



Public Sector Medical Plans and Provider Networks

National Health Policy Forum
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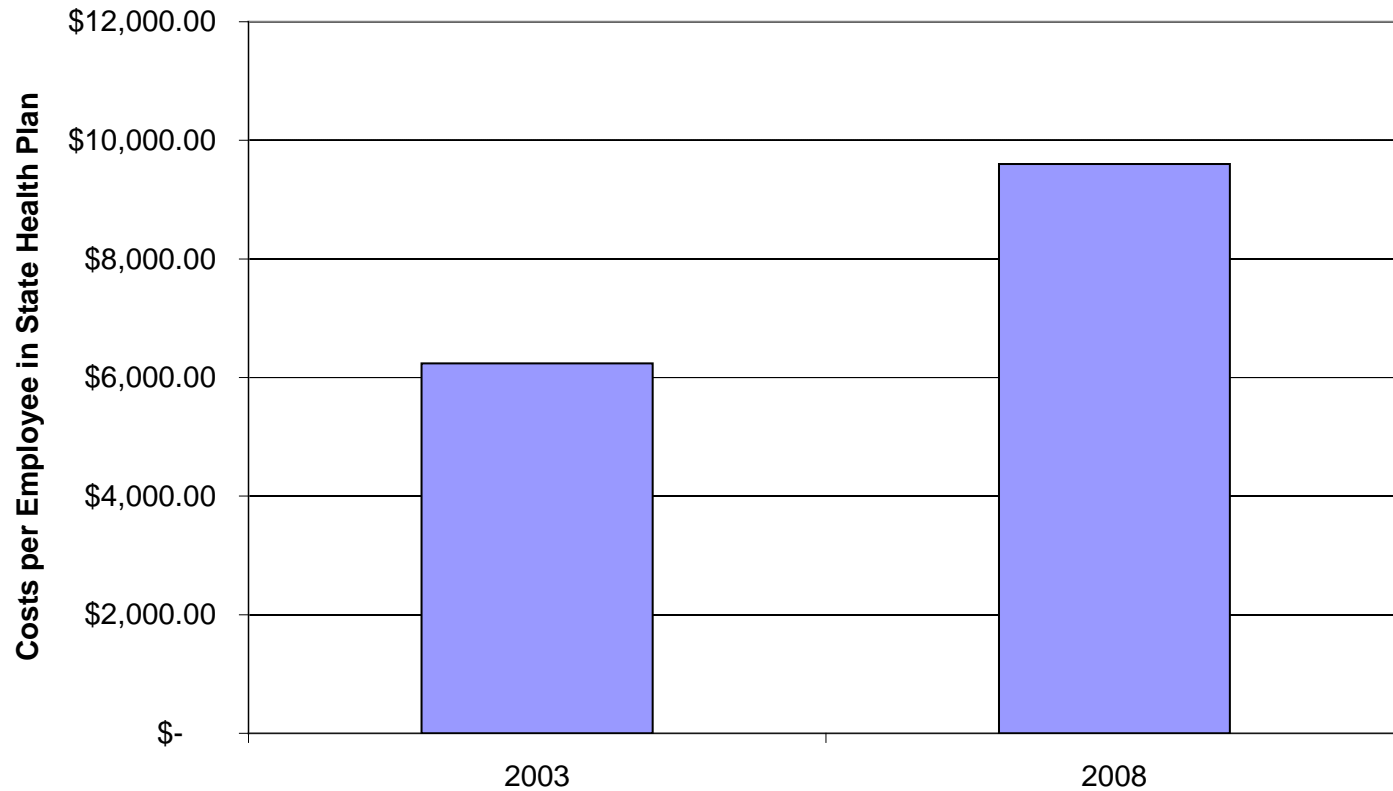
- Financial realities of Tennessee's public sector plans
- Challenges to our ability to maintain **comprehensive**, **affordable** and **dependable** coverage in the future
- Is the status quo sustainable?
- Discussion of proposed solution

Per Employee Costs Rose 54% in 5 Yrs



State Plan Spent \$9,600 Per Employee in 2008

(54% Increase from \$6,238 in CY 2003 to \$9,600 in CY 2008)

