Managing the Costs of Health Care Coverage: Emerging Practices Among Public-Sector Employers

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Executive Summary

Rapidly escalating health care costs are an increasing burden on public-sector employers and employees. To mitigate these trends employers are increasingly relying on employee incentives to influence healthier behavior, more appropriate use of health services, or both. Because public-sector employee tenure is typically long relative to the private sector, strategies such as disease management that are aimed at reducing long-term disease burden hold more potential in these settings.

While some strategies, such as reductions in administrative fees, use of lower-cost providers, or more effective capture of pharmaceutical rebates, provide one-time savings, others, including practices that reduce the incidence and acuity of diabetes, heart attack, and stroke, have the potential to provide compounded savings over time.

Some of these emerging practices are being managed at the employer or county level, while many are being introduced by coalitions of organizations within or across states. In implementing such strategies, public entities are rethinking not only how they deal with benefits and the health care delivery system, but also about potential alliance partners with similar goals who can increase their influence.

This paper provides specific examples of emerging public-sector cost-management strategies and the partnerships and coalitions that have supported them. Although the full impact of these approaches remains to be seen, an initial assessment of their potential and associated trade-offs and challenges is offered.

Introduction

Rapidly escalating health care costs are an increasing burden on employers and employees. This report presents cost-management strategies that public-sector employers are initiating, either alone or in partnership with insurers, unions, and employees in an attempt to reign in health care costs.

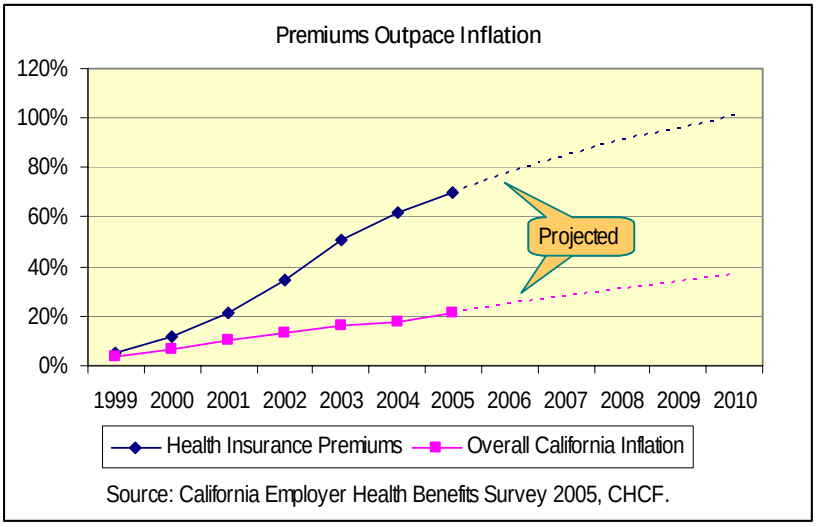
Many of these emerging strategies rely on employee incentives to change health practices for the better. To effectively implement some of these strategies, such as health promotion and the use of providers with superior performance, employers have learned that it may be advantageous or even necessary to reduce employee cost sharing. Public employers are also realizing that because employee tenure is typically long, strategies such as disease management that are aimed at reducing long-term disease burden offer more potential savings than they might among private employers, where employee turnover is higher.

Health Care Costs Continue to Escalate Rapidly

Health care costs are rising at a multiple of two to four times that of the general Consumer Price Index, wages, and revenue. If this trend continues, health insurance costs will rise by over 60 percent while wages will increase by only 20 percent during the first six years of this decade.

The cumulative impact in untenable. Double-digit increases only add to the financial pressures experienced by the public-sector employer.

Figure 1. Health Insurance Premiums Outpace Inflation.



New Accounting Standards Draw Attention to Public Employers' Obligations

The Governmental Accounting Standards Board's (GASB) August 2004 guidelines require public employers to accrue on their balance sheets liabilities for promised retiree medical benefits associated with past service. This standard, which requires employers to treat health and other (than pension) post-employment benefits (OPEB) in a manner similar to pension benefits, is a major shift from the previous practice of pay-as-you-go accounting.

