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HOW STATES CAN REFORM HEALTH CARE TODAY

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CHAPTER 1

Demonstrate Leadership

Reform the State Employee Health Plan

Brian C. Blase, PhD

KEY TAKEAWAYS

- To obtain the dual benefit of lower costs for the state government as well as driving overall efficiencies in their health sector, states should introduce reforms into their state employee health plans.
- This chapter discusses six such reforms: (1) greater transparency about the plan, (2) permitting the plan to merge with group purchasing organizations to obtain better value for plan members, (3) insisting on bottom-up pricing and avoiding inflationary pricing structures such as discounts from billed charges, (4) prohibiting the use of facility fees in the state employee health plan if inpatient hospital-based care is not necessary, (5) incorporating reference-price and shared-savings payment structures, and (6) utilizing individual coverage health reimbursement arrangements.

PROBLEM

State and local governments are often the largest employers in the state, employing about 16.2 million full-time equivalent employees across the United States in 2014, including roughly 6.6 million working in elementary or secondary education and 2.1 million working in higher education.[1] Public employees and their dependents typically receive health benefits through

their employer, and local government employees, including schoolteachers and college employees, participate in the state employee health plan in nearly half the states.[2] Among state and local government workers, 89 percent are offered health benefits, and 78 percent of these workers enroll.[3] Aside from reducing the costs to the state of the state employee health plan, better managing the plan provides the state with an opportunity to reform its entire health sector simply through reforms to its own employee health plan.

Montana's experience starting in 2015 shows the potential benefit of state action to reform state employee health plan contracts and vendor management. Montana renegotiated contracts with hospitals to pay prices slightly more than twice what Medicare pays and to reduce payment variation. Before the reforms, Montana paid hospitals 191–322 percent of Medicare rates for inpatient services and 239–611 percent of Medicare rates for outpatient services.[4] Under the reform, Montana paid 220–225 percent of Medicare rates for inpatient services and 230–250 percent of Medicare rates for outpatient services.[5]

Montana also prohibited balance billing in its state employee health plan and tied annual hospital rate increases to Medicare payment growth. Moreover, Montana demanded a full accounting of pharmaceutical costs, including fees paid to various entities in the supply chain, and eliminated duplicate programs and many vendor contracts.

Before Montana initiated these reforms, its state health plan faced large projected deficits. Montana's reforms turned those projected deficits into large surpluses and succeeded in reducing what it paid for its employee health plan by about 8 percent in the first two years.[6] Figure 1.1 contrasts the projected state employee health plan reserves before the reform with the actual results of the reform. According to an independent evaluation of the plan, Montana achieved savings of $30.3 million for inpatient care and $17.5 million for outpatient care in the first three years.[7] As a testament to the reform's success, employer and employee premiums have not changed since 2016, and they are projected to remain flat through 2023.[8] The Montana legislature passed two bills to allow employer premium holidays and to retain the funds—$25.4 million in 2018 and $27.9 million in 2021.

Other states could follow Montana's example. The recommendations in this chapter are less sweeping than what Montana did and thus should represent an easier political lift than setting all hospital rates in the state employee health plan as a percentage of Medicare rates. But effectively implementing the recommendations could lead to a significant drop in total spending

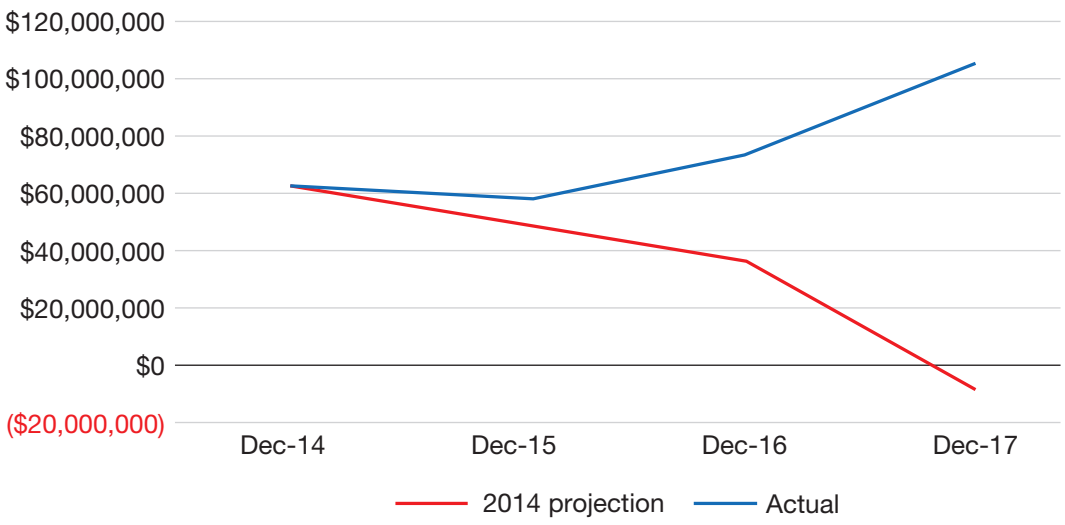

Figure 1.1 State health plan reserves.

on public employee health benefits. Moreover, because state employee health plans have many members, external benefits will likely accrue to private-sector employers and employees—both through lower health care prices that the reforms produce and by influencing private sector employer adoption of similar reforms.

OPTIONS FOR STATE EMPLOYEE HEALTH PLAN REFORM

States should only enter into agreements with third-party administrators (TPAs) that agree to transparency about the plan, including price and claims information

Writing in *Health Affairs* in 2019 about employer efforts to constrain health care prices, Gloria Sachdev, Chapin White, and Ge Bai note, "One reason for employers' lack of success in health care cost containment efforts is their limited awareness of the prices they are paying providers. Just like consumers in other markets, employers need to know the prices that their insurance carriers have negotiated for them."[9] Perhaps surprisingly, many states have difficulty accessing this information for their state employee health plans. When limited data is analyzed, significant problems appear, such as overpayments by the third-party administrator (TPA) managing Tennessee's state employee health plan.[10] ClaimInformatics, which performed an analysis for Tennessee at no charge to the state, found $17.6 million of overcharges on nearly 150,000 claims for professional services.[11]

As an example of the power of transparency, a May 2019 report on hospital prices from the RAND Corporation found that Parkview hospital system based in Fort Wayne, Indiana, was among the highest-priced hospital systems in its study of hospital prices across 25 states.[12] These findings caused local employers to push for reform. According to Anthem, Parkview agreed to lower its prices for hospital services by more than 25 percent.[13]

States should consider permitting the state employee health plan to merge with group purchasing organizations to obtain better value for plan members

States should consider allowing employers within the state to join the state employee health plan to gain negotiating leverage with health systems. Many of Colorado's public employers have joined about a dozen other employers in the state to form the Colorado Purchasing Alliance.[14] This purchasing alliance is using data to determine regional centers of excellence (facilities and providers with a favorable price-quality mix) and direct plan members to those facilities and providers for services and procedures that those facilities excel at providing. The alliance is also harnessing the increased purchasing power of its membership to obtain better prices for services, looking at local facilities and providers as well as those outside Colorado.

States should insist on bottom-up pricing and refuse to set any rates as discounts from billed charges

The "chargemaster rates" that hospitals and other health care providers bill are substantially inflated and do not resemble anything close to a market price, yet many contracts are negotiated for payment as a percentage discount off these "prices." After hospitals sign contracts with insurers or TPAs, they often increase these "prices," which ratchets up the payments they receive. Standard hospital contracts often also include an escalator clause, resulting in a guaranteed automatic increase every year. These payment structures are inherently inflationary. At a minimum, states should ensure that what they pay does not automatically increase when a hospital raises its chargemaster rates. The contract a state signs with a TPA must clearly state that a plan will not pay the additional amounts related to increased chargemaster rates or escalator clauses. The state should put a performance guarantee into the contract.

States should prohibit the use of facility fees in the state employee health plan if inpatient hospital-based care is not necessary

Many plans pay more for outpatient services performed in a hospital or its affiliated facilities than at an independent doctor's office. This is largely because hospitals and their affiliates charge "facility fees." A facility fee is a charge intended to compensate for the operational expenses of the hospital or health system, separate and distinct from the physician or medical provider's professional fee.

A bill for an office visit at a hospital-owned medical practice will often include a facility fee, meaning that the plan will pay much more for the same episode of care at a hospital-owned facility than at an independent doctor's office. Similar differential payments occur for medical procedures performed in a hospital outpatient department compared to lower-priced ambulatory surgical centers (ASCs) that are not owned by a hospital. These payment differentials raise state employer health plan expenditures. Moreover, they lead to more consolidated health care markets by incentivizing hospitals to purchase independent physician practices, imaging centers, and ASCs. The reduction in competition means higher prices and spending. Moreover, there is evidence that nonhospital facilities, such as ASCs, provide a higher quality of care and achieve better outcomes than hospitals.

Medicare has taken action to reduce the extra payments received by hospital-affiliated facilities for identical services that can be provided in physician offices. In a 2019 Medicare payment rule, the Centers for Medicare and Medicaid Services reduced government payments for evaluation and management services provided at off-campus hospital sites to what Medicare pays physicians for services delivered in their offices.[15] Doing so saves taxpayers and beneficiaries money and reduces the incentive for hospital systems to acquire physician offices, which improves competition in local health care markets.

The National Academy for State Health Policy (NASHP) has proposed model legislation—patterned after Medicare payment policies—that prohibits the payment of facility fees for services located more than 250 yards from a hospital campus.[16] It also prohibits facility fees for typical outpatient services that are billed using evaluation and management codes, even if those services are provided on a hospital campus. In other words, facility fees can only be charged for procedures and services provided on a hospital's campus, at a facility that includes a licensed hospital emergency department, or for emergency procedures or services at a freestanding emergency facility.[17]

The NASHP model legislation prohibits inappropriate facility fees across the board and may be, understandably, too sweeping for policymakers reluctant to interfere in private contracts. However, states should prohibit their state employee health plan from paying facility fees for all outpatient evaluation and management services, along with any other outpatient, diagnostic, or imaging services identified by states as inappropriate for facility fees, regardless of the location of the service. To effectuate this recommendation, states would put this requirement into their TPA contracts, along with conducting an audit of facility fees after each plan year.

States should utilize reference prices and shared savings for shoppable services

Reference pricing has demonstrated success in lowering health care prices and spending. Under reference pricing, the employer or insurer agrees to pay a set amount per procedure or service regardless of the provider chosen and the amount charged. The employee remains free to receive care from a provider that charges more, but the employee is then responsible for the difference between that provider's rate and what their plan pays (the reference price). Consumers thus retain broad choice among providers but have strong incentives to avoid high-priced ones.

Reference pricing is most applicable for "shoppable" and relatively standardized services such as laboratory tests, imaging, blood work, and orthopedic procedures such as knee and hip replacements. For reference pricing to be successful in producing overall savings and a more efficient health sector (by moving services from higher-priced providers to lower-priced providers and getting high-priced providers to reduce unnecessary costs), it needs to cause a shift in consumer behavior.

Like reference pricing, shared savings models provide employees with an incentive to use lower-priced providers. Through shared savings, employees receive a portion of the savings achieved when they choose a lower-priced provider. For example, if a reference price for a service is set at $1,000 and the employee obtains the service for $800, the employer might provide the employee with a portion of the $200 savings. This could be utilized to reduce the patient deductible or could be provided as a cash payment to the individual.[18] New Hampshire and Kentucky have had positive results with shared savings payment structures.[19]

There are two prominent examples that show the benefits of reference pricing. In 2011, the California Public Employee and Retiree System

(CalPERS) implemented reference pricing for several shoppable services, including orthopedic procedures and colonoscopies. Also in 2011, Safeway implemented reference pricing for laboratory tests and images for 492 procedures and services. In both cases, spending above the reference price did not count toward the member's deductible or out-of-pocket maximum.

The California experience shows that reference pricing incentivized employees to shop, caused high-priced providers to significantly lower prices, and led to large average price and spending reductions. According to a 2018 paper by the American Academy of Actuaries (AAA), "Evaluations of CalPERS' more expensive surgical services report consumer switching rates ranging from 9 percent to 29 percent; evaluations of Safeway's less expensive diagnostic services report switching rates of 9 percent to 25 percent."[20] Table 1.1 is reproduced from the AAA paper and summarizes the effects of reference pricing models for CalPERS and Safeway. Average savings of around 20 percent were achieved with the reference pricing payment system.

In a 2014 study, Chapin White and Megan Eguchi defined a set of 350 shoppable services that would be well suited to reference pricing.[21]

TABLE 1.1 Reference pricing in practice, impact on savings and behavior

System	Procedure(s)	Reference price percentile	Savings (%)	Consumers switching (%)	Reduction in high-priced provider prices (%)
CalPERS	cataract surgery	66th	17.9	8.6	NA
CalPERS	colonoscopy	66th	21.0	17.6	NA
CalPERS	hip and knee replacement	66th	20.2	28.5	34.3
CalPERS	arthroscopy: knee	66th	17.6	14.3	NA
CalPERS	arthroscopy: shoulder	66th	17.0	9.9	NA
Safeway	492 CPT codes, lab services	50th	20.8	12.0	NA
Safeway	diagnostic lab testing	60th	31.9	25.2	NA
Safeway	imaging: CT	60th	12.5	9.0	NA
Safeway	imaging: MRI	60th	10.5	16.6	NA

Note: NA means that the reduction in provider prices was not an aspect of the analysis.
Source: American Academy of Actuaries, "Estimating the Potential Health Care Savings of Reference Pricing," November 2018, https://www.actuary.org/sites/default/files/files/publications/Reference Pricing11.2018.pdf.

Assuming a reference price set at the 65th percentile of allowed amounts, with 30 percent of consumers switching from higher- to lower-priced providers, White and Eguchi estimated that spending on the 350 shoppable services could be reduced by 14 percent, equating to a total reduction in health care spending of 5 percent. The AAA, which estimated savings using a variety of assumptions and reference price thresholds, projected savings similar to those of White and Eguchi, with the impact on expenditures greater from providers lowering prices than from consumers switching providers.[22]

Crucially, when evaluating CalPERS, economists Christopher Whaley and Timothy Brown found that about 75 percent of the price reductions spilled over to the non-CalPERS population, meaning that people benefited from the implementation of reference pricing even if they did not directly shop.[23] This happened because many providers lowered their prices across the board for these services. This demonstrates that a state's action to employ reference pricing for its public employee health plan will also provide benefits to many others outside the state.

Utilizing individual coverage HRAs

Since 2020, employers have been able to provide employees with contributions through health reimbursement arrangements (HRAs) allowing employees to purchase coverage in the individual health insurance market. These plans are comprehensive and must comply with Affordable Care Act requirements. In general, individual coverage HRAs provide employees with much greater choices of coverage and help employers by lessening their administrative burden along with providing greater cost predictability. Employees do not pay income or payroll taxes on the HRA contribution. One option for states is to transition state employees into the individual market by using an individual coverage HRA. A bonus with this policy is that it would almost certainly improve the state's individual health insurance market. Individual coverage HRAs should produce more engaged and cost-conscious consumers. By increasing choice and empowering more people to shop for health plans in the individual market, individual coverage HRAs should spur a more competitive individual market that drives health insurers to deliver better coverage options to consumers.

OVERCOMING OBSTACLES INSIDE AND OUTSIDE GOVERNMENT

While no states have taken the sweeping steps that Montana took to reduce expenditures in its state employee health plan, some states are acting. Public employees in Colorado are joining with local businesses to demand better deals and utilize regional centers of excellence. The state of Indiana insisted that the TPA managing its employee health plan, which it put out for bid, create a preferred tier of providers who have agreed to accept payments that are a percentage of Medicare rates.

The reforms outlined in this chapter do not represent an all-or-nothing approach, and states can implement them in stages. For instance, a state may wish to start with demanding transparency of the TPA that manages the state employee health plan, requiring access to their claims data in order to perform deep dive analytics and attempt to minimize unnecessary and wasteful expenses.

There are two main obstacles to state employee health plan reform: obstacles within the government and obstacles outside the government. First, state bureaucracies tend to avoid actions that might upset public employees. State action to reform the state employee health plan might be framed by opponents of such action as a reduction in benefits. State government leaders often lack incentives to pursue meaningful state employee health plan reform, so it often takes leaders who are intensely interested in being wise stewards of public resources. Hiring the right people in positions such as budget director and head of the office of state personnel is crucial.

Second, the health care industry has enormous political power, and the status quo generates large industry profits. Properly structured reform would reduce profits of both health insurers and hospital systems, particularly the higher-priced ones, in the state. These industries will resist reform. For example, hospitals will strongly resist the recommended prohibition on inappropriate facility fee charges in the state employee health plan.

There is also another more practical obstacle—restructured benefit designs may generate confusion if there is not sufficient education about the changes. For example, while reference pricing holds the promise of large savings, plan enrollees need to be properly educated about how the structure works. States should make an expert or a professional service available to work with employees and family members if they need help in choosing providers. There are many applications and benefits experts who will help

employers educate employees and make shopping as easy as possible for plan members.

CONCLUSION

State governments have significant influence over the health policy within their state. One underappreciated way that government can affect policy in their state is by the design of their employee health plan. By taking the steps discussed in this chapter, states can improve the efficiency of their employee health plan. Such steps will produce external benefits in the state through both lower prices and providing a model of feasible reforms for private employers.

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