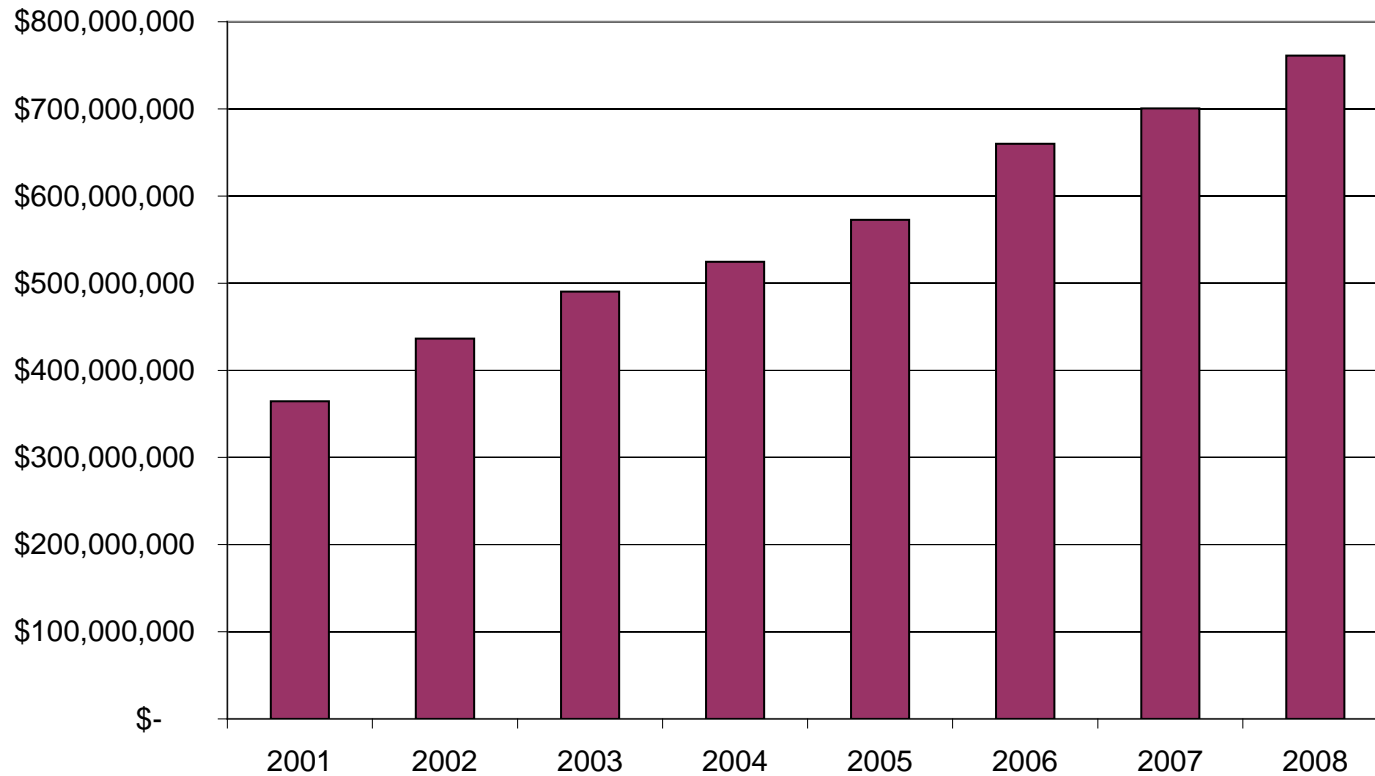


Costs Continue to Rise

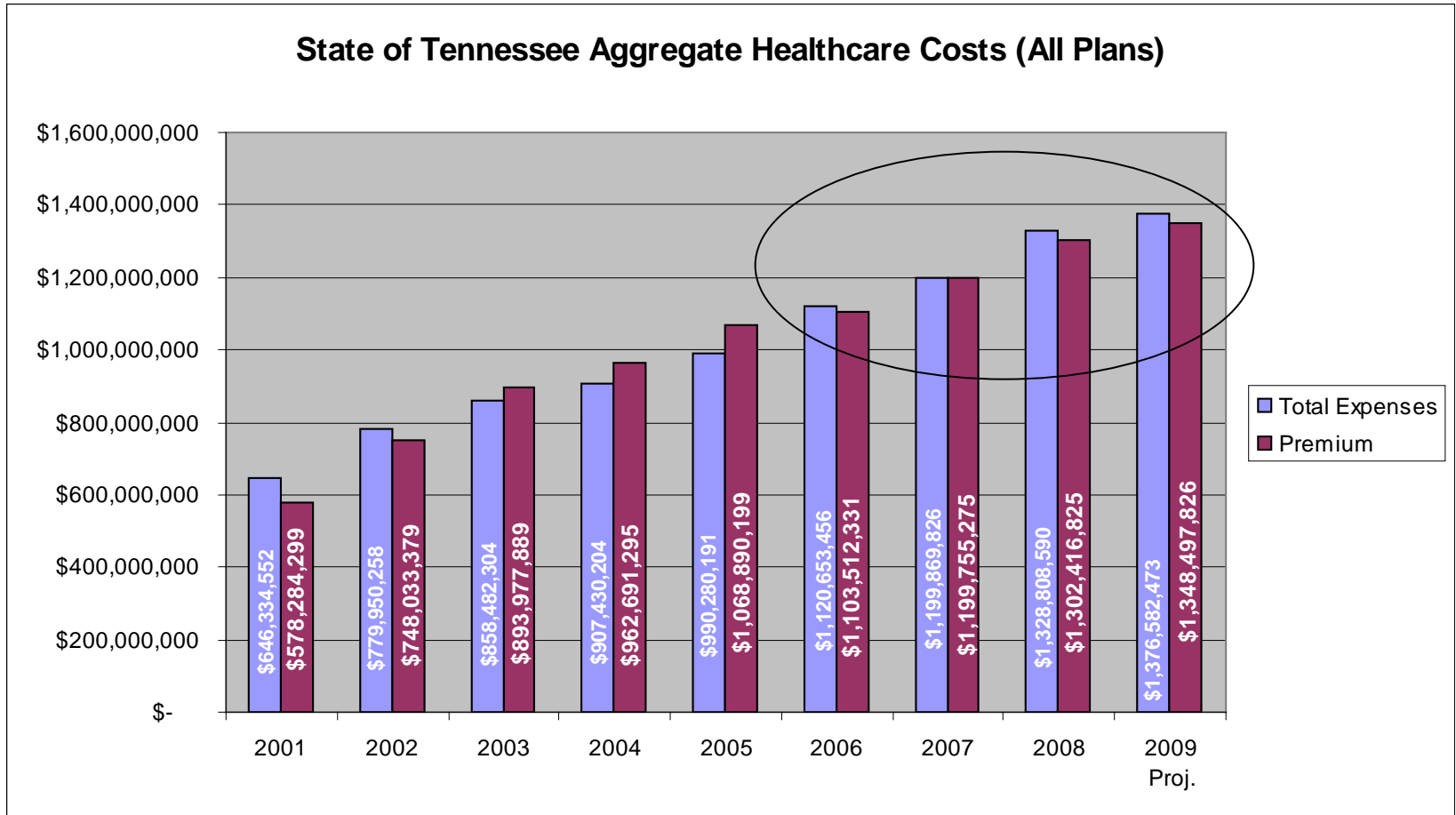


Total State Plan Costs More Than Doubled in 8 Years

(Increase from \$364M CY 2001 to \$761M in CY 2008)



Costs Exceed Premiums: 2006-2009

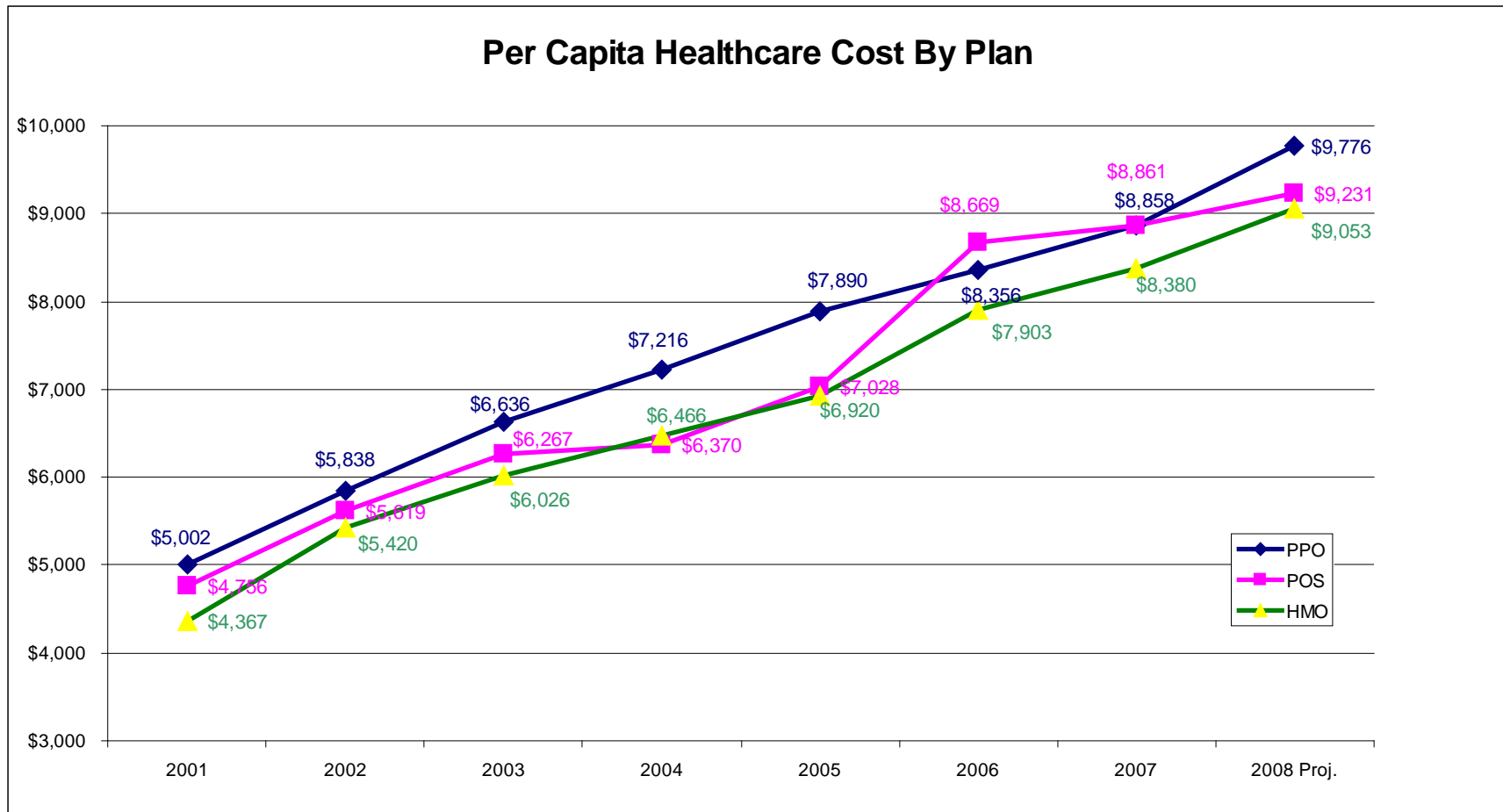


Notes: Plan costs include paid claims for medical, pharmacy, EAP, and mental health, and administrative costs.

Sources: State of Tennessee paid claim reports.



Increases Consistent Across Options



Notes: Plan costs include paid claims for medical, pharmacy, EAP, and mental health, and administrative costs.

2004: Implemented benefit changes to deductibles, out-of-pocket limits, and pharmacy copays.

2006: Transitioned POS population to CIGNA, resulting in higher plan costs.

The Fiscal Reality of Health Care



Increased Costs

- Heavy disease burden
- High utilization
- Aging population
- Delivery system inefficiency



Finite Resources

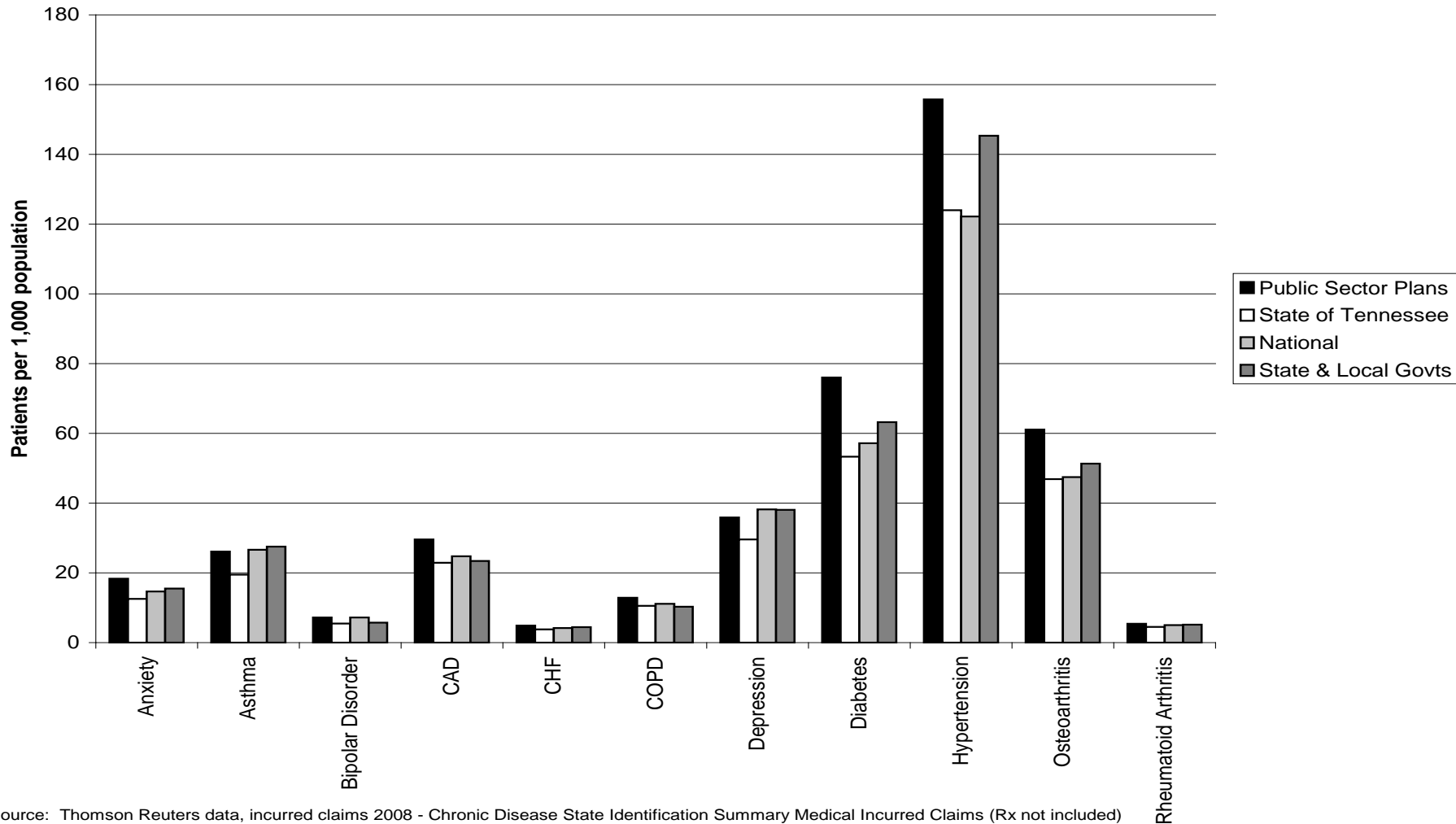
- Declining state revenues
- Stagnant wages

Tennessee's Disease Burden Exceeds All Benchmarks



11 Disease Categories Considered	State of Tennessee			National Norms	Excess Disease Burden		Tennessee Norms	Excess Disease Burden		State & Local Govts Norms	Excess Disease Burden	
	Patients per 1,000	Medical Costs per Patient	Total Members per 1,000	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost	Patients per 1,000	Marginal Patients per 1,000	Marginal Cost
Anxiety Disorder	18.33	\$167	273	14.68	3.65	\$166,786	12.57	5.76	\$263,202	15.48	2.85	\$130,230
Asthma	26.09	\$400	273	26.63	-0.54	-\$58,943	19.50	6.59	\$719,322	27.55	-1.46	-\$159,364
Bipolar Disorder	7.20	\$865	273	7.20	0.00	\$0	5.48	1.72	\$406,094	5.75	1.45	\$342,347
Coronary Artery Disorder	29.56	\$4,764	273	24.79	4.77	\$6,203,885	22.88	6.68	\$8,688,040	23.42	6.14	\$7,985,713
CHF	4.89	\$3,462	273	4.18	0.71	\$671,016	3.81	1.08	\$1,020,701	4.41	0.48	\$453,645
COPD	12.86	\$850	273	11.15	1.71	\$396,964	10.54	2.32	\$538,571	10.26	2.60	\$603,571
Depression	35.69	\$440	273	38.17	-2.48	-\$297,593	29.58	6.11	\$733,183	38.08	-2.39	-\$286,793
Diabetes	76.03	\$503	273	57.15	18.88	\$2,593,974	53.29	22.74	\$3,124,310	63.19	12.84	\$1,764,122
Hypertension	155.76	\$182	273	122.18	33.58	\$1,667,814	124.01	31.75	\$1,576,924	145.34	10.42	\$517,529
Osteoarthritis	61.11	\$2,040	273	47.48	13.63	\$7,589,852	46.88	14.23	\$7,923,962	51.30	9.81	\$5,462,689
Rheumatoid Arthritis	5.41	\$1,932	273	5.02	0.39	\$205,732	4.53	0.88	\$464,216	5.15	0.26	\$137,155
	Marginal Cost Due to Excess Disease Burden				\$19,139,488 or 2.1% of total medical cost			\$25,458,524 or 2.7% of total medical cost			\$16,950,844 or 1.8% of total medical cost	

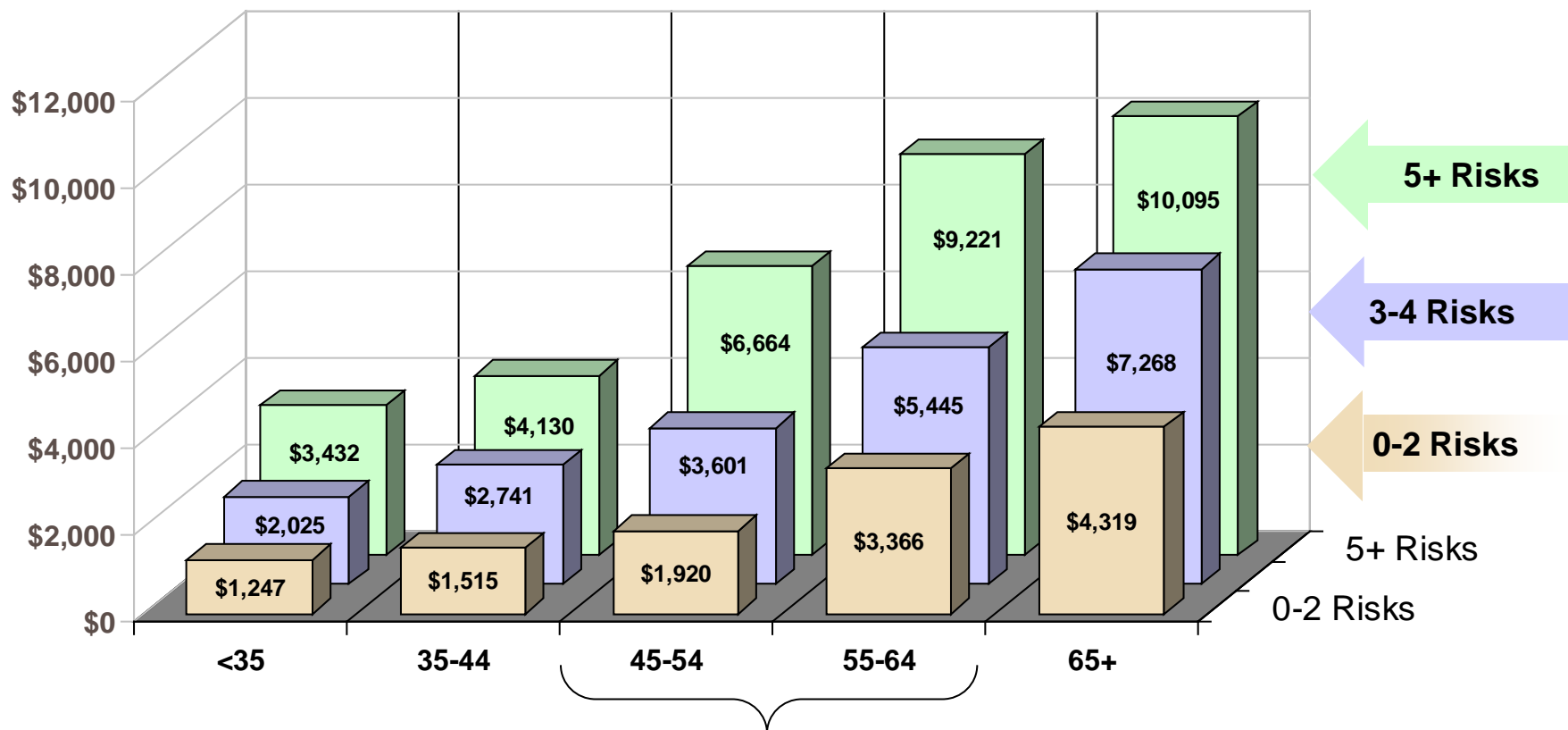
Public Sector Plans Fare Worse with Disease Prevalence



Source: Thomson Reuters data, incurred claims 2008 - Chronic Disease State Identification Summary Medical Incurred Claims (Rx not included)



Aging Membership Also Drive Costs



56% of State of Tennessee's participants (enrolled) are between 45 and 64

Public Sector Challenge



- Total claims costs: \$9,600 per employee in 2008
- State will pay about \$820 million in 2009 for premiums for the State Plan and Local Education Plans
- Costs have exploded
 - Claims Increased 55-65% between 2002 and 2007
 - Total spending doubled in just eight years
- State revenues continue to decline
- Budget constraints on state contribution due to continued deterioration in state revenues

What have we done to keep costs down?



- Pharmacy management
 - Reduced copays for diabetic drugs and supplies
 - New pharmacy cost-sharing
 - Elimination of brand-name PPI drugs
- New pharmacy contract (2010)
- Tobacco quit initiative (through 2009)
- Dependent eligibility verification
- Plan redesign for 2011

Even So, Status Quo is Not Sustainable



- If we make no other changes, we would have to more than **quadruple** the deductibles in the current PPO over the next three years to stay within a 3% budget target
- A sustainable solution requires a partnership: the State, employees, health care providers and contractors

Plan Redesign



- The Committees have several ways to control spending in the plans. These include:
 - **Reduce the demand for care by improving member health status**
 - **Achieve efficiencies in the delivery of care**
 - **Apply tighter utilization management**
 - Shift a greater proportion of health care costs to plan members
 - Reduce the scope of covered benefits
 - Reduce the extent of network coverage

Plan Redesign Goals



- Specific objectives to:
 - Preserve a comprehensive, dependable and affordable benefit
 - Minimize cost-shifting
 - Realize savings through improved health and smart purchasing, both by the state and by members
- Over-arching goal to preserve:
 - Quality
 - Choice
 - Dependability
 - Affordability

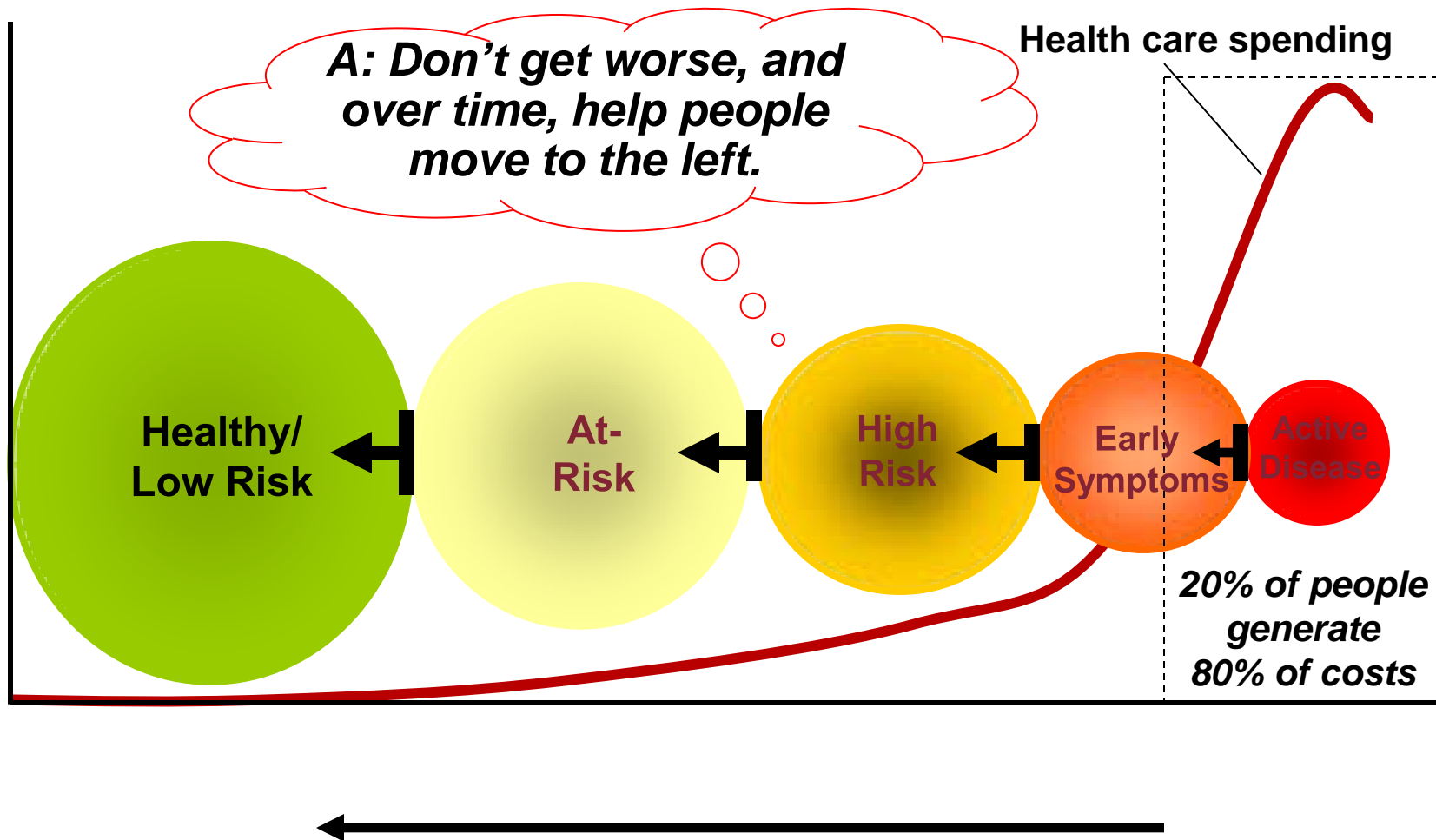
Plan Redesign Elements



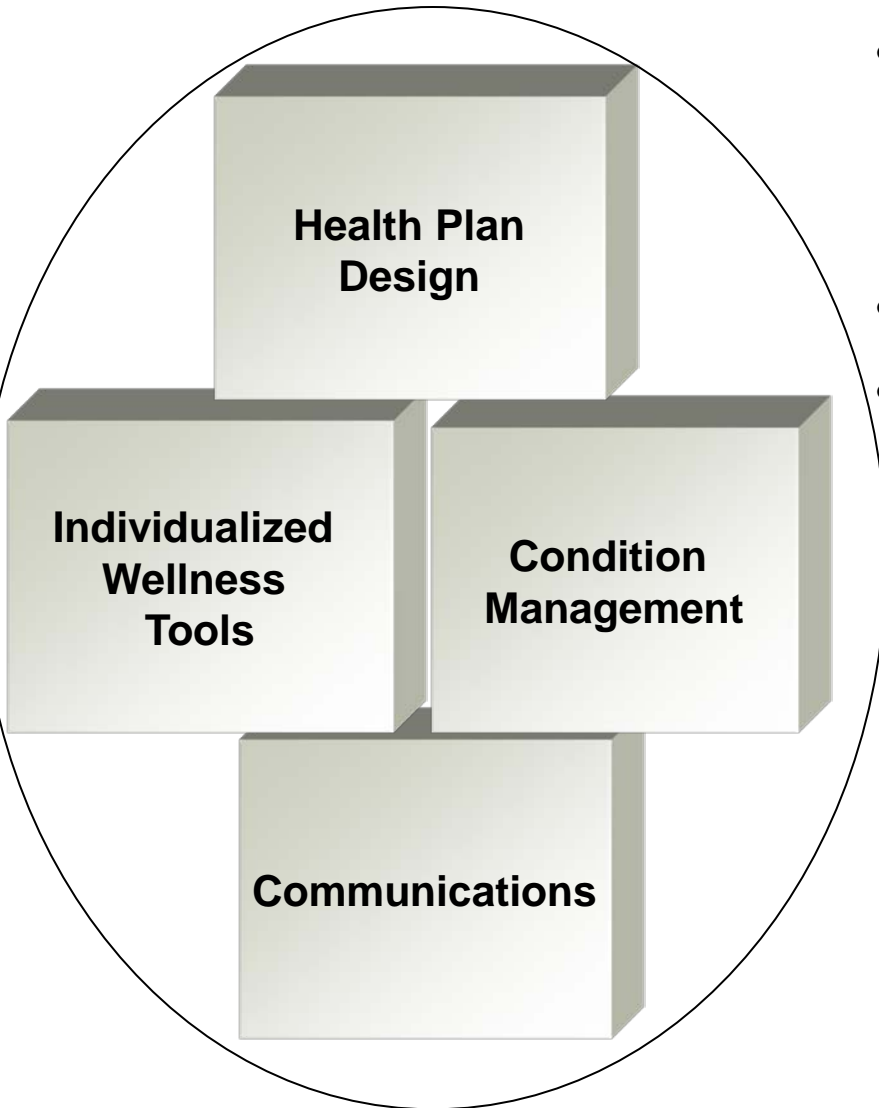
- Address cost drivers, reducing future cost increases
- Provide meaningful choice for members
- Implement programs to improve the health of members
- Create incentives for the efficient consumption of healthcare and for accountability for member health and well-being
- Leverage core competencies of contractors; hold them accountable
- Minimize changes that reduce benefits or shift costs



What Does Good Care Look Like?



Wellness Integrated into Health Plan



- **Holistic view**
 - Designed to engage members in decisions that affect their health and health care
- **Not a product - a long term process**
- **Building blocks**
 - Plan designs that “incent” health management participation
 - Integrated Health Management
 - wellness & member tools
 - condition management
 - Ongoing member communications

Plan Values



Value	Plan-level Implications	Member-level Implications
Quality	Better health outcomes at the group level	Right care at the right place and the right time – across the entire health spectrum (from prevention through active disease)
Choice	Design clear-cut options	Ability to meet member needs throughout their life cycle; rewards good choices
Dependability	Sustainable changes: investments targeted to underlying cost drivers	Plan “comes through when needed”; no fine print!
Affordability	Bending the cost curve – lower year-over-year increases	Better value for health dollars spent out of the paycheck

“Value-Based” Benefit Design



- Standard PPO
 - Open to all members
 - No wellness participation requirement
 - Default option unless member chooses Partnership Plan
- Partnership PPO
 - Head of contract and spouse must commit to Partnership Promise
 - Health risk assessment and/or biometric screening
 - Follow up to address high-risk factors
 - Receive annual wellness check and preventive services
 - Maintain or improve “risk score” through actions and/or outcomes
 - **Partnership rewarded through lower premiums and lower cost-sharing through co-pays, deductibles, out-of-pocket maximum**
- Positive choices = savings to Plan and members



Network Side of “VB” Design

- Presumed use and effectiveness of DRGs
- Catching a Cloud
 - High performance networks
 - Centers of Excellence
 - Medical homes
- Politics of labeling
 - Why isn't my doctor/constituent in-network?
 - What do you mean my doctor isn't "high quality?"
- Concentrated (monopoly) power of providers/insurers
 - Where one carrier dominates
 - When critical providers (particularly hospitