellness programs should offer monetary rewards to encourage participation. In the case of Rhode Island, the incentive was the credit against employee contributions for health insurance. The program is currently in its fourth year and currently has a participation rate of 65 percent. In addition, employees have improved biometric results and there are demonstrated financial benefits to the state and the employees. An important point for others to consider is that the program was implemented incrementally, making it easier for individuals (and unions) to digest. Participation requirements were phased in over four years so employees could gradually adjust to the new program.

The system also added weight loss options to the wellness program, including participation in Weight Watchers. An individual who participates in 75 percent of the sessions is reimbursed for 50 percent of the cost of the program. Rodriguez concluded that interaction with other state employees helped the program to succeed and that social networking can encourage individuals to be more active. She stated that United Healthcare had been very helpful in creating low-cost programs, such as the "Benefits 101" tutorial and Shape-Up social fitness networking programs along with helpful analytic tools. The analysis of the Rhode Island program was that employees who are not engaged in the wellness program cost 150 percent more than those that enrolled in the wellness program. Finally, she reported that employee survey results indicate that most employees think the program has increased their health knowledge and they have made a positive lifestyle change as a result of the program.

Tennessee: Laurie Lee

The second panelist was Laurie Lee, executive director of the Benefits Administration Division for Tennessee. Lee opened by stating that Tennessee is behind the curve in improving and managing its health plans for public employees. The state did not make any significant plan changes between 1995 and 2010. Tennessee has three financially independent risk pools. Each risk plan includes employees, dependents, and retirees under age 65. The risk pools are state employees and those at institutions of higher education, employees at public school (K–12), and employees of local governments.

Lee described a two-part solution for improving the Tennessee health plans. First, she stated that if they began by competitively re-procuring the TPA and pharmacy service providers for the three heath plans, the state would be able to save about $700 million over five years. However, this is just a temporary solution to achieve savings in per-unit costs and does not affect the growth rate. They were able to get better pricing by having providers bid at the regional level. Second, she described several changes in plan design and the implementation of a wellness program, which together could save an additional $700 million over five years. The plan design changes were implemented to build in mutual accountability at the member level. The new health plan design includes two plans, a standard PPO and a partnership PPO. The only difference between the two plans is the cost sharing.

Like Rhode Island, Tennessee is implementing plan changes incrementally, with the first year focusing on awareness. In the first year, in order for workers to participate in the lower cost partnership PPO, individuals (and their spouses, if applicable) had to complete a health questionnaire and biometric screening, which turned out to be more complicated than expected. In the first year, 78 percent chose the partnership PPO, 13 percent chose the standard plan, and 9 percent were defaulted into the standard plan. A major challenge was having people complete the wellness requirements by the specified deadline. Dealing with the rush around the deadline, the appeals process, and the inquiries after the deadline was a logistical nightmare according to Lee. Tennessee is now rewriting its contract with the wellness initiative provider to hold the contractor accountable for improvement in biometric and cost data, correcting a major mistake made the first time around.

Virginia: Gene Raney

Gene Raney, director of the Virginia Department of Human Resource Management, was the final panelist in this session. His office oversees state and local health plans in Virginia. He concentrated his remarks on the cost and effectiveness of Virginia's bariatric surgery program. The program was targeted to be cut due to exorbitant costs, but has been transformed into a model program that saves money and improves health. In fiscal year 2008, state employees had 509 bariatric surgeries at a cost of $10 million. With costs going up, a few catastrophic claims, and reports of patients regaining weight, the state felt compelled to reassess the program. At this point, Raney helped develop a program to improve outcomes. The program focuses on reinforcing lifestyle changes and addressing behavioral health issues. Obesity often comes with depression, emotional eating and addiction. These issues must be addressed to achieve long-term sustainable weight loss.

The program now requires that individuals show that the procedure is deemed to be medically necessary and participate in a mandatory year-long pre-surgery coaching program and supervised weight management program. The state also offers an opportunity for 24 months of post-surgery coaching via telephone or Internet. Among those completing the surgery, 70 percent of patients have utilized these services. The new program started in February 2010 with 213 participants. Only 20 percent of participants had dropped out after one year, which is no different than the fall-out rate for 15-week programs elsewhere.

In order to encourage participation in all aspects of the program, the state is offering a refund of co-payments after 12 months and again 24 months after surgery. The state is also considering waiving all co-payments due to the administrative burden of monitoring the current policy. Records indicate that those who stay in the coaching program for 60 days are more likely to stick with the program, and after 75 days, most people have begun to lose weight. Some individuals have decided to stick with coaching even after they become eligible for surgery. In Raney's assessment, the new requirements have been cost effective.

Panel Three: Cost Sharing and Health Benefit Design

Frank Sloan, Alexander McMahon professor of health policy and management, Duke University, chaired the third panel, which examined policies on cost sharing and health benefit design issues. In the closing comments he described some of his research in Oregon, arguing that ideally a plan would prioritize health services and seriously consider where the money is being spent. In contrast, most plans simply pay out claims or rely on Medicaid to dictate how money is spent. The challenge is in how to administer claims and implement these priorities in practice. The list of priorities is costly and difficult to develop and then must be updated continuously. The panelists described how their plans could be a model for private sector employers.

Georgia: Trudie Nacin

Trudie Nacin, division chief, Georgia State Health Benefit Plan, was the first panelist. Nacin observed that Georgia is similar to North Carolina in terms of population demographics. Like North Carolina, Georgia has large rural areas throughout the state, where it is challenging to provide services to state employees. Georgia and North Carolina cover approximately the same number of workers in their respective state health plans.

In response to the unsustainable growth in plan costs, administrators in Georgia implemented a series of plan design changes in 2007. Prior to that time, Georgia was offering a PPO and a HMO. First, a consumer-driven plan was implemented, which included a Health Reimbursement Account (HRA) and a Health Saving Account (HSA) qualified high deductible plan. Nacin reported that eventually the plan was popular among employees, with approximately 50 percent currently participating. She said, however, that one of the biggest

challenges was communicating how the changes would benefit the employees. At present, the state has eliminated their PPO plan, leaving approximately half of workers enrolled in the HMO plan. In addition to these changes in plan offerings, Ms. Nacin described the introduction of a comprehensive wellness program.

Nacin concluded with a description of the funding challenges facing the Georgia health plan. About 75 percent of the funding for the plan comes from employer contributions (a percentage of salaries) and 25 percent comes from employee contributions. In 2008, due to furloughs and other budgetary measures, the salary base dropped and, therefore, contributions to the health plan fell. The health plan had built up significant reserves, but these funds were redirected to other programs. With the consumerism plans, the state was able to keep premiums from increasing for about a year-and-a-half. Then, reduced revenue made it necessary to implement other cost cutting measures and Georgia stopped contributing to the HRAs. However, the state implemented wellness incentives for contributions to HRA, including a $25 contribution for completing an online wellness assessment and a $100 contribution if the worker had a physical exam. Nacin believes that $125 is not a large enough incentive to get workers to change their behavior; she suggested that $200–$250 might be needed.

Indiana: Don Hackler

The second panelist, Don Hackler, director of the Indiana State Personnel Department, began his remarks by saying, "If anybody had told Chrysler in 1946 that the cost of health care per car was going to exceed the price of steel per car, I think we may have ended up with a completely different health care system than we have today." However, working within the confines of the current system, Hackler believes that workers must have some "skin in the game," or financial incentives to reduce their consumption of health care. Indiana was among the first states to implement a Consumer Driven Health Plan (CDHP). These high deductible health plans are designed to incentivize individuals to improve their long-term health, learn to purchase medical services efficiently, make informed health care decisions, and enact positive behavioral change.

Although the participation rate was only 4 percent in 2006, the year the CDHP was introduced in Indiana, enrollment is at 91 percent today. The original plan design included the standard 80/20 split in coverage, no plan premium, and the opportunity to open a HSA. The HSA and the state's contribution of 60 percent of the $5,000 deductible to the individual's HSA was a unique feature of the plan and the one that Hackler notes as the most successful component. The state has since reduced its contribution to a participating employee's HSA to 45 percent of the $5,000 deductible.

Successful adoption of a new plan will depend on communication and willingness to alter plan design to better meet the wants of the members. Communication is key when rolling out a new plan. Through an intensive effort, utilizing various media, participation increased dramatically.

A second component that increased participation was the ability to change plan components to address members' needs. Through discussion with members, plan administrators learned that the timing of the employer contribution to the employee's HSA was an item of concern. By adjusting the timing of the disbursements, they were able to alleviate some of that concern.

Although plan administrators were concerned that individuals who switch from HMOs/PPOs to a CDHP would stop using medical services to save money, resulting in poorer health, Indiana has found that those who switched into the new plan use services at a similar rate to those remaining in the traditional HMO/PPO plans. The CDHP has worked well as a cost controlling measure for Indiana. Their costs are currently trending upward at 3.6 percent per year versus a 7 percent average growth rate for their TPA.

Future efforts include an emphasis on wellness, wtih incentives to remain tobacco free and complete a biometric analysis and join a gym, rewarding participation with contributions to the employees' HSA account. Transparency in costs is a major concern. Hackler believes that a true reduction in costs will not be achieved until this occurs.

Oregon: Joan Kapowich

The final panelist was Joan Kapowich, administrator of the Oregon Public Employees' Benefit Board. She outlined several innovative programs used to contain costs in the state.

The first of these, implemented in 2006, was the adoption of a medical home framework that provides team-based care to patients. Although this began as a small pilot program, approximately 35 percent of employees are now enrolled.

Additional efforts include innovative health care delivery systems, pay for performance, and a value-based plan design. Express health services, a program that provides onsite care for non-acute conditions, is

aimed at expanding access to care. Patients can also use an online tool, Info Rx, to learn about the costs and benefits of medical procedures, thereby helping them make better decisions. The Pay-for-Performance program is designed to incentivize providers to meet plan goals.

The final component is a focus on value-based benefits. These include preventative care, tobacco cessation and weight management programs, generic medications for chronic conditions—all of them free—and discounted co-payments for chronic disease visits. Oregon has had particular success with tobacco cessation and weight management programs. In a unique program, the state partnered with Weight Watchers and estimates a $2 million return on investment in the first year alone through decreased medical costs.

To reduce over utilization of preference-sensitive procedures, such as knee surgeries, Oregon requires that patients first complete the decision support program and then pay a co-payment of $100 to $500 for the procedure. Shifting some of the cost to the patient can lead to a reduction in utilization. In fact, since the program began in 2010, there has been an estimated reduction of costs and utilization on the order of 15 to 30 percent.

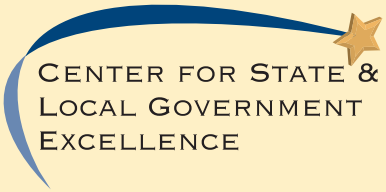
Kapowich's current area of focus is on the implementation of a health management model. This is an action-based model that provides a negative incentive in the form of a financial penalty for failure to complete health assessments, abstain from tobacco use, etc. When Oregon changed many aspects of their health program at once, employees did voice complaints, and Kapowich advises a more temperate approach for other states. However, despite initial backlash, compliance is expected to reach 90 percent this year.

Concluding Observations

Throughout the day, participants engaged in a lively discussion of policies that have been recently adopted by the states represented, producing some important observations:

- States differ in population size and density, per capita income, and the role of the public sector. Despite these differences, state can learn from each other by reviewing and evaluating innovative policies that are adopted by other governments.
- All public agencies are struggling with health care costs that continue to rise more rapidly than revenues. As a result, expenditures on health insurance for public employees are rising as a proportion of state budgets.
- Health care associated with chronic diseases and an aging workforce requires a rethinking of certain policies. Similarly, health problems associated with obesity threaten to push costs up faster in the future. These issues highlight the importance of developing effective wellness programs. For health management, an important component is modifying employee behavior, which may require cash incentives. For example, in Rhode Island and Oregon, weight loss programs were successful at reducing costs and were popular among employees. They found that rewards for healthy behaviors are popular among employees and can be an effective way to improve employee health and reduce costs.
- Managing prescription drug costs is a key element of controlling the rising cost of providing health insurance. During the first panel, specialty drugs were cited as an important component of the rising cost of medical care. In Kentucky, the KTRS joined a drug purchasing coalition to reduce costs and implemented measures to reduce the use of specialty drugs. Organizations such as Community Care of North Carolina aim to reduce costs by providing case management services that allow for prescriptions to be better coordinated for a patient seeing multiple physicians or receiving treatment far from home.
- Incremental rollout of new policies is often more effective than all-in-one changes. Many of the representatives of the state health plans reported on how a gradual introduction of new provisions created momentum and achieved a greater buy-in from unions and employees. In addition, all of the participants described the important role of communication in the success of new policies. Plan administrators must provide clear and useful information on policy changes and how these changes affect workers.

Comments by participants indicated the value of this symposium and a need for similar programs to serve as a method of information exchange among public health plan administrators.



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