In addition to GASB's significant book-keeping demands related to the valuation and disclosure requirements, governmental employers will need to consider the implications of expensing these post-employment benefits and disclosing their unfunded post-retirement obligations. Employers with large unfunded OPEB obligations—requiring annual contributions as high as five to ten times cash expenses[1]—are likely to feel the greatest impact on their operations.

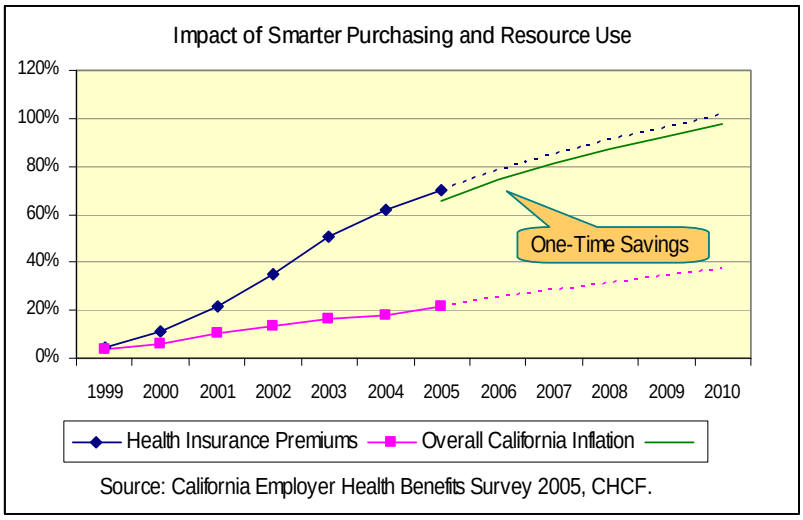
The disclosure rules may alter union negotiations and public policy discussions and some employers may see their bond ratings downgraded, which will increase their borrowing costs.

In total, the pressure on employers to control the costs of health care for their employees is immense. This paper addresses the strategies that are being used by public employers to stem this rising tide.

Reaping the Reward: One-time or Ongoing?

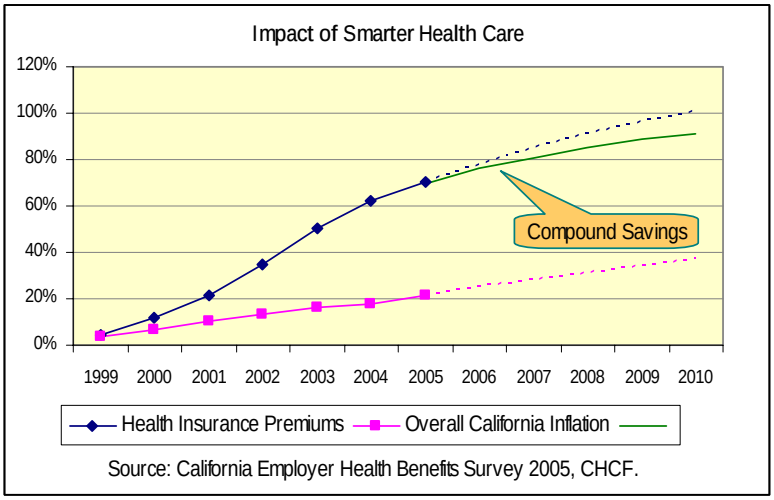
One-time Savings—Rate of Rise Remains Constant. Savings strategies generally provide either a one-time benefit or an ongoing cumulative benefit to the employer (Figure 2). *Such strategies provide a one-time movement of expenses to a lower level, but the slope, or trendline—the overall rate of increase in health costs—remains unchanged.* Savings of this type typically occur from reductions in administrative fees, use of lower-cost providers, or more pharmaceutical rebates. While this type of savings reduces cost immediately, it does not alter the long-term health care trend.

Figure 2. One-time Savings.



Compound Savings—Rate of Rise Diminishes. Figure 3 shows the effect of strategies that produce compound savings by preventing or forestalling complications over many years. *Such strategies alter the spending trend, in effect bending the curve in a favorable direction.* Practices that result in better health care for the population, such as those that reduce the incidence of diabetes, heart attack, and stroke, can potentially produce this "trend-bending" effect. While these approaches generally take longer to demonstrate savings, by altering the long-term trend, they can potentially produce greater savings compounded over the years. Both types of cost reductions are important.

Figure 3. Bending the Trend.



Employers generally examine the specifics of their workforce and situation when considering which strategies best complement their short- and long-term goals. Strategies that bend the trend are of particular value to public-sector employers because of the long duration of service and the offering of retiree coverage. Thus changes in health behavior that result in improved health status after a number of years will likely benefit the employer as well as the employee. On the other

hand, these strategies are more complex to implement and administer and are less likely to produce savings in the short run.

This paper presents examples of strategies emerging in the public sector that serve as models that can be adapted by a wide range of entities. The strategies have been categorized according to their ability to produce one-time vs. compound savings (Table 1).

Table 1. Stemming the Rise of Health Care Costs—
Overview of Strategies and Implementation Mechanisms*

STRATEGY	APPROACH	IMPLEMENTATION MECHANISMS
Strategy 1: One-time Savings—Rate of Rise Remains Constant		
1A. Smarter Purchasing by Employers	• Group purchasing • Reductions in administrative fees • Pharmaceutical rebates	• Coalitions • Negotiations
1B. Smarter Selection of Resources by Employers	• Use of lower cost hospitals • Use of more efficient providers • Elimination of low performing providers	• Financial incentives o Lower copays o Eligibility or benefit limitations o Tiered contributions • Foster use of o Top-tier (more efficient) providers o Lower-cost drugs, etc.
Strategy 2: Compound Savings—Rate of Rise Diminishes		
2. Smarter Care Choices by Workers	• Wellness • Health risk appraisal • Smoking cessation • Use of providers with best practices • Disease management	• Financial incentives o Lower or eliminate copays for services shown to reduce total cost of care o Eligibility or benefit limitations o Tiered contributions • Foster use of o Best-practice providers o Preventive and treatment strategies proved to improve outcomes and reduce total cost of care

* While employers can directly affect decisions regarding plan purchasing and resources they make available for member use, they can only encourage behavior change that will drive better health care decisions and outcomes for members.

Strategy 1A. Smarter Purchasing by Employers

Approaches associated with smarter purchasing include group purchasing, reductions in administrative fees and increased pharmaceutical rebates. To obtain advantageous pricing, employers often use coalitions and negotiations. Smarter purchases produce a one-time savings: a single movement of the trend line downward, but without affecting the rate of rise (slope). Examples of more effective purchasing practices that are emerging follow.

RXIS: A Four-State Pharmacy Purchasing Coalition

Goal	Receive 100% of pharmacy rebates to stretch limited dollars.
Tactic	Combine collective purchasing power of four state governments and negotiate to receive rebates.
Estimated Savings	After costs, an estimated net reduction in pharmacy costs of up to 5 percent.

Background: Beginning in 2002, a coalition of four state (Delaware, Missouri, New Mexico, and West Virginia) employee health insurance programs entered into a unique relationship with the St. Louis-based pharmacy benefit manager Express Scripts Inc.[2] This "Rx Issuing States" (RXIS) initiative addresses the dramatic increase in prescription drug costs by consolidating negotiating power, achieving efficiencies, and capturing rebates through a multi-state purchasing collective. The RXIS goal is to pay the PBM a fair, flat fee while having 100 percent of the rebates turned over to the states. In contrast, under most arrangements with states, PBMs receive a large share of the rebates.

Program Details: The RXIS collective aggregates nearly 700,000 lives: about 210,000 lives in West Virginia and 490,000 lives in the other participating states, including both public employees and State Children's Health Insurance Program enrollees. The collective acts as the bargaining unit to negotiate with the drug manufacturers through its PBM, with each state paying a pro-rata share of the administrative fees. Because fees paid to PBMs are typically based on volume, by pooling individuals from multiple states the collective is able to lower per-unit administrative costs. In addition, it is less expensive to conduct periodic audits of the PBM when all participating states share the cost. The most important aspect of RXIS, however, is the arrangement whereby participating states receive 100% of the pharmacy rebates.

Potential Impact and Trade-Offs: During the 2002-03 fiscal year, the state of West Virginia received rebates of 10 percent of drug costs, with overall savings for that year of about $8 million. Savings from both rebates and shifts to less costly agents are expected to total about $25 million over the three years of the contract ending June 2005. After accounting for the new costs of the program, this will represent a net reduction in pharmacy costs of about 5 percent per year. To achieve these savings, close cooperation among multiple state governments was essential.

