



cutting through complexity

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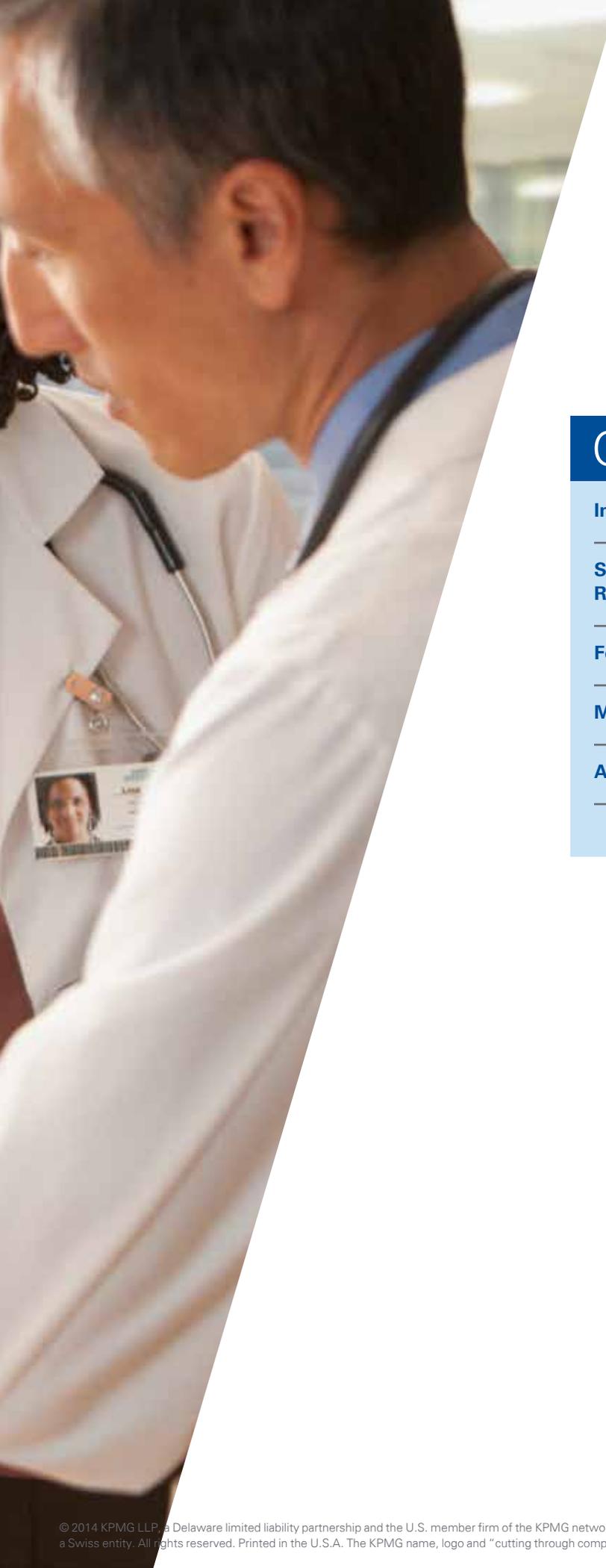
Value-based purchasing strategies for state employees

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Introduction

Rising healthcare costs and widespread variation in quality continue to be a growing concern for large employers and other purchasers of healthcare, including state governments. According to a new research study from the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, in 2013, states insured 2.7 million employee households, and states and their employees spent \$30.8 billion on premiums.¹ Like their private sector counterparts, states are looking for innovative and tested strategies to increase value by obtaining higher-quality care at more affordable prices for their covered populations, or health benefit plan members.²

¹ “State Employee Health Plan Spending,” (August 2014) The Pew Charitable Trusts, and the John D. and Catherine T. MacArthur Foundation, <http://www.pewtrusts.org/en/multimedia/data-visualizations/2014/state-health-plan-premiums-employee-contribution-arrangements-vary>

² Many states cover employees, their dependents, retirees, and sometimes employees, dependents, and retirees from other public agencies; while terminology differs from state to state, for purposes of this paper, we will refer to these covered populations as “members.”



To help shed some light on such strategies, the KPMG Government Institute partnered with Catalyst for Payment Reform (CPR), a nationwide nonprofit coalition focused on improving the value of healthcare for large employers and other healthcare purchasers, to reach out to several states to learn about their goals and efforts in this area. Over two months, we conducted research and interviews with a dozen state healthcare leaders and other experts, querying them about top concerns and purchasing and benefits strategies. We learned that value-based purchasing,³ along with benefit and network design, continue to be critical tactics for driving change.

Based on our research and interviews, we identified four strategies that progressive states are banking on:

- I. Steering members to high-performing providers, supported by price and quality transparency**
- II. Changing benefit designs to offer incentives (and disincentives) to members to lead healthier lives and choose high-value clinical care**
- III. Enhanced care coordination, including patient-centered medical homes (PCMHs) and Accountable Care Organizations (ACOs)**
- IV. Multipayer approaches to payment reform and delivery system redesign.**

We will explore each of these strategies in greater depth, offering specific examples of states taking action. Then we will suggest some questions state leaders should explore to help them gauge which strategies are right for them given the healthcare market dynamics in their state. To lay the groundwork first; we begin with a bit more background on states as purchasers of healthcare for public employees, retirees, and their dependents.

About the KPMG Government Institute

The KPMG Government Institute was established to serve as a strategic resource for government at all levels, and also for higher education and nonprofit entities seeking to achieve high standards of accountability, transparency, and performance. The Institute is a forum for ideas, a place to share leading practices, and a source of thought leadership to help governments address difficult challenges, such as effective performance management, regulatory compliance, and fully leveraging technology.

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³ We define value-based purchasing using a definition from the National Business Coalition on Health: Value-based purchasing is a “demand side strategy” to measure, report, and reward excellence in healthcare delivery. Value-based purchasing involves the actions of coalitions, employer purchasers, public sector purchasers, health plans, and individual consumers in making decisions that take into consideration access, price, quality, efficiency, and alignment of incentives. Effective healthcare services and high-performing healthcare providers are rewarded with improved reputations through public reporting, enhanced payments through differential reimbursements, and increased market share through purchaser, payer, and/or consumer selection.

States as purchasers of health coverage: Rising prices, richer benefits

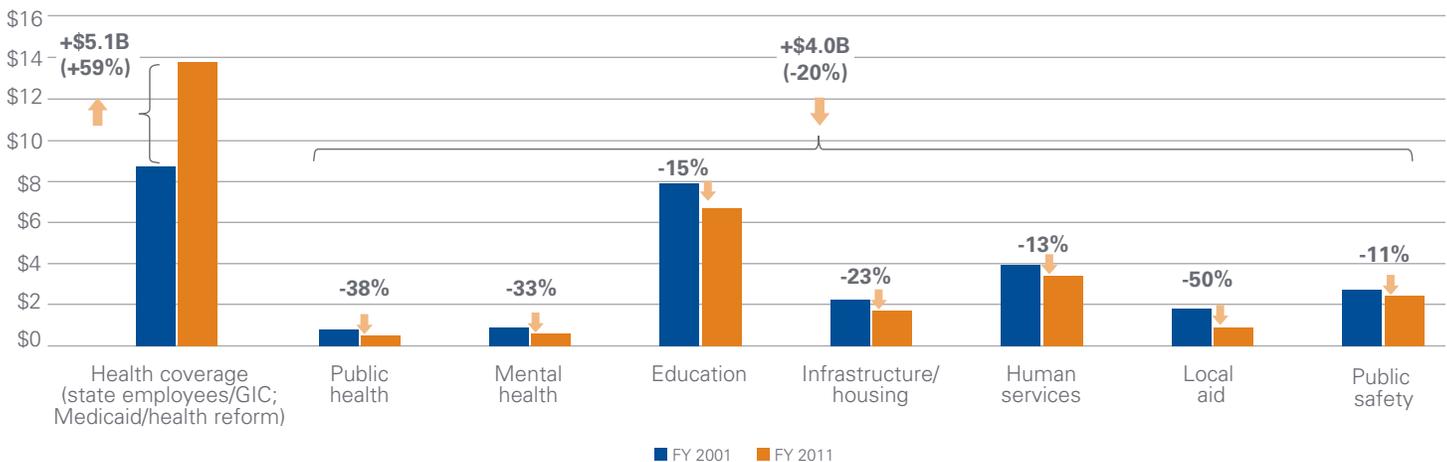
Employee health coverage is a major expense for states, and costs continue to rise

According to the Agency for Healthcare Research and Quality (AHRQ), there were almost 20 million people employed by both state and local governments in the United States in 2012, or about one-tenth of the U.S. workforce.⁴ According to the National Conference on State Legislatures (NCSL), at least half of states also provide for select other public employees to be covered under the same, or parallel, health benefit plans. Most commonly, states' health coverage programs

include city, town and/or county workers, and public school teachers and employees.⁵ According to a 2012 report from the Brookings Institution, state and local governments spent \$475.4 billion on healthcare in 2012, representing almost 35 percent of their collected tax revenue. About one-quarter of that spending was on employee health benefits for current employees (both on state and local employees), while 40 percent of that spending was for Medicaid, and approximately eight percent was for retiree health benefits.⁶ In 2013, states and employees paid \$30.8 billion in premiums for coverage of 2.7 million state employees.⁷

The increasing costs of healthcare squeeze out other public spending priorities in Massachusetts

STATE BUDGET, FY2001 VS. FY2011 (BILLIONS OF DOLLARS)



This snapshot of spending on healthcare for state employees and Medicaid in Massachusetts shows how increasing healthcare costs squeeze out spending on other programs. Dollar figures are inflation adjusted using a measure specific to government spending as developed by the U.S. Bureau of Labor and Statistics.

Source: Blue Cross Blue Shield Foundation of Massachusetts.

⁴ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2012 Medical Expenditure Panel Survey-Insurance Component. Table III.B.1

⁵ National Conference of State Legislatures: State Employee Health Benefits (Accessed May 16, 2014) <http://www.ncsl.org/research/health/state-employee-health-benefits-ncsl.aspx>

⁶ Boyd, Daniel, "The Potential Impact of Alternative Healthcare Spending Scenarios on Future State and Local Government Budgets" (April 11, 2014), Brookings Institution, Accessed May 15, 2014, <http://www.brookings.edu/research/papers/2014/04/11-health-care-spending-state-local-budgets-boyd>

⁷ "State Employee Health Plan Spending," (August 2014) The Pew Charitable Trusts, and the John D. and Catherine T. MacArthur Foundation, <http://www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/state-local-government-spending-on-health-care-grew-faster-than-national-rate-in-2012>



Did you know?...



- Almost one in every ten employees in this county has health coverage through a state or quasi-state agency.



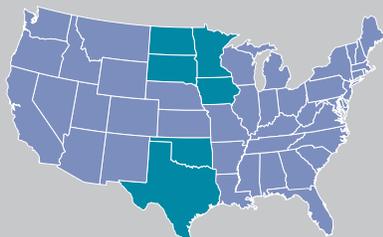
- States and local governments spend almost 35 percent of the tax revenue they collect on health coverage.



- The average state and local employee tends to be older and more expensive to insure compared to private sector employees.



- In 2013, six states paid 100 percent of the premium for employee-only coverage.



Total U.S. healthcare spending grew relatively slowly in 2012, rising about 4 percent, but healthcare spending by states and localities increased by 8 percent, according to data from Centers for Medicare and Medicaid Services (CMS).⁸ As Pew Charitable Trusts explains, “the most significant elements of this expansion were state and local contributions to public employee health insurance premiums and to Medicaid, which experienced inflation-adjusted increases of 444 percent and 375 percent, respectively.”⁹

⁸ Centers for Medicare and Medicaid Services, National Health Expenditure Accounts, “Sponsor Highlights,” January 2014, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>, and Bureau of Economic Analysis, National Income and Product Accounts, “Table 3.3, State and Local Government Current Receipts and Expenditures,” <http://www.bea.gov/iTable/iTableHtml.cfm?reqid=9&step=3&isuri=1&903=88>

⁹ “State, Local Government Spending on Healthcare Grew Faster Than National Rate in 2012” (January 2014) The Pew Charitable Trusts, State and Consumer Initiatives, <http://www.pewstates.org/research/reports/state-local-governmentspending-on-health-care-grew-faster-than-national-rate-in-2012-85899445452>

¹⁰ Dale H. Yamamoto, “Healthcare Costs—From Birth to Death,” Society of Actuaries (June 2013), <http://www.soa.org/Files/Research/Projects/research-health-care-birth-death-report.pdf>

On average, workers covered by state employee health benefits tend to be more expensive to insure because they are older, sicker, and a greater percentage are female.¹⁰ In 2010, state and local governments insured a higher proportion of older workers and dependents (defined as age 50 or above) and a greater proportion of females compared to private sector employers. Thirty-six percent of public sector health plan workers and dependents were ages 50–64, compared with 26 percent among private firms. Similarly, females were more predominant in the insured population of public employers (57 percent) than in that of private employers (51 percent), and people covered by public sector employers also had a higher prevalence of many chronic conditions than people covered by private sector employers.¹¹

