

INITIATIVES AND DIRECTIONS AMONG STATE EMPLOYEE HEALTH PLANS

Presentation to State Health Plan Board

June 3, 2016



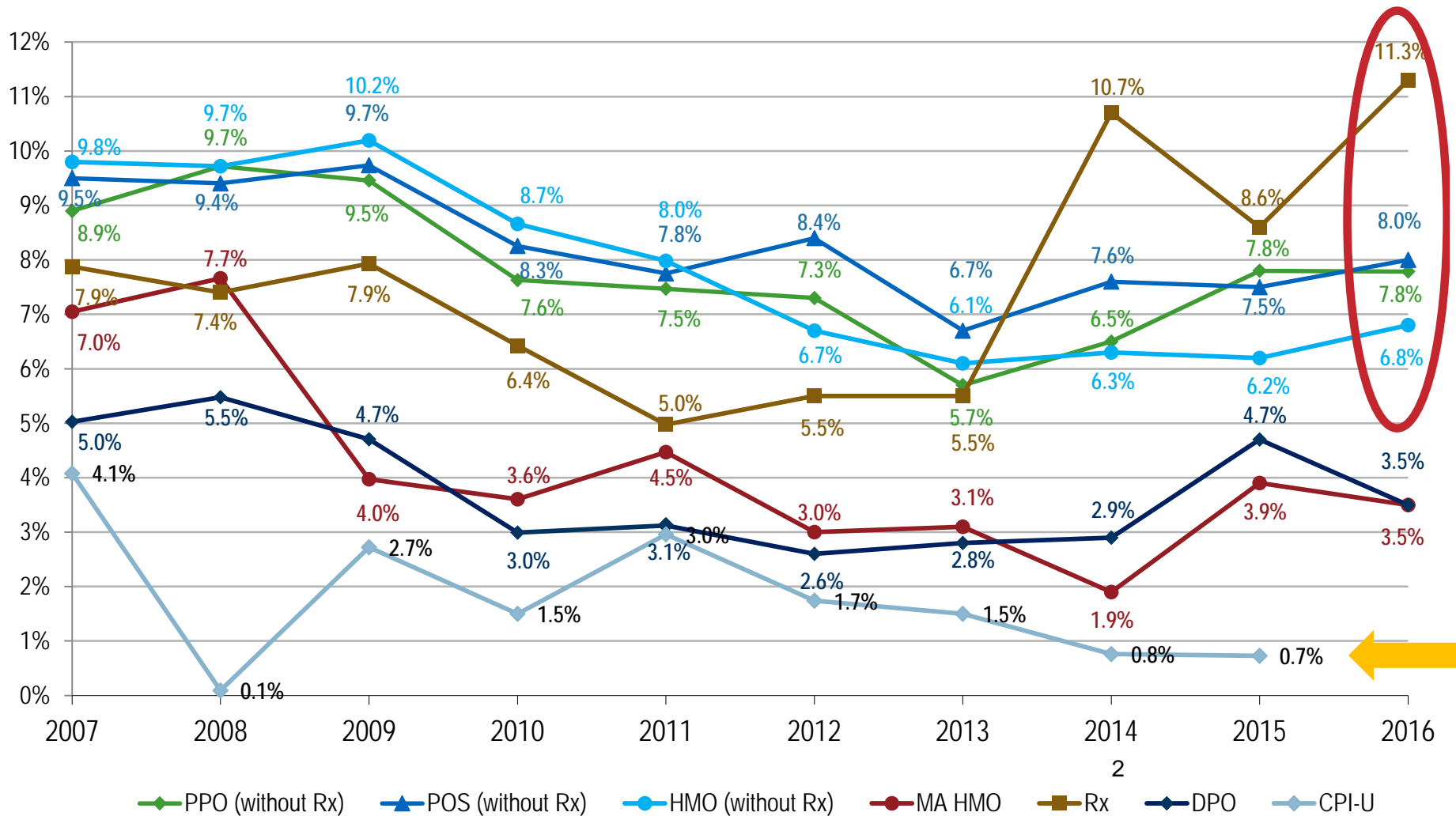
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State Employee Health Plans

Lay of the Land

- All state health plans are facing budget and funding issues, some more directly than others
- Health benefit plan costs keep going up faster than state employee compensation
 - Each year more of the employee's pay must go to pay for health benefits or the state must pick up an increasing share of the costs
- Plans are continually looking for innovative ways to control and contain the increase of health plan costs and keep member premiums affordable
- The Affordable Care Act requires minimum levels of coverage, some of which have driven up plan costs
- Starting in 2018 (now delayed to at least 2020) plans will have a ceiling on the nontaxable value of benefits they can provide to employees and retirees
 - 40% Excise Tax (known as Cadillac Tax) will apply for **total** plan costs over fixed dollar thresholds
 - To stay under the Excise Tax threshold, plans will eventually have to shift more out-of-pocket costs to participants or change how care is provided
 - Can't just charge participants more premium, since tax is based on total cost

Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2007 – 2014 Actual and 2015 and 2016 Projected¹



Source: 2016 Segal Health Plan Cost Trend Survey

¹ All trends are illustrated for actives and retirees under age 65, except for MA HMOs.