Strategy 1B. Smarter Selection of Resources by Employers

Approaches associated with smarter selection of resources include the use of lower-cost hospitals and more efficient and higher-quality physicians. Like Strategy 1A "Smarter Purchasing" approaches, these tactics also produce a one-time savings and generally do not affect the rate of rise of health costs. However, while 1A approaches are directly implemented by employer action, 1B approaches require an added step: enrollees must choose to use these better resources. Employers use financial incentives to encourage members to make smarter choices.[3] Below are examples of emerging trends employing smarter selection of resources.

Massachusetts Group Insurance Commission: Tiered Networks

Goal	Create tiered physician and hospital networks with incentives to use efficient, quality providers.
Tactic	Use pooled health plan data to identify providers who score well on quality, cost-effectiveness, and patient satisfaction and provide financial incentives for enrollees to use these superior performing providers.
Estimated Savings	While there are no publicly available savings estimates for the Massachusetts GIC program, based on results of other similar programs, depending on baseline market efficiency and skillfulness of implementation, the GIC initiative could theoretically provide a savings of 1 4 percent of total medical paid.

Background: The Massachusetts Group Insurance Commission (GIC) was established by the Legislature in 1955 to provide and administer health insurance and other benefits to the Commonwealth's employees and retirees, their dependents, and survivors.[4] The GIC is a quasi-independent state agency governed by an 11-member commission appointed by the governor. Commission members encompass a range of interests and expertise including labor, retirees, public interest, administration, and health economics.

The GIC mission is to deliver high-quality care at a reasonable cost. The GIC's FY2006 appropriation is $1,023 million with approximately 267,000 people enrolled in GIC plans.

Program Details: The GIC recently launched the Clinical Performance Improvement (CPI) Initiative. The goal of this three-year strategic plan is to engage health plans, providers, and enrollees to improve quality and contain costs.

To do this, the GIC analyzed provider practice patterns for over nine million episodes of care from calendar years 2002 to 2004 to develop provider profiles based on quality and cost-effectiveness. This data analysis was provided to all six health plans. Because the health plans have shared their data, the analysis will more precisely identify high- and low-performing providers than if data were available from only a single health plan. The ultimate goal of this initiative is for each of the GIC's six health plans to create tiered networks (primary care,

specialty, or both) that consider cost efficiency/utilization data, quality measures, and patient satisfaction at the physician level.

While members retain access to all providers in the health plans' networks, GIC has created a new "Select and Save" program that provides financial incentives for members who seek physicians who are mindful of treatment quality and cost. Each plan created its own benefit design consistent with the CPI Initiative. Some plans provide tiered copays for primary care physicians and others for specialists. Patients may generally choose between $15 and $25 copays, with the lower copay attached to physicians who rate well on both quality and cost. A similar copay system is already in place for hospitals in three of the GIC plans.

While there has been some physician resistance and questions of methods and reporting, the provider community generally has been supportive of the concept of transparency. GIC reports that an important part of the process has been working actively to keep provider representatives apprised of efforts, while working with other health care purchasers and organizations throughout the country to begin developing mutually acceptable quality benchmarks.

Potential Impact and Trade-Offs: The appeal of this approach is the potential to reduce total health costs by 1 to 4 percent starting in the first year. This huge opportunity for savings is dependent on correctly categorizing providers as to cost-effectiveness. The ability to pool data from multiple health plans is vital to identifying meaningful differences among providers. However, gaining health plan cooperation requires careful planning, strong leadership, and a major commitment by multiple parties.

CalPERS Partnership for Change: Hospital Efficiency and Quality Reimbursement Project

Goal	Reward hospitals for efficiency and quality.
Tactic	Establish purchasers' coalition to work with the health plan hospitals to develop a standardized, universal performance report card to reward California hospitals for efficiency and quality.
Estimated Savings	Similar programs provide savings of up to 0.3 percent of total medical paid, depending on how stringently criteria are applied and the skillfulness of implementation.[5]

Background: The California Public Employees' Retirement System (CalPERS) established a purchasers' coalition to collaborate with hospitals to deal with the lack of correlation between hospital costs and quality of services.[6] CalPERS is the nation's third-largest purchaser of employee health benefits and serves 1.2 million public employees, retirees, and their families.

Program Details: The "Partnership for Change" project is designed to give purchasers and consumers tools for evaluating hospital effectiveness, quality, and patient satisfaction. The project's goals are to:

- Promote performance measurement and public reporting;
- Promote competition by negotiating hospital rates based on performance and value;
- Provide reliable data for purchasers and health plans to make decisions;

- Give hospitals benchmarked, comparative data that they can use to improve the quality of their services; and
- Advance the standardization of hospital performance measurement requirements and reduce the burden of compliance.

CalPERS is planning to reward hospitals based on efficiency and quality, which may include criteria such as reduced mortality and readmission rates. In addition, CalPERS has taken a more severe approach to cost containment than most employers (either public or private) by eliminating a number of hospitals entirely from its network because their costs are deemed to be too high.

Potential Impact and Trade-Offs: Providing transparency regarding hospital costs and outcomes does not equate to reduced costs. Employers must provide incentives to members to use better performing facilities, since much of the anticipated savings will result from moving care from high-cost to lower-cost hospitals, in part through removal of high-cost hospitals from the network. This will require powerful incentives, because members may have strong attachment to these higher-cost facilities. In the absence of clear incentives, previous experience is that report cards themselves are often insufficient to drive major change in consumer choice. While having the data is a necessary first step, employers will likely need to experiment with various types of incentives and closely monitor outcomes to move, over time, to quality improvement and cost reduction.

Minnesota's Smart Buy Alliance: Rewards Performance, Reporting, and Technology

Goal	Shift care to more cost-effective providers.
Tactic	Form alliance to identify lower-cost providers and encourage their use through lower out-of-pocket costs.
Estimated Savings	While there are no publicly available savings estimates for this program, based on results of other similar programs, depending on baseline market efficiency and skillfulness of implementation, this initiative could theoretically provide a savings of 1 to 4 percent of total medical paid.

Background: The State of Minnesota has joined with private business and labor groups in a "Smart-Buy Alliance" to drive improvement in quality and efficiency.[7] Alliance members purchase health insurance for 3.5 million people, or 70 percent of the state's residents. The Minnesota Department of Employee Relations purchases care for more than 100,000 state employees and their dependents. In addition, DHS represents about 660,000 members of Medicaid, the State Children's Health Insurance Program (CHIP), and state health care programs.

Program Details: Alliance members purchase health care individually but have agreed to set uniform performance standards, cost/quality reporting requirements, and technology requirements for health plans and providers. They plan to favor providers and health plans that are certified for highest quality.

Under the Minnesota system, health plans contract with the state and offer various combinations of physicians, hospitals, and outpatient centers, called "care groups." To compare the care groups, the Alliance developed a claims data warehouse and analyzed the underlying costs of each care group. Costs were aggregated, risk-adjusted, and translated to a per-member-per-month cost by care group. Each care group was placed into one of four tiers based on cost; there was a 60 percent difference between costs in the highest and lowest tiers. The Alliance uses varying copay and deductible levels to encourage use of more efficient providers while keeping premiums the same for all employees.

Potential Impact and Trade-Offs: Like the Massachusetts GIC, Minnesota is pooling health plan data to better understand provider quality and cost-effectiveness. This alliance will have extremely robust data since it includes 70 percent of state residents. Because the cost spread between highest and lowest tiers is large, steering members to higher-tier, lower-cost providers holds potential for substantial savings. However, eliminating the lower-tier providers will likely prove a difficult political challenge. Once again, developing such a strategic alliance requires leadership, close cooperation among many parties, and incentives that drive enrollees to change physicians.

Strategy 2. Smarter Care Choices by Workers

Smarter health care is driven by evidence-based medicine. Some approaches include wellness programs, smoking cessation, health risk appraisals, and disease management programs as well as primary, secondary and tertiary preventive care. These approaches typically target high-cost populations and can have a substantial impact because small minorities of enrollees with significant health problems drive a large share of total medical costs. These tactics have the potential to alter the long-term trend of medical spending: care that prevents a heart attack in 5 years may also prevent a stroke in 10 years and heart failure in 15 years.

But implementing smarter health care approaches requires a two-pronged approach: providing arrangements that support the use of evidence-based care and providing incentives for members to seek such care. And smarter health care decisions often take several years to bear fruit. Employers use incentives such as lower out-of-pocket expenses, eligibility and/or benefit limitations, and tiered contributions. Because public-sector employees have longer average tenure, which may extend to retiree medical benefits, this strategy is particularly well suited to the public sector. Examples of smarter care choices follow.

King County—Healthy Incentives Program

Goal	Modify the rising trend of health care costs by reducing risk factors and incidence of disease to improve overall health of population.
Tactic	Provide financial incentives for members to participate in disease management and other health-promoting activities.
Estimated Savings	King County spent $136.7 million on health care in 2004 and hopes to save $18.5 million by 2009, or approximately 2.7 percent annually. However, this approach is untested and it will take several years to truly estimate future savings.

Background: The King County Health Advisory Task Force is a public/private, labor/ management regional collaborative committed to system-wide transformation to improve the quality of health care and control costs in the four-county region of King, Kitsap, Pierce, and Snohomish Counties in Washington state.[8] Based in part on the task force's work, King County recently launched its "Healthy Incentives" program.

Program Details: Under the new Healthy Incentives program beginning 2007, employees receive the same level of medical coverage they previously received but their participation in Healthy Incentives affects their out-of-pocket expenses. There are three out-of-pocket expense levels, as shown in Table 2. Prior to the Health Incentives program, King County did not require employees to contribute to health coverage for themselves or family members.

Table 2. Healthy Incentives Cost-Sharing Levels

	Gold	Silver	Bronze
Annual deductible	$100 Individual $300 Family	$300 Individual $900 Family	$500 Individual $1,500 Family
Co-insurance (in-network provider)	10% (County pays 90%)	20% (County pays 80%)	20% (County pays 80%)

A member who takes the wellness assessment earns silver. A member who takes the wellness assessment and follows up with an individual action plan tailored to the member's risk of developing or controlling a chronic disease earns gold. If a member does nothing, s/he earns bronze. The out-of-pocket level for the entire family will be based on the family member earning the fewest points.

Potential Impact and Trade-Offs: The King County approach incorporates both aspects necessary to foster a shift toward smarter medical care: opportunities to participate in evidence-based care and incentives for members to seek such care. If successful, this program will achieve both its goals of increasing quality while decreasing cost. Success, however, will be driven by the degree of participation and the ability of disease management programs to work with providers to assure evidence-based care. The greatest savings will accrue to those employers with longer-duration employee tenure. Once again, developing a coalition and gaining union agreement was an integral part of bringing this strategy to reality.

M-CARE: An Evidence-based Pharmacy Benefit

Goal	Modify the rising trend of health care costs by reducing risk factors and incidence of disease to improve overall health.
Tactic	Provide financial incentives for members with diabetes to take medications that have been proven by medical evidence to improve clinical outcomes and reduce the total cost of health care.
Estimated Savings	Evidence-based pharmacy programs are very new. Based on preliminary results of similar pharmacy programs,[9, 10] depending on baseline market efficiency and skillfulness of implementation, this approach has the potential to reduce total medical costs by up to 1 percent over a few years, as well as the possibility of producing compound returns beyond that.

Background: M-CARE was developed by the University of Michigan in 1986 and is owned by the Regents of the University of Michigan. M-CARE provides health insurance to more than 200,000 members across southeastern Michigan and nearly 1,500 employer groups. Beginning July 1, 2006, participants will have no copayment for certain drugs that control blood sugar, lower blood pressure, cut the risk of heart and kidney problems, or ease depression.

Program Details: Under this new program, "MHealthy: Focus on Diabetes," drugs that have been shown to help prevent serious and potentially fatal diabetes complications will be available without a copay. MHealthy is one of the first programs in the nation designed specifically to evaluate the impact of targeted copay reduction for preventive medications.[11]

The primary objective of MHealthy is to remove financial barriers in order to increase patient compliance with prescribed drug regimens, thereby decreasing long-term medical problems. M-CARE couples the copay elimination for effective drugs with intensive patient education. Although only about 3 percent of University of Michigan enrollees have diabetes, it is common for diabetic patients to account for 10 percent of total medical costs.

Potential Impact and Trade-Offs: Like the King County plan, M-CARE fosters wellness and disease management, but with three key differences: (1) the M-CARE plan was initiated without an alliance; (2) M-CARE targets patients with a specific diagnosis, diabetes; and (3) M-CARE allows patients with diabetes to take effective medications free of charge. Both programs offer synergy: the low or no copay reduces the economic barrier to drug purchase while the educational or disease management component encourages compliance. Given that care for diabetes represents about one-tenth of total costs, if this program were to reduce medical costs by 10 percent, a reasonable target, then medical costs for the entire population would be reduced by 1 percent. This dual approach has the potential to deliver compound returns over the years, thereby bending the trend, especially among employees with long tenures.

Observations

Employers in the public sector are embarking on efforts to slow the escalation in health care costs. This movement, driven by cost pressures and exacerbated by GASB requirements, is pushing the public sector to explore new options and approaches.

Managing change in health care benefits is complex, time consuming, and difficult to implement in the multifaceted world of the public sector. Furthermore, many of these newer trends extend beyond the direct control of the employer and labor trusts, requiring the individual enrollee to make difficult behavior changes and engage more fully in self-care. To encourage such changes, employers are using a combination of financial incentives and disease management tools.

As these examples illustrate, some of these emerging approaches are being managed at the county level, but many are being introduced by coalitions of organizations within or across states. In implementing such leading edge strategies, public entities are rethinking not only how they deal with benefits and the health care delivery system, but also how potential alliance partners with similar goals can increase their influence. Developing and maintaining coalitions requires time, commitment, and finesse. However, as shown by the M-CARE diabetes program, it is possible to move toward trend-bending, evidence-based care without such alliances.

Endnotes

[1] "Fitch Ratings weighs in on credit implications of GASB 45." *Government Finance Review*. Oct 2005. http://www.allbusiness.com/finance/620683-1.html

[2] *HealthLeaders News* 18 January 2005. www.healthleadersmedia.com

[3] Under the right circumstances, 1B strategies that move members to more efficient providers have the potential to produce compound savings over the medium-to-long term. This would require that most patients with expensive chronic conditions migrate to the most efficient providers, those who more expertly and efficiently manage the care of high-cost patients.

[4] Mercer internal survey. www.mass.gov/gic/annualreportb

"Change Agent Dolores Mitchell Pushes Envelope Again and Again." Helen Graves. July 1, 2006. Permission to reprint July 2006 from Women's Business Boston.

FY05 in Review, "The GIC Presses Ahead." http://www.mass.gov/gic/annualreportb.htm accessed July 12, 2006.

[5] The CalPERS program, which involves only hospital costs, is likely to generate smaller savings than the Massachusetts GIC, program, which includes both physicians and hospitals.

[6] McKinley, Clark, Office of Public Affairs. "CalPERS OKs Hospital Reimbursement Project – Seeks Changes in How Hospitals Are Being Paid." February 2005. www.calpers.ca.gov

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CalPERS Leads "Partnership for Change" to Promote Value in Hospital Care. September 6, 2005. http://www.calpers.ca.gov/index.jsp?bc=/member/perspective/2005fall/partner-for-change.xml&pst=RETIRED&pca=ST

[7] *HealthLeaders News*, 18 January 2005 www.healthleadersmedia.com and www.cmwf.org.

[8] Mercer internal survey. www.metrokc.gov/exec/hatf/, www.metrokc.gov/employees/default.aspx.

[9] After two to three years, a similar Pitney Bowes program that reduced the cost of diabetes-related drugs and supplies has shown that overall health costs per plan participant with diabetes decreased by 6 percent.
[10] Mahoney J. "Reducing Patient Drug Acquisition Costs Can Lower Diabetes Health Claims." *Am J Manag Care*. 2005;11:S170-S176. http://www.ajmc.com/article.cfm?ID=2932
[11] M-CARE Co-pays for some proven preventive medications will now be free. Concept inspired by U-M research on co-pays' impact on long-term health. http://www.umich.edu/news/index.html?Releases/2006/Apr06/r042406. Accessed August 25, 2006.