States are significantly more likely to cover retiree and pre-retiree populations compared to private sector employers.¹² This can contribute overall to higher spending on health coverage for these populations—as states cover more people who are also typically more expensive to insure.¹³

Coverage for public sector employees may, in general, be more comprehensive than private sector coverage, contributing to the higher overall cost of coverage (and premiums). State health plans are generally “rich,” paying on average 92 percent of the typical enrollees’ healthcare costs. These plans would be designated “platinum” plans within the new health insurance marketplaces.¹⁴

¹¹ Truven Health Analytics, “Health Risk in the Public Sector Employer Population: Costs and Solutions” (April 2013), http://img.en25.com/WeWeb/TruvenHealthAnalytics/PublicVSPprivateWP_WEB_9751.pdf

¹² “State Employee Health Plan Spending,” (August 2014) The Pew Charitable Trusts, and the John D. and Catherine T. MacArthur Foundation, <http://www.pewtrusts.org/en/multimedia/data-visualizations/2014/state-health-plan-premiums-employee-contribution-arrangements-vary>

¹³ Maciag, Mike, “Public Sector Has Some of Oldest Workers Set to Retire” (August 23, 2013) *Governing*, <http://www.governing.com/blogs/by-the-numbers/gov-aging-public-sector-has-some-of-oldest-workers-set-to-retire.html> and McArdle, Frank & Tricia Neuman & Jennifer Huang, “Retiree Health Benefits at the Crossroads” (April 14, 2014) Kaiser Family Foundation <http://kff.org/report-section/retiree-health-benefits-at-the-crossroads-overview-of-health-benefits-for-pre-65-and-medicare-eligible-retirees/>

¹⁴ “State Employee Health Plan Spending,” (August 2014) The Pew Charitable Trusts, and the John D. and Catherine T. MacArthur Foundation, <http://www.pewtrusts.org/en/multimedia/data-visualizations/2014/state-health-plan-premiums-employee-contribution-arrangements-vary>

In 2013, the average per-employee per-month premium for coverage of employees with dependents was \$1238 per month. The average premium for employees only was \$571 per month.¹⁵

By comparison, the average per-employee-per-month premium for employee-only coverage in a “large” firm in the private sector was \$497 in 2013.¹⁶

The employee contribution to healthcare premiums is lower, on average, for state and local government employees than other employees. This may help compensate for the lower salaries public sector employees generally receive compared to their private sector peers.¹⁷

According to 2011 data, 27 percent of state and local government employees were covered by a Health Maintenance Organization (HMO), while 62 percent were covered by a Preferred Provider Organization (PPO).¹⁸ Since 1998, HMO enrollment has dropped sharply while PPO enrollment has increased.¹⁹ This is similar to the trend in the private sector, where a growing number of private employers are offering—and employees are choosing—PPOs because of their ability to offer more flexibility and provider choice.²⁰ And, like the private sector, a growing number of states are offering high-deductible plan options. In 2013, 19 states offered at least one plan with an annual deductible of \$1,500 or more, up from 16 states in 2011. Among those 19 states, a median of 7 percent of state employees enrolled in them. Nationwide, only 4 percent of state employees enrolled in such a plan. Forty-five percent were enrolled in plans with no deductible.²¹

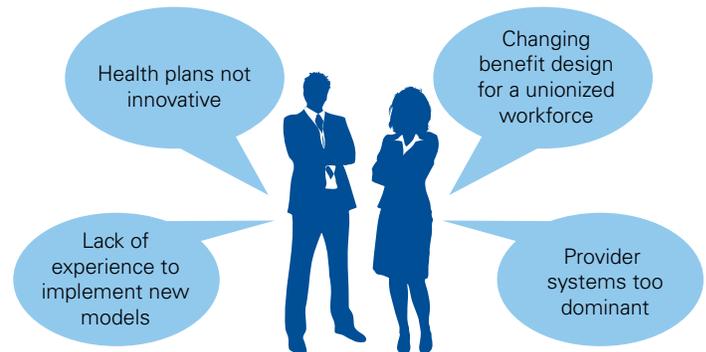
States face similar challenges and opportunities when they work to improve healthcare value

Over the course of two months, we interviewed leading staff and subject-matter professionals from 12 states and state-focused organizations, asking them about the challenges,

opportunities, and strategies for enhancing the value of healthcare (See Appendix I for a complete list of interviewees). Based on the interviews we conducted, a number of common themes emerged regarding both the challenges and opportunities states encounter in both benefit design for state employees and payment reform.

Top of mind for all healthcare leaders—and state leaders are no exception—is rising healthcare costs, including well-known cost drivers like chronic conditions and specialty drug prices. State leaders told us initial implementation of the Affordable Care Act has been challenging, with their staff working to understand and manage new regulations and policies.

Challenges top of mind for state healthcare leaders



Also, state leaders said that changing benefit design for a workforce that is often partially or fully unionized can be challenging. In addition, several leaders we spoke with expressed frustration that their health plans were not more innovative, especially in developing new models for payment. Some indicated they would like to try direct contracting²² but felt they lacked sufficient staff or expertise.

¹⁵ Ibid. Note: The report also points out that the average per-employee premium masks sharp differences across the states. Arkansas, Mississippi, New Mexico, South Carolina, and South Dakota, for example, had relatively low per-employee premiums, whereas the average per-employee premiums for Alaska, New Hampshire, New Jersey, Vermont, and Wisconsin were comparatively high.

¹⁶ Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013. This number from the Kaiser/HRET survey applies to firms of 200 or more employees and may not represent an “apples-to-apples” comparison with the research conducted for the Pew/MacArthur report. A better “apples-to-apples” comparison might come from examining the cost of employee coverage for very large firms, since these organizations would be closer in size to state employee agencies. Regardless, experts generally agree the cost of care and coverage for public employees is higher for public sector employees because of their demographics and health status.

¹⁷ Murray, Sara, “Public Employees Get More Benefits,” (July 28, 2010) *Wall Street Journal*. Available at <http://online.wsj.com/news/articles/SB10001424052748703292704575393301234839806>

¹⁸ National Compensation Survey, “How have health benefits changed in state and local governments from 1998 to 2011?” (U.S. Bureau of Labor Statistics, June 2012), *Beyond The Numbers, Pay & Benefits* 1(5). <http://www.bls.gov/opub/btn/volume-1/how-have-health-benefits-changed-in-state-and-local-governments-from-1998-to-2011.htm> (Accessed May 2014) <http://kff.org/other/state-indicator/single-coverage/>

¹⁹ Ibid.

²⁰ Japsen, Bruce, “HMOs Decline, Consumer Plans Rise as Health Insurance Option,” (September 17, 2012) *Forbes*. Available at <http://www.forbes.com/sites/brucejapsen/2012/09/17/hmo-declines-consumer-plans-rise-as-health-insurance-option/>

²¹ “State Employee Health Plan Spending,” (August 2014) The Pew Charitable Trusts, and the John D. and Catherine T. MacArthur Foundation, <http://www.pewtrusts.org/en/multimedia/data-visualizations/2014/state-health-plan-premiums-employee-contribution-arrangements-vary>

²² Direct contracting essentially involves an employer or purchaser contracting directly with a provider system, so that system can care for the employer/purchasers’ members or employees and get paid to deliver that care directly. The health plan, which typically acts as the agent completing provider contacts, is removed as the “middle man.”

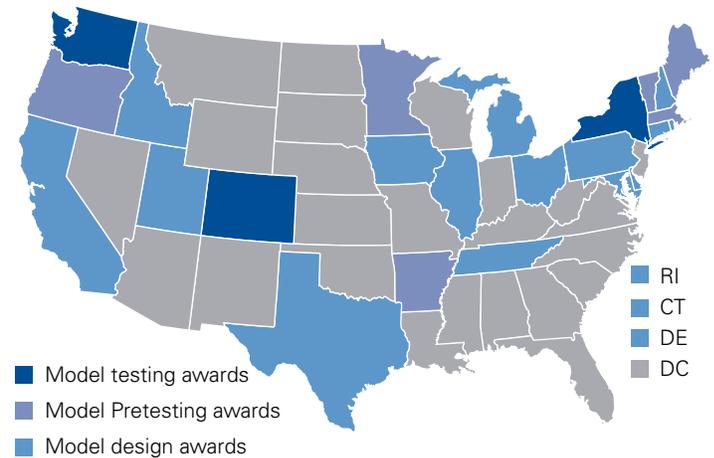
Almost every state leader with whom we spoke indicated at least some region or regions within their state had a dominant provider system or systems powerful enough to dictate prices and the terms of contracts, making it difficult to reduce spending, implement new payment models, and/or benefit designs.

Research has consistently shown that in regions where a provider system or systems have significant market power, those providers can set higher prices and demand participation in networks, among other competitive advantages. Finally, a number of leaders discussed a concern that there is a lack of evidence, or demonstrated return on investment (ROI), for specific payment models and benefit design changes, especially regarding wellness programs.

The leaders we interviewed cited unique opportunities due to the fact that state employee populations are relatively stable, often participating in their health benefits programs for life. While this means state employee agencies must absorb the costs that come with an aging population, it also means they can innovate with programs like wellness incentives that may yield ROI over a long-time horizon. Some leaders we spoke with also felt the relative size of their covered population gave them strength in healthcare markets, especially when working with health plans and provider systems. Some leaders were optimistic they had the size and resources to partner with other payers, notably Medicaid, to work on significant changes to payment and delivery system reform. Some leaders

also noted they faced promising new opportunities from the State Innovation Model (SIM) grants from the Center for Medicare and Medicaid Innovation at CMS. CMS is

State innovation model initiative states



Source: Centers for Medicare and Medicaid Services

spending up to \$300 million to support the development and testing of state-based models for multipayer payment and healthcare delivery system transformation with the aim of improving health system performance for residents of participating states.²³

²³ Centers for Medicare and Medicaid Services, "State Innovation Models Initiative: General Information," <http://innovation.cms.gov/initiatives/state-innovations/>

Four promising strategies for states

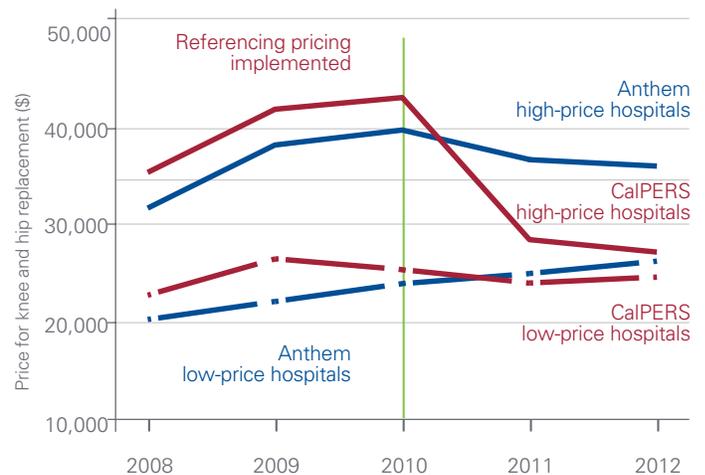
Based on our interviews with leading staff, subject-matter leaders and other research, the following four strategies emerged as promising avenues for states to pursue. Some of these have already been shown to reduce costs and improve healthcare quality for covered populations. Others appear promising, but additional time, exploration and evaluation is required to judge their success.

I. Steering members to high-performing providers, supported by price and quality transparency

Like their private sector counterparts, state health benefits leaders recognize that there is wide variation in healthcare quality with little correlation to price. Savings can be realized when members are encouraged to use high-quality, efficient, lower-priced providers (to the extent such providers can be identified). This can take several different forms. Purchasers can offer lower premiums and/or cost sharing in return for employees seeking care from healthcare providers shown to deliver higher-quality care more efficiently and affordably (purchasers can use an array of quality and efficiency metrics to measure this, as described in further detail below). Such strategies require employers to support employees and members with meaningful information about price and quality. But with the right benefit design and effective transparency tools in place, there is an opportunity to implement reference pricing, as well as narrow, limited and tiered networks.

The example of California Public Employees Retirement System (CalPERS)' experience with reference pricing may be the best known.²⁴ CalPERS, which buys healthcare for state employees, contracting agency and school employees and retirees in California, successfully shared price information on

CalPERS: Prices paid for knee and hip replacement surgery in high-price and low-price California hospitals, 2008–12



Source: *Health Affairs*²⁴

providers offering hip and knee replacements with CalPERS members throughout California, set a reference price for the procedures of \$30,000, and then asked members to pay the difference if they visited a more expensive provider. Member education about prices and price variation, and assurance that a high quality provider would always be available in the region, were significant parts of the program.²⁵ As a result, CalPERS saved \$5.5 million over the first two years of the program.²⁶

²⁴ Robinson, James C and Timothy T Brown, "Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices For Orthopedic Surgery," (August 2013) *Health Affairs* 32(8) Available at <http://content.healthaffairs.org/content/32/8/1392.abstract>

²⁵ David Cowling, Presenter, Alliance for Health Reform, WellPoint, "Reference Pricing: Will Price Caps Help Contain Healthcare Costs?" November 18th, 2013, transcript available http://www.allhealth.org/briefingmaterials/REFERENCEPRICINGTRANSCRIPT_Z1.PDF

²⁶ Ibid.



The Group Insurance Commission (GIC) is a purchaser of health benefits for approximately 425,000 state employees, retirees, and dependents in Massachusetts and is a good example of a state agency using limited networks and tiering to drive members to higher-value care. As described in a recent Health Affairs article about the state,

"In limited-network products, enrollees must obtain care from hospitals and physicians that an insurer designates as offering good quality at a reasonable cost; enrollees are not covered for care outside the designated network. In tiered-network products, enrollees may receive care from non-preferred providers, but doing so involves additional cost sharing—which can be thousands of dollars if enrollees obtain care from providers in the highest-cost tiers... The GIC, which manages state employee health benefits, has been a major force behind tiered-network products in Massachusetts."²⁷

Since 2004, GIC worked with Massachusetts health plans to evaluate the efficiency and quality of specialists to create a standard set of performance measures that could be used to steer patients toward high-value providers and encourage low-value providers to improve. Each health plan used a standard set of performance measures, placing preferred, high-performance providers in higher tiers and more poorly performing providers in lower tiers. A visit to a low-tier provider will cost a member significantly more.

Since 2007, GIC has also offered active state employees an array of limited network plans. Today, each health plan has to offer a limited network, which is 20 to 30 percent less expensive (these typically have fewer providers, and high-cost providers are excluded).²⁸

As reported in Health Affairs, enrollment in these options has more recently increased:

"In 2011 the GIC began a new effort to encourage enrollment in its lower-cost products by offering a three-month premium "holiday" for employees who selected one of six limited-network options. In fiscal year 2012, 31 percent of state workers selected such an option, compared to 19 percent in the prior year. Also, in July 2011 the state's health insurance exchange, the Massachusetts Health Connector, began requiring that all new beneficiaries eligible for fully subsidized coverage enroll in one of its two limited-network plans."²⁹

Massachusetts has been able to keep its rates of healthcare spending on state employees relatively low due to a variety of cost control strategies that include offering limited networks and tiering to state employees. According to the Massachusetts Budget and Policy Center, "the decline in spending (on state employee health in the FY2013 budget) is largely the result of GIC efforts to hold down premium cost increases in recent years through a variety of strategies, such as encouraging state employees to choose health plans with limited networks. Last spring the GIC announced that the average premium increase for employee health coverage for next year will be 1.4 percent, the lowest since 1999."³⁰

Limited networks can also be a useful strategy in regions with a dominant provider system or systems, where that system is a "price-maker," not a "price-taker." Encouraging employees and members to join a limited network plan option—that may not include that dominant, expensive provider system—can help rein in costs.

²⁷ Mechanic, Robert E, Altman, Stuart H and John E McDonough, "The New Era of Payment Reform, Spending Targets, and Cost Containment in Massachusetts: Early Lessons for the Nation," (September 2012) *Health Affairs*. Available at <http://content.healthaffairs.org/content/early/2012/09/17/hlthaff.2012.0338.full>

²⁸ Dolores Mitchell of Group Insurance Commission of MA, telephone interview with authors, April 28, 2014

²⁹ Mechanic et al. 2012 Available at <http://content.healthaffairs.org/content/early/2012/09/17/hlthaff.2012.0338.full>

³⁰ Massachusetts Budget and Policy Center, "Budget Monitor: Healthcare," (2013) http://www.massbudget.org/reports/includes/832/health_care.pdf

Crafting provider networks to help improve care quality and manage costs

There are many different types of network strategies employers and purchasers can use to help achieve their goals of reducing costs and improving the quality of care. For example, in very high-cost regions of the country like Massachusetts, limited networks can help contain costs in a state where historically high costs have no demonstrated correlation to provider quality. Purchasers may also choose to use a narrow network for a very specific service, such as cardiac care. Tiered networks can help consumers understand variation in provider costs and quality, when high-quality, affordable providers are placed in the “more desirable” tier, (often with the lowest cost sharing). While it is not likely one network of providers will offer best-in-class care at the lowest cost for every service, these strategies can challenge the healthcare system to improve care quality and hold down costs.

However, according to NCSL, states wishing to pursue this strategy for the future may encounter a new factor: existing or proposed state laws. Since the passage of the ACA, there is a rise in the number of bills being introduced by state legislatures that would regulate the use of limited or narrow provider networks. For example, a new Michigan law states, “Beginning Jan. 1, 2014, an insurer (or healthcare corporation) shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the commissioner pursuant to federal law.”³¹ However, such measures are aimed at curbing denial of necessary medical services, and usually would not prevent “high-performance” options or HMO models.³²

Some healthcare providers may lobby against efforts to create tiered, narrow, or limited networks; consumer advocates pushing for choice may do so as well. As health plans worked to create narrow networks in the new state exchanges, there was strong pushback from state legislators and consumer advocates concerned about access and consumers needing to switch providers.³³

The influx of narrow network products on the new public exchanges and the visibility of the GIC’s efforts mean that we are likely to see more of these select network strategies in the near term. There is no doubt that when used strategically, they can help a purchaser reduce spending and potentially steer members to high-value providers, particularly for specific services. But longer term, these select network strategies may be an insufficient band-aid and, if the providers are not selected

just right, could potentially lead to higher costs. Payers need to create the right incentives for all providers to offer high-quality, lower-cost care, which will require payment models that reward providers for value, not volume. More research is needed to determine which payment models work best, and in what circumstance.

Payment reform: When does it work?

Payment reform is neither a monolithic concept, nor a silver bullet for the problems plaguing our healthcare system. For a number of payment reform models, including pay-for-performance, PCMHs, ACOs, and bundled payment, more studies of these models “in action” are required to determine when, where, and how they are most effective at reducing costs and improving care quality.³⁴ Many of the public leaders we interviewed expressed a desire for more detailed data and evidence about how and when specific models are likely to work best.

II. Changing benefit designs to offer incentives (and disincentives) to members to lead healthier lives and choose high-value clinical care

As discussed above, a number of states offer members financial incentives (and disincentives in the form of higher co-pays) to help direct them to higher-value providers, but a number of the state leaders and experts we talked to said states also rely on financial levers to help drive members toward desired health behaviors, and toward the use of high-value clinical services. For example, many states have wellness programs that give members incentives (“carrots”) to help avoid chronic disease or to improve chronic disease self-management, and also have penalties (“sticks”) to discourage undesirable health behaviors, like smoking.

Most of the leaders we interviewed expressed belief that achieving a positive ROI on healthcare spending from these “carrot” programs relies on 1) targeting appropriate clinical populations; 2) allowing an appropriate time horizon to capture offsets in hospitalizations and emergency room (ER) visits; and 3) alignment of consumer engagement incentives with those in place for providers (e.g., pay-for-performance metrics). They also found that programs offering incentives in the wellness and chronic disease management categories may actually add costs, at least in the short term. But given many employees are covered by the state long term, even for life, most of the leaders we spoke to believe these efforts will result in ROI.

They also feel increased pressure from legislatures to make wellness a priority.³⁵

³¹ <http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx>

³² Dick Cauchi and Ashley Noble of NCSL, interview with authors, April 30, 2014

³³ Jay Hancock, “Narrow Networks Trigger Pushback from State Officials,” (November 25, 2013) Kaiser Health News, <http://www.kaiserhealthnews.org/stories/2013/november/25/states-balk-at-narrow-networks.aspx>

³⁴ Delbanco, Suzanne. “The Payment Reform Landscape,” Health Affairs Blog, September 30, 2014, http://healthaffairs.org/blog/author/suzanne_delbanco/

³⁵ Dick Cauchi and Ashley Noble of NCSL, interview by authors, April 30, 2014

They may also reap more immediate benefits if wellness programs reduce employee absenteeism.

The Pennsylvania Employee Benefit Trust Fund (PEBTF) is an example of an agency with a history of using a simple benefit design and incentives to steer members toward a desired behavior. For many years, PEBTF has offered first dollar coverage for physicals to try and encourage members to get an annual exam (this is now required under the ACA). Beyond this, PEBTF also offers members financial incentives to participate in wellness and disease management programs. PEBTF recently launched a “Know Your Numbers” campaign that required members to get a wellness screening—to know their numbers such as cholesterol and blood pressure—to receive a reduction in their premium contribution rate. PEBTF saw an exceptionally high participation rate from members — 80 percent—and will now be expanding the program to include spouses.³⁶

According to NCSL, a number of states offer financial incentives to employees who participate in wellness programs and health risk assessments (HRA), which can include everything from rewards like additional paid time off, to reductions in health premiums.³⁷ At least 10 states offer some type of incentive for weight loss.³⁸ Maine offers a credit for completing an HRA and for selecting a primary care physician.³⁹ Some states have also used a “stick” approach, penalizing employees for undesirable behaviors; for instance, a handful of states have levied premium surcharges on smokers.⁴⁰ Offering carrots instead of sticks may be easier for states, especially when they have to negotiate benefits with unions who have a history of opposing benefit design changes like increased cost sharing.

The role of unions in benefit design

About half of all state workforces are unionized, making changes to benefits a negotiated process rather than a unilateral decision. Most of the state leaders with whom we spoke indicated that getting unions to approve benefit design changes, especially those that raised employee cost sharing, or limited network options, were usually challenging. Some union organizations have publicly opposed cost-sharing in healthcare. Some states may find offering incentives instead of financial penalties or cost sharing to be easier.

³⁶ Kate Farley of PEBTF, interview by authors, May 7, 2014

³⁷ National Conference of State Legislatures, “Wellness Programs for State Employees Becoming More Widespread” (Accessed May 15, 2014) <http://www.ncsl.org/research/health/state-employee-health-benefits-ncsl.aspx> – Wellness

³⁸ George Washington University, Dept. of Health Policy, “State Employee Health Benefits Coverage for Weight Loss Interventions” (Accessed May 15, 2014) Compiled for Strategies to Overcome and Prevent (STOP) Obesity Alliance http://www.stopobesityalliance.org/wp-content/themes/stopobesityalliance/pdfs/State_Employee_Health_Benefits_Plans_Treatment_of_Obesity_Interventions.pdf

³⁹ Christine Brawn of Maine, telephone interview by authors, May 1, 2014

⁴⁰ National Conference of State Legislatures, “Smoking Cessation Programs” (Accessed May 15, 2014) <http://www.ncsl.org/research/health/state-employee-health-benefits-ncsl.aspx>

In addition, some states have had success implementing value-based insurance design (V-BID) for their employees. According to the University of Michigan Center for Value-Based Insurance Design, the premise behind V-BID is to reduce barriers to high-value clinical services (and providers), and discourage the use of lower-value services and providers. V-BID is driven by the concept of “clinical nuance” which recognizes that: (1) medical services differ in the benefit they provide to the patient, and (2) the clinical benefit derived from a specific service depends on the characteristics of the patient receiving it, who provides it, and where the service is delivered. Plans incorporating V-BID establish lower cost sharing on high-value services, drugs, providers, and settings as a means to increase utilization of care producing a worthwhile investment in health.⁴¹

Historically, these states have had success using V-BID for high-value prescription drugs—for example, charging lower co-pays for highly effective diabetes medication. A recent *Health Affairs* review of 14 “carrot only” V-BID programs reported that targeted copayment reductions led to improved medication adherence, lower consumer out-of-pocket costs, and no increase in total spending for payers.⁴² But similar to wellness initiatives, V-BID programs are more likely produce a positive ROI over a longer time horizon, as it takes time to reap the benefits of preventing expensive complications due to chronic conditions.⁴³ Given the success with high-value prescription drugs, more states are beginning to expand the V-BID concept across the care continuum, such as offering lower cost sharing for recommended clinician visits for specific conditions, guideline-based laboratory testing and durable medical equipment (e.g., blood pressure cuffs and spirometers for asthma) as well as recommended ancillary services, such as eye examinations for individuals with diabetes mellitus.

For example, in 2012, Connecticut introduced the Health Enhancement Program (HEP) for state employees, based on V-BID principles. HEP rewards employees financially for completing activities desirable for their health, such as getting dental cleanings and participating in appropriate chronic disease management services. State employees, in turn, pay lower premiums and co-pays and can even receive bonus incentive payments. HEP has noted some early success, such as fewer ER visits, better medication adherence, and a slowing of the rate at which healthcare spending is increasing.⁴⁴

The National Governors Association is currently working with the University of Michigan V-BID Center and several states to summarize these programs and their learnings.

⁴¹ The University of Michigan Center for Value-Based Insurance Design, “V-BID in Action: A Profile of Connecticut’s Health Enhancement Program” Brief, January 2013, http://www.sph.umich.edu/vbidcenter/publications/pdfs/V-BID%20brief_CT%20HEP%20final.pdf

⁴² Lee, Joy L, and Mattew L. Maciejewski, Shveta S Raj, William H Shrank and Nltees K Choudhry, “Value Based Insurance Design: Quality Improvement But No Cost Savings,” (July 2013) *Health Affairs* 32(7). <http://content.healthaffairs.org/content/32/7/1251.full>

⁴³ Mark Fendrick, Center for Value Based Insurance Design, interview with authors May 14, 2014

⁴⁴ Ibid.

III. Enhanced care coordination, including patient-centered medical homes (PCMHs) and Accountable Care Organizations (ACOs)

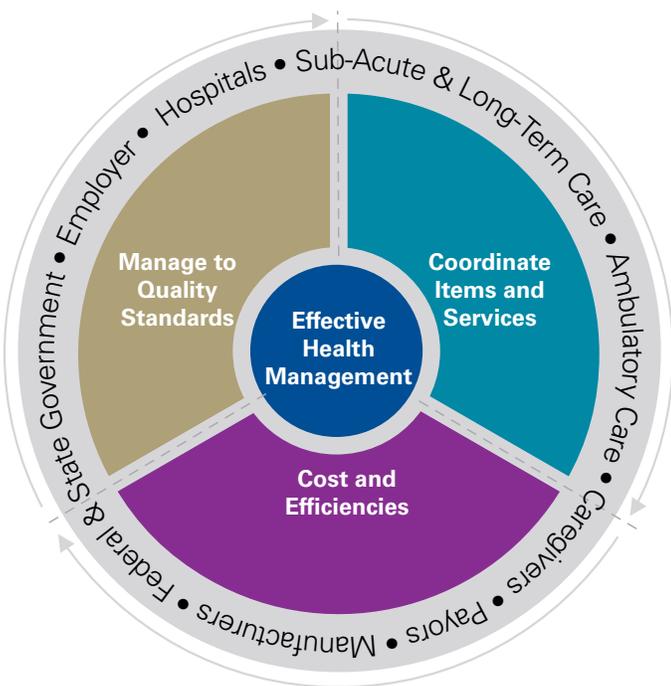
The third strategy that emerged from our interviews was investment in care coordination, especially since many state employees stay in their jobs for many years; those who “vest” into the system may even receive health coverage for life. Enhanced care coordination includes models such as ACOs, PCMHs, and other integrated care models where providers have financial incentives to manage care for their patients. These strategies tend to focus heavily on primary care, as well as better management of chronic conditions.

In 2010, CalPERS launched an “integrated care model” serving 40,000 members in the greater Sacramento region. Working with a health plan and provider systems, the parties achieved \$15.5 million in savings that year, while also reducing bed days, average length of stay, and readmissions. CalPERS is now expanding the model to other markets in the state.⁴⁵

New York has had success using care teams in the Adirondack region as part of the Adirondack Region Medical Home Pilot. This collaborative is a public-private effort, headed by New York State’s Department of Health in conjunction with multiple payers, including the New York State Health Insurance Program (NYSHIP), which covers state and local government employees and retirees, to promote preventive care and enhance management of chronic conditions in upstate New York. The pilot will officially be evaluated next year. Informally, NYSHIP reports that it is seeing good ROI—as much as two-to-one—especially with respect to a decrease in ER visits and increased use of generic drugs.⁴⁶

The Employees Retirement System of Texas (Texas ERS) has also had a positive experience with the PCMH model; they pay participating provider groups a per-participant-per-month fee to manage and coordinate care.⁴⁷ The medical groups in turn are expected to use these fees to hire care coordinators; they can share in savings when they meet or exceed quality and cost thresholds. Approximately 45,000 covered individuals are enrolled in the medical homes currently offered through four provider groups. Participating provider groups are held accountable for the total cost of care—not just that delivered by the medical group. Results show that the medical groups are producing healthcare costs lower than the surrounding markets by 6 to 12 percent, even after adjusting for demographic difference.⁴⁸ Texas ERS also sets performance targets designed to reduce the health benefit cost while meeting quality standards of care. The PCMH projects have successfully reduced the health benefit cost below their ERS-prescribed performance targets, saving the state an estimated \$11 million in FY12 and \$17 million in FY13. Savings are also shared with the provider systems. In general, drug therapy costs for the PCMH projects rose, but there were significant decreases in other services, such as inpatient hospital stays.⁴⁹

Components of an ACO



⁴⁵ Doug McKeever of CalPERS, telephone interview with authors, April 28, 2014

⁴⁶ Robert Dubois of NYSHIP, telephone interview with authors, April 21, 2014

⁴⁷ “Participant” can refer to covered employees as well as their dependents.

⁴⁸ Rob Kukla of Texas ERS, telephone interview with authors, May 21, 2014

⁴⁹ Texas Employees Group Benefits Program, “Cost Management and Fraud Report FY2013,” http://www.ers.state.tx.us/About_ERS/Reports/2013_Cost_Management_Report/

Provider market power

Almost every state leader we interviewed mentioned they encountered significant provider market power in at least one region of their state. Consolidation among healthcare providers in U.S. healthcare markets has become ubiquitous, and healthcare economists broadly agree that provider consolidation is a major driver of price increases. In regions with a dominant provider system, that system can essentially become a “price-maker” instead of a “price-taker.” Strategies that may work particularly well to encourage patients to seek care from high-value providers within regions with strong provider market power include:

- Tiered and narrow networks
- Price transparency with benefit design such as reference pricing
- Value-based insurance design
- Direct contracting with providers

IV. Multipayer approaches to payment reform and delivery system redesign

Finally, a number of the leaders we interviewed indicated that multipayer collaborations may show to be an effective strategy for reducing costs and improving the quality of care; several states offer promising models. Many of these efforts are supported, at least in part, by State Innovation Model grants from CMS’s Center for Medicare and Medicaid Innovation.

Arkansas Medicaid, the Arkansas Department of Human Services, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas partnered to create the Arkansas Healthcare Payment Improvement Initiative (APII). Under the initiative, payers will eventually designate “accountable providers” for specific patients for specific episodes of care, and those providers will be eligible for shared savings (or shared risk) depending on the quality and cost of care they deliver. The APII aims to reduce spending by 10 percent (with a corresponding reduction in trend) and have 80 percent of Arkansans in medical homes by 2017.⁵⁰

In California, as part of the state’s SIM grant work, CalPERS is working with Medi-Cal and Covered California on initiatives for maternity care; they are discussing opportunities to use bundled payment to encourage appropriate care and reduce unwarranted cesarean deliveries. In addition, they are encouraging providers to participate in the California Maternal Quality Care Collaborative.⁵¹

Tennessee’s Division of Benefits Administration, which covers state, local, and education employees, and TennCare, the state’s Medicaid agency, along with the state’s commercial insurers, are working together on a payment and delivery system reform initiative designed to affect 80 percent of the states’ residents within the next five years. The work is also part of the SIM grant for the state. Tennessee is starting with retrospective episode-based payments for care episodes such as hip and knee replacement and perinatal care. There is also a focus on moving residents into PCMHs as well as plans to change long-term care. Overall the state anticipates cost avoidance of approximately \$1.1 billion after delivery system reinvestments across the healthcare system during the three-year grant period.⁵²



⁵⁰ Welborn, Sally & Joseph W. Thompson, “Building a healthier future for all Arkansans,” March 19, 2014, slide presentation shared with authors

⁵¹ Doug McKeever, CalPERS, interview with authors, April 28, 2014

⁵² Tennessee Healthcare Innovation Plan, Working Draft, December, 9 2013 <http://www.tn.gov/HCFa/forms/SHIP.pdf>

Maximizing value: Which strategy fits best?

While there are many variables that affect which payment reform options and benefit designs are best suited to a particular state, taking inventory of its existing programs and environment and of the “market forces” in play will better help a state to identify the most critical variables.

From the state as employer perspective, successful payment reform implies tackling five key components:

Transparency

- Transparency is the foundation of any value improvement endeavor
- The quality and cost of the care delivered to members (e.g., diabetic care, hip replacement, breast cancer care) should be known (this can be largely established using already available data)
- Members should have access to this information when selecting plans and choosing providers

Provider incentives

- Aligning incentives to reinforce desired outcomes
- Providers delivering care to members should be incentivized to deliver excellent outcomes at low cost
- Care management and coordinator should be integrated in provider’s activities and focus, not superimposed on them

Primary care

- Moving care “upstream” increases value
- Primary care, including preventative services, occupational health, and care coordination should be readily available and accessible
- Primary care should coordinate access to and ensures adequate utilization of specialist care

Member incentives

- Aligning incentives to reinforce desired outcomes
- Are incentives in place to stimulate health lifestyle choices?
- Are incentives in place to choose high-quality, low-cost care providers?

Payer alignment

- Payer alignment will reduce administrative costs and increases impact
- Does the state align its efforts for delivery and payment reform across the domains where it is purchasing, regulating, or reforming care (Medicaid employees’ health plans, exchanges, multipayer reform plans)?



Take a “self”-inventory

State leaders can start by assessing their existing programs and environment using the five dimensions shown in the graphic on the previous page. Do members have a relatively high degree of price and quality information available to them? If so, your state may be well positioned to try reference pricing, or limited networks, along the lines of CalPERS’ and GIC’s efforts. If not, states can take further steps to support transparency for their members, looking to states like Massachusetts, Maine, and New Hampshire as models.⁵³

Are members being given the right incentives to stay well and seek recommended care? Connecticut’s HEP program may provide a useful model in this area.

Are your existing payment models offering incentives to providers to deliver high-value care? Are there incentives for primary care? If not, this is an important place to start. You may find useful models for fostering care coordination in the work of CalPERS, Texas ERS, and NYSHIP.

Are your payment models in alignment with other major payers, including the state’s Medicaid program and the private sector? Arkansas and Tennessee offer powerful examples of agencies working together and aligning payment.

Examine the dynamics of the market

Experts agree that local providers, health plans, employers, and other healthcare purchasers can have a huge impact on the success or failure of various payment reform models in a given market. The interplay of who has power in the market—who is calling the shots—may make all of the difference in

identifying what payment reform options are available or which should be tried first. Catalyst for Payment Reform developed a comprehensive Market Assessment Tool (MAT) to help healthcare stakeholders understand the type of market⁵⁴ they operate in and the best possible course forward for payment reform.⁵⁵

Most states contain more than one distinct healthcare market, and while it is difficult not to implement uniform reforms across the state, it may be beneficial to consider the dynamics of each major market before devising a plan for the state.

State leaders should consider which stakeholders are most influential, either on a statewide basis or in specific regions of the state and what implications that has for reform strategies.

For example, in a region with a dominant provider system, the state may wish to pursue a limited network strategy. If a provider system is eager to partner, the state may wish to create an ACO, similar to the Texas ERS approach. In a region with a large and powerful employer, the state agency may wish to collaborate in a multisector initiative.

What is next?

As healthcare costs continue to rise, states, like private employers, remain very concerned about how they will continue to afford to buy healthcare for public employees and retirees. Some of the models we outline have already shown that they can cut costs or reduce the trend in the growth of healthcare costs. State leaders are hopeful that other strategies, like investing in wellness, will also pay off over the long term.

⁵³ Catalyst for Payment Reform and Healthcare Incentives Improvement Institute, “Report Card on State Price Transparency Laws,” (March 18, 2013). <http://catalyzepaymentreform.org/images/documents/reportcard.pdf>

⁵⁴ While there is not one specific definition for a healthcare market, we define a healthcare market as a specific geographic area where healthcare services are provided and accessed by the local population. In some cases, this may be a city, and in some areas of the country, a county or an even larger region where the population may travel a significant distance to routinely access health services.

⁵⁵ More information about CPR’s Market Assessment Tool is available at <http://www.catalyzepaymentreform.org/2013-03-03-05-08-38/2013-03-03-05-10-43/market-assessment>

Appendix I – Interviewees

We would like to thank all of those that put in the time to share their invaluable insights and experiences (in alphabetical order):

- Christine Brawn, Executive Director, Office of Employee Health and Benefits, Maine Bureau of Human Resources
- Richard Cauchi, Program Director, Health, National Conference of State Legislatures (NCSL)
- Robert Dubois, Director, Employee Benefits Division, New York State Health Insurance Program (NYSHIP)
- Kathryn Farley, Executive Director, Pennsylvania Employee Benefits Trust Fund (PEBTF)
- Mark Fendrick, MD, Director, Center for Value Based Insurance Design
- Anne Gauthier, Senior Program Director, National Academy of State Health Policy (NASHP)
- Jason Hsieh, Program Director, National Governors Association (NGA)
- Robert Kukla, Director, Benefits Contracts, Employees Retirement System, Texas (ERS)
- Laurie Lee, Executive Director, State of Tennessee, Benefits Administration
- Douglas McKeever, Chief, Health Policy Research Division, California Public Employees Retirement System (CalPERS)
- Dolores Mitchell, Executive Director, Group Insurance Commission, Commonwealth of Massachusetts (GIC)
- Ashley Noble, JD, Research Analyst, Health Program, National Conference of State Legislatures

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