² Prescription drug trend data for 2007 only reflects retail. For 2008 – 2016, prescription drug retail and mail order delivery channels are combined.



State Plan Initiatives:

1. Benefit Plan Design and Program Changes
2. Provider Network Contracting
3. Premium Subsidy Approaches
4. Retiree Health Benefit Programs
5. Other Interesting Developments

State Employee Health Plan Offerings

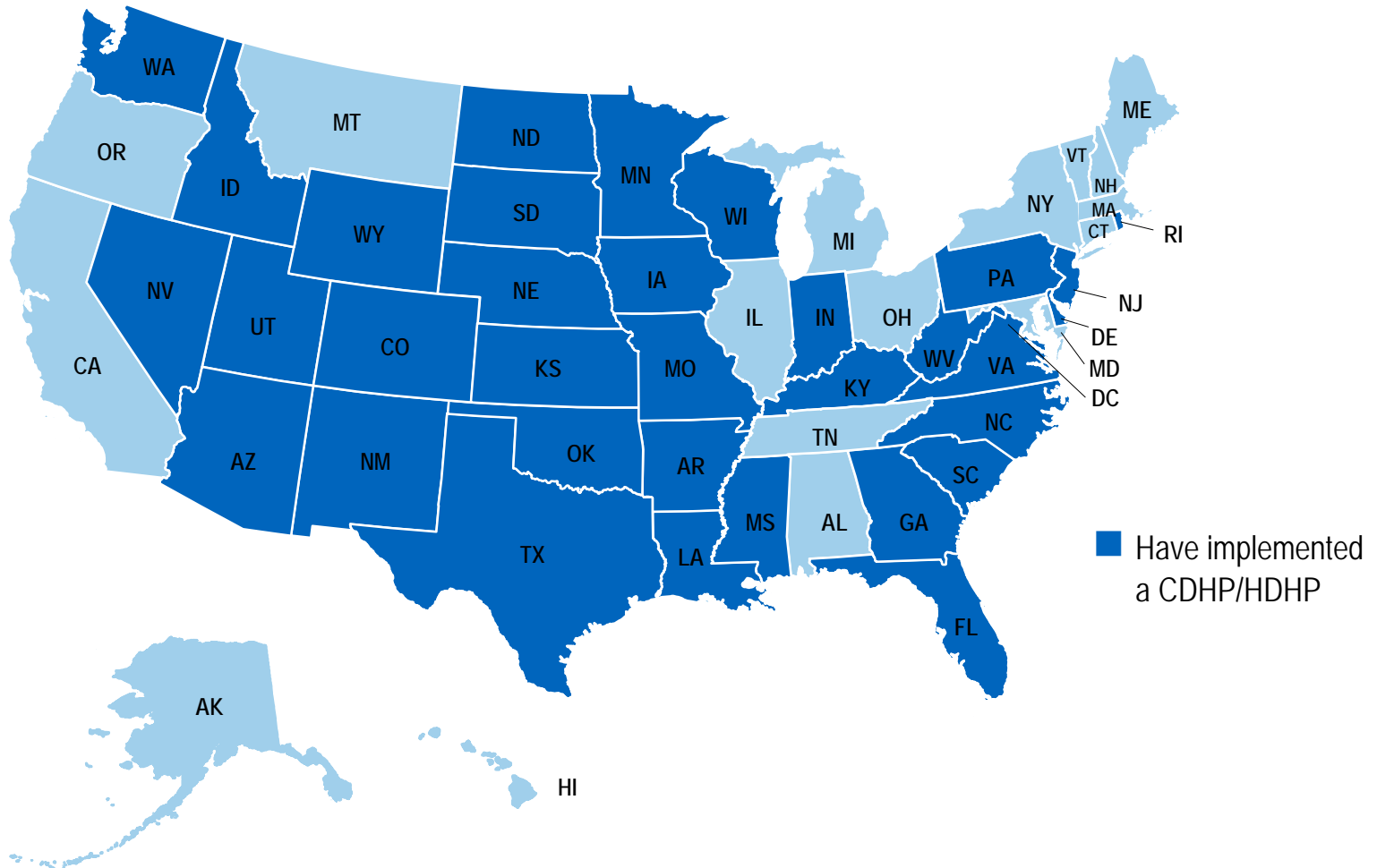
- Stability and progressive migration:
 - States have moved progressively from Indemnity to PPO to CDHP
 - Changes tend to be incremental
 - Introduce new plan types then phase out older ones over a few years
- Majority of enrollment is currently in PPO type plans
- CDHP has grown rapidly in the last four years

Plan Type	1999 Segal Survey	Percent of States	2014 Segal Survey	Percent of States
Indemnity Plans	43	84%	7	14%
PPO/POS	26	51%	47	92%
HMO/EPO	43	84%	29	57%
CDHP/HDHP	0	0%	30 <i>(now 33)</i>	59% <i>(65%)</i>

Source: Segal State Health Plan Survey 1999 and Segal State Study 2014

Consumer Directed Health Plans

As consumerism plays a larger role in plan features, the majority of states (33) have implemented Consumer Directed Health Plans (CDHP) or High Deductible Health Plans (HDHP)



How States Encourage CDHP Participation

Preferential Premium Structure

Indiana

- Three CDHP options plus one PPO
- Wellness CDHP is only available to members that meet the wellness participation requirement
- Significant differences in employee premium for different plans

State of Indiana Plan Options	Monthly Premium Employee Only
Wellness CDHP	\$30
CDHP – 1	\$57
CDHP – 2	\$222
70/30 PPO	\$635

How States Encourage CDHP Participation

Preferential Premium Structure continued

- **Arizona** and **Georgia** also offer a preferential premium structure to encourage CDHP enrollment:

State of Arizona Plan Options	Monthly Premium Employee Only	State of Georgia Plan Options	Monthly Premium Employee Only
PPO	\$102	UHC HMO	\$170
EPO	\$40	BCBS HMO	\$130
HSA	\$20	Kaiser HMO	\$140
		BCBS Gold HRA	\$159
		BCBS Silver HRA	\$105
		BCBS Bronze HRA	\$66
		UHC HDHP	\$57

- **North Carolina State Health Plan** allows members to earn down their CDHP premiums for completion of designated wellness activities

How States Encourage CDHP Participation *continued*

HSA/HRA Contribution Incentives

- A number of states offer increased HSA/HRA contributions for CDHP/HDHP members tied to participation in a wellness and/or disease management programs

Attractive HSA/HRA Contribution Levels

- Employees selecting these plans can recoup a significant portion of the deductible through HSA/HRA credits
- **Kansas** has experienced promising enrollment in their CDHP, likely a result of the rich State contributions to HSAs that offset the plan's design:
 - \$1,500 for single
 - \$2,250 for family
- **Indiana** contributes between \$600 to \$1,250 for single and \$1,200 to \$2,500 for family based on the CDHP plan selected



Wellness Plan Design

- A majority of states offer wellness programs designed to promote healthy behaviors
- Programs range from cash reduction of premiums, to point systems for incentives, to required activities to avoid surcharges

Georgia	Rhode Island	Connecticut
<ul style="list-style-type: none">• Up to \$480 to offset plan expenses.• \$240 for completing a well-being assessment and having a biometric screening.• \$240 earned by participating in phone coaching or the completing online well-being activities.	<ul style="list-style-type: none">• Up to \$500 for completing certain activities.• Each activity is allocated a dollar amount and paid as a credit to employee premium cost share on their paycheck deductions.	<ul style="list-style-type: none">• Requires age-related activities.• All family members must participate• \$100 monthly premium reductions and waived medical deductibles.• Chronic care management are eligible for reduced copays on PCP visits and treatment specific prescriptions.

Wellness Plan Design *continued*

- Many states already offer **free health resources**, such as:
 - Health coaching or on-line apps to:
 - Track health habits
 - Help participants quit smoking, eat better, get more physical activity, sleep better or manage stress
 - Group-based activities organized through onsite wellness coordinators

- An increasing number of states are exploring how to leverage **social media** and **smart phone apps** to encourage a healthy lifestyle:
 - **Using Twitter, Facebook, Instagram**, and other apps to push the message of wellness, and to communicate how participation in these programs can improve quality of life through positive behavior change.
 - **Ongoing personal reminders** supporting the activities featured in the wellness program
 - **Fitness tracking** tied to competitive groups
 - **Articles and videos** to broaden employee perspective on maintaining health
 - **Fun and health features**, e.g., coordinating with a local onsite farmers market to publish healthy recipes based on the market's available produce



Worksite Wellness Initiatives

➤ Best Practice Programs are:

- Integrated among state / agency / local coordinators to offer local programs
- Balanced between incentive-based programs and other resources
- Branded to state (not health plans)
- Available to all employees, retirees and dependents

CommonHealth of Virginia

- Created in 1986, more than 500 agency locations now participate
- Nine regional coordinators help support local programs
- “Start a Fitness Class at Work” and similar toolkits offered

Work Well Texas!

- State legislation requires agencies to support wellness, including:
 - Development of an agency wellness council
 - Allowing employees 30 minutes during normal working hours for physical activity three times per week
 - Providing eight hours of additional leave time each year for completing a health risk assessment/physical examination
- State provides guidance, model programs and policies to support local wellness initiatives

Worksite Wellness Initiatives

Work Well (Minnesota)

- Promotes worksite wellness programs within state agencies
- Agency wellness committees meet to plan activities and environmental changes that promote good health
- Best practices shared through statewide interagency Wellness Champions team

LiveWell Vermont

- Promotes employee /retiree health through:
 - Onsite biometric screenings
 - Telephonic wellness coaching
 - Quarterly wellness challenges
 - State employee Healthy Recipe Book
- Health & wellness workshops/classes—both **onsite** and **online**

Washington Wellness

- Supports local wellness coordinators at participating employers
- “Build Your Wellness Program” roadmap for agencies to secure leadership support, promote activities, evaluate results
- Specific resources for local wellness leaders to help promote “physical activity”, “healthy eating”, “living tobacco free”, etc.

Plan Design Tiered Structure

- Different state health plans use different tiered plan designs to incent plan members to utilize high-quality, efficient facilities and providers
 - **Illinois'** Quality Care Health Plan (QCHP) provides three deductible levels that are determined by the employee's salary, and includes enhanced benefits for receiving care from a designated QCHP provider
 - **West Virginia** maintains a Comprehensive Care Partnership (CCP) program in which enrolled members receive reduced plan cost share for services rendered at a CCP provider. These services include primary care, coordination of care, and where available specialty care
 - **Massachusetts** tiers the plan cost share for specialty physician office visits and inpatient hospital medical care. Three tiers are used to provide improved member cost-sharing for utilizing more cost effective and/or higher quality facilities
- Some states have implemented salary-based tiered plan designs
 - **West Virginia** tiers both deductibles and out-of-pocket maximums for three of its plan offerings; each plan has a range dependent upon the employee's salary. (WV also applies different premiums based on that same ten-tier salary band structure)



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3. Premium Subsidy Approaches
4. Retiree Health Benefit Programs
5. Other Interesting Developments

Health Provider Network Contracting

- The majority of state plans contract with medical carriers (BCBS, UHC, Aetna, etc.) to access hospital and physician networks and the accompanying discount arrangements:
 - Usually discounts and network guarantees are negotiated as part of the third party administration contracting process
 - Generally, the best discounts overall are available through the larger medical carriers
 - Once contracted, states typically have limited ability to change or realign network provider reimbursement except through systemic renegotiations
- While more prevalent in the private sector, some states are exploring alternative provider contract arrangements including:
 - Directly contracting with selected providers and facilities
 - Regional contracting through local HMO or local physician practice groups
 - Tiering physician groups based on risk adjusted experience
 - Global or reference-based payments for certain episodes of care
 - Bifurcated Networks
 - Value-Based Shared Savings Arrangements

Regional Contracting Arrangements

Some states contract provider networks geographically

- **Tennessee** divides the state into three regions:
 - Each region contracts with two medical administrators for its plan offerings
 - Both primary networks are available in many locations.
- **Alaska** participates in a coalition, including five union groups and other non-public health plans:
 - Coalition negotiates and contracts directly with the hospital network in Anchorage for improved discounts over those that can be obtained through Premera Blue Cross
- **Wisconsin** contracts with 17 fully insured HMOs:
 - Each HMO offers its plan in counties where it determines it can compete best
- Additional states offering multiple plan network options by geography include:
 - **California**
 - **New York**
 - **Florida**
 - **Massachusetts**
 - **Illinois**
 - **Oregon**
 - **Iowa**

Alternative Contracting Arrangements

States also differentiate among providers within the network and/or negotiate directly with major provider groups

- **Minnesota** employs a tiered provider network approach
 - Physician groups are placed within one of four tiers based on risk-adjusted historical cost
 - Member cost share for benefits is keyed to the provider's tier—higher tiered providers have higher copays
 - Physician groups are allowed to negotiate more deeply discounted contracts with the three plan administrators (BCBSMN, HealthPartners, PreferredOne) to move into a lower provider tier
- **Delaware** is beginning to negotiate directly with its four key hospitals
 - Goal is to leverage the plan's utilization to obtain preferential pricing with their major hospitals

To manage alternative provider contracts successfully, the state must establish and monitor data metrics that are highly correlated with quality and health improvement.

Centers of Excellence

Centers of Excellence are hospitals or physicians that are highly proficient in specific episodes of care, such as cancer treatment, bariatric surgery, or transplants. These centers typically demonstrate higher quality outcomes often at a lower cost

- **California** (CalPERS) contracts directly with high performing hospitals for specific surgeries and provides a set payment (reference based pricing) against the total cost
 - Due to success with knee and hip replacement surgery, California has expanded these arrangements to other surgical procedures
 - Also, more hospitals have agreed to meet the reference pricing and be added to the direct network
- **Virginia, Wisconsin, and Minnesota** contract with selected hospitals and physician groups for specific procedures like Bariatric surgery and transplants at a discounted rate for state employee members
- **Vermont** covers transplants at 100% when services are rendered at designated facilities
- **Alaska** is contracting directly with providers not in the Blue Cross network to eliminate balance billing on end stage renal disease

Bifurcated Network Contracting

Bifurcated networks allow plan sponsors to split medical networks based on separate provider contracting arrangements

- **New York** contracts with separate medical plan administrators to provide their physician services and hospital facility services
 - United Healthcare currently provides the physician network and administers physician claims for all participants
 - Empire BCBS provides the hospital facility network and administers hospital claims
- **Maryland** is an all-payer state for hospital costs
 - The state regulates all inpatient and outpatient hospital charges through an all-payer rate regulation system
 - Health plans and network administrators are limited on their ability to negotiate hospital discount arrangements
 - However, health plans and network administrators are generally open to negotiate discounts with non-hospital providers as most of these services do not fall under the all-payer regulations
- **Kansas** contracts separately with Quest Diagnostics and Stormont-Vail/Cotton-O'Neil to provide outpatient and non-emergency laboratory testing
 - Members that utilizes these facilities can receive services with no member cost share, or discounted pricing terms dependent on the participant's plan election

Value-Based and Shared Savings Contracting

Value-based and shared savings network arrangements share gains with the network providers, the plan and the members

- These arrangements foster a partnership among all parties
 - Plan members are encouraged to engage through the use of incentives and disincentives
 - Medical administrators and network providers are rewarded/penalized on their ability to manage the health risk of the population
 - The plan sponsor benefits through higher quality care and lower overall claims costs
 - Requires clear communication on the guidelines, measurements, and reasons for the program
- **Maryland** has a value-based shared savings arrangement with all three of its medical administrators (CareFirst, UHC, and Kaiser)
 - Administrators are measured on their ability to improve certain provider quality metrics over the contract duration
 - Each administrator receives points for meeting annual targets and based on the total point accumulation receives a payment incentive or pays a penalty
- Some states are beginning to look at episode of care/reference-based pricing and global provider network budgets as another form of a value-based approach



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Percentage Based Employee Cost Share

- Majority of states require employees to pay a certain percentage of the total premium
- Most use same or similar percentage for dependent coverage as for employee only coverage
- State plans typically do not offer flex credits or tie premiums to other cafeteria benefit plan options

2014 Median State Premium Subsidy

Plan Type	Coverage Tier	Employer Share	Employee Share
PPO/POS Plans	Employee Only	85%	15%
	Family	81%	19%
HMO/EPOs	Employee Only	88%	12%
	Family	84%	16%
HDHP/CDHPs	Employee Only	95%	5%
	Family	81%	19%

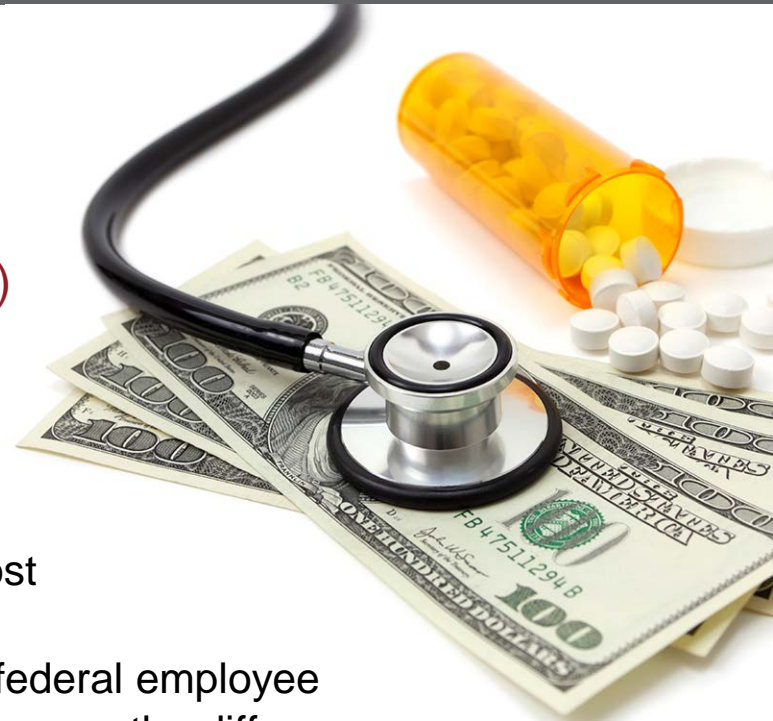
Flat Dollar and Pegged Premiums

Flat Dollar (Employee's share is defined)

- **Minnesota** employees pays a flat dollar amount across all tiers

Pegged Premium (Employer's share is defined)

- The **Federal Employee Health Benefit Program (FEHBP)** provides a base premium payment for all available plans based on a calculated pegged subsidy
 - Federal subsidy is 72% of the average of the lowest cost national PPO plans
 - Flat dollar amount applies to any plan purchased by a federal employee
 - If employee chooses more expensive plan, employee pays the difference
 - If employee chooses less expensive plan, employee's cost is reduced dollar for dollar
- **General Motors** has historically pegged its employer contribution to the health plan that demonstrates the highest quality metric in that region
 - The pegged contribution is fixed for all available plans
 - Employee selecting lesser quality plan pays the difference in cost



Tiered Premium Structure

Pay-Based Tiers

- Employee premium share is based on compensation from the employer, with higher paid employees paying a larger percentage share of the premium cost:
 - This approach is attractive where a large portion of the workforce has low family income
 - While member premiums will be more constant as a percent of their pay, some employees view this as discriminatory against those who make median and higher pay
- **Illinois** sets the employee premium share based on 6 salary bands
- **West Virginia** includes 10 salary bands in their premium tier structure
- **Rhode Island** sets premiums based on 2 salary tiers, with employee premium share ranging from 20% – 25%. The family coverage level includes three tiers with employee premium share ranging from 15% – 25%

Plan-Based Tiers

- Employee premium is based on the overall cost of the **plan**, with the state providing a fixed amount:
 - Tiers may be based on overall plan cost, quality metrics or a combination of factors
- **Wisconsin** tiers employee premiums based on the tier in which the plan is assigned:
 - Tier 1 (lower cost) plans have lower employee premiums than Tier 2 or Tier 3 plans

Premium Credits

- The majority of state plans offer wellness programs that provide premium incentives for participation:
 - In partnership with HealthQuest, **Kansas** offers a point-based wellness program:
 - Participants are required to complete a health assessment, but then can accumulate points for completing different activities
 - Point allocation differs depending on the healthy activity
 - Employees can receive up to \$240 in annual premium credits for accumulating 30 points
 - Premium incentives are applied to the following plan year
 - **Connecticut** offers a monthly premium reduction of \$100 for all family units that complete the age-related preventive care requirements
- Medical Opt-Out Payment
 - **Oregon** offers employees with other medical coverage \$233 per month for opting out of the state plan
 - **Wisconsin** offers employees up to \$2,000 per year to opt out of the plan if covered elsewhere



Premium Surcharges

➤ A number of states apply a tobacco surcharge:

- At the time of Segal's 2014 State Health Plan Study, 14 states included premium changes as a result of tobacco use:

Northeast	South	Midwest	West	Total
0	7 (AL, GA, KY, NC, SC, TX & WV)	4 (IN, KS, MO & SD)	3 (MT, OR, & WA)	14



- **Indiana** builds a tobacco surcharge into the premium:

- To receive the non-tobacco rate, employees must identify at enrollment as non-tobacco users and submit to tobacco testing throughout the year
- Those that sign the agreement and later fail a tobacco test will be subject to termination of employment

- **Alabama** includes a \$60 surcharge for tobacco use:

- Surcharge is applied separately to both the employee and their enrolled spouse (maximum of \$120)
- Premium discount of \$25 per month is available for employees that participate in the wellness program

➤ Spousal Premium Surcharge

- **Alabama** and **Oregon** include a \$50 premium surcharge for all employee and retiree spouses that are eligible for other health insurance coverage



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Retirees Included in Active Employee Plans

Most states include both Medicare and Non-Medicare eligible retirees in the same plans covering their active employees

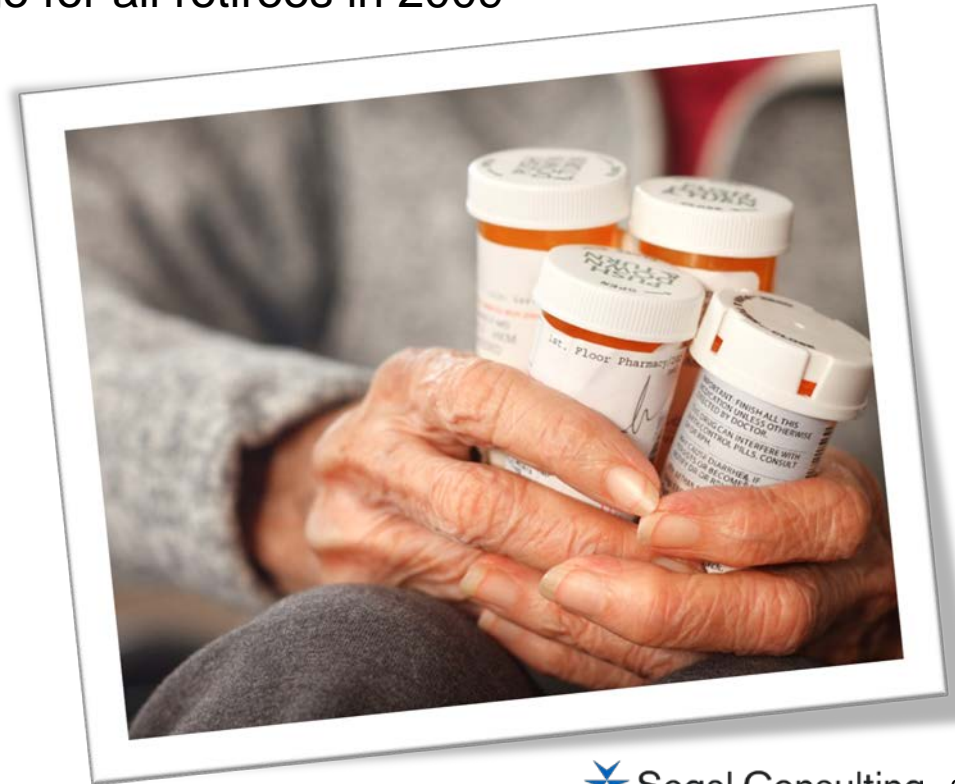
- Usually the same employer subsidy as actives, reduced for Medicare eligible retirees
- Rates are reduced for Medicare primary retirees
- Rate setting uses the entire member group including both actives and retirees
- Implicit subsidy for early retirees, sometimes for Medicare retirees



Medicare Advantage Plans

A number of states offer Medicare Advantage Plans for Medicare eligible retirees

- MAPD carve-out may be optional or mandatory
- **Illinois** requires retirees and survivors who become eligible for Medicare to enroll in one of the HMO or PPO Medicare Advantage programs or opt out of coverage
- **Idaho** implemented Medicare Advantage for all retirees in 2009
- **Pennsylvania** mandated Medicare Advantage Prescription Drug plans for all Medicare eligible retirees in 2010
- **Arizona** offers a Medicare Advantage HMO alongside a traditional Medicare Supplemental Plan



Medicare Retiree Exchanges

States are beginning to look at outsourcing their retiree health insurance to an exchange

Outsource to a Private Exchange

Ohio Public Employee Retirement System (OPERS)

outsourced all 145,000 of its retirees to a contracted private exchange vendor effective 1/1/2016:

- Vendor provides Medicare Advantage and Medicare supplement options for Medicare eligible retirees
- Vendor also counsels non-Medicare retirees to purchase exchange
- Fixed Health Reimbursement Arrangement amounts from OPERS, retiree pays the difference
- Phasing spousal coverage subsidy out by 2018
- Many early retirees qualify for federal exchange subsidy better than OPERS' fixed contribution
- Significant reduction in plan staff, since most work is done by the private exchange vendor



Medicare Retiree Exchanges *continued*

Build a Self-Administered Exchange

Pennsylvania Public School Employees' Retirement System (PSERS) provides a voluntary, retiree-pay-all, health benefit program for Medicare eligible retirees who lose health coverage from their local school districts:

- Now over 100,000 members and growing by 6,000 per year
- Health Options Program offers a variety of choices in an exchange environment:
 - Two self-insured Medicare supplement plans
 - Three self-insured Medicare Prescription Drug Plans (through a direct EGWP contract with CMS)
 - Dental benefits
 - Five fully insured Managed Care Organizations each offering a competitive Medicare Advantage group plan, and competing regionally where they are approved by CMS
- Third-party administrator handles eligibility and customer service, plus member counseling and premium administration

Defined Contribution Retiree Subsidy Strategies

More states are moving toward a defined contribution subsidy for retiree health benefits

Flat Dollar Contributions

- **New Hampshire** has begun to explore defined contribution alternatives to their current subsidy structure where Medicare eligible retirees receive a 100% subsidy, to address budget pressure
- **Michigan** is phasing in a flat dollar subsidy amount for all new retirees that is dependent upon the years of service with the State. Some current retirees are under a collectively bargained arrangement
- **Kansas** is exploring removing all subsidies for retirees

Using Accumulated Sick Leave

- **Wisconsin** retirees are allowed to use their accumulated sick leave at retirement to pay health plan premiums
 - On average the sick leave accounts for approximately two years' worth of premium payment
 - Once sick leave runs out, retirees are responsible for 100% of the retiree premiums

Removal of Rx Coverage

- **Maryland** is currently scheduled to cease providing prescription drug coverage for Medicare retirees in 2020 with the closure of the Part D doughnut hole. Retirees would have to purchase their own Medicare Part D coverage outside the state health plan



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Telemedicine/Tele-Health Services

More states are looking at Tele-Health services as a low cost option for basic health treatments

- **Georgia** implemented a Telemedicine and Virtual Visit program effective in 2016
 - Members are charged the physician copay for each session
- **Delaware** provides Telemedicine services through its bundled carrier contracts
- **Minnesota** provides members with access to Doctor on Demand through BCBSMN
 - Participants are charged a \$10 copay for access to a health care provider via the internet
- **Kentucky** offers live face-to-face sessions through mobile devices or computer webcams
 - For common health concerns such as colds, fevers, rashes, and allergies
 - These sessions are currently offered at no cost to the employee
- **Virginia** has recently conducted a pilot Telemedicine program for remote and hard to access areas of the State



Onsite Clinics and Concierge Care

Onsite clinics can save cost and promote smart plan utilization, particularly where large groups of employees are concentrated

- **Tennessee** inherited clinics from the State Department of Health and now utilizes these as onsite clinics for employees in select locations around the state
- **South Dakota** is in the process of identifying a vendor to administer an onsite clinic
- **Arizona** has contracted with a local care center located within a mile of their Capitol building. The center provides acute care, minor injuries, immunization/vaccinations, lab services, and includes an onsite pharmacy

Concierge care coordination can provide a higher perception of plan service while encouraging preventive medicine

- **New Jersey** implemented a concierge service that allows participants to pick a primary doctor and choose a direct primary care-style practice that gives around-the-clock access to preventive and primary care services

340B Prescription Drug Pricing

340B prescription drug contracts are available through hospital pharmacies and may provide better pricing on certain drugs than available through a pharmacy benefit manager

- **University of Virginia** utilizes its on-site UVa Medical Center pharmacy for access by University health plan members:
 - Encourages member access by offering prescription pick-up and delivery of scripts at various locations on campus
 - Offered a mobile pharmacy (van) for non-restricted prescription delivery
 - Member acceptance has been somewhat slow, since many prefer to use neighborhood pharmacies near their residence rather than be seen picking up prescriptions on the University campus



Integration of Initiatives

To be most effective, initiatives need to be well-reasoned and integrated

- Keep goals clearly in mind:
 - Cost containment
 - Premium and cost sharing equity
 - Population health improvement
 - Access
 - High quality and cost efficient care
- What is the objective for each program and how does it fit into the overall strategic plan?
- A single initiative may have only a small overall effect, while carefully coordinated sets of initiatives can have major impact
- Important to involve providers and carriers as well as participants
- Member satisfaction is important, but so are health management and the long-term affordability of the plan

Impact of Initiatives

It is important to determine how initiatives affect different program concerns and how they work together

Initiative	Plan Costs	Out-of-Pocket Costs	Participant Contributions	How Care Is Provided	What Care Is Required
Plan Design	✓	✓	✓		
Wellness	✓				✓
Provider Contracting	✓			✓	
Premium Subsidies	✓		✓		
Retiree Health Strategies	✓		✓	✓	
Telemedicine	✓			✓	
Onsite Clinics	✓	✓		✓	
340B Drug Pricing	✓	✓		✓	

Thank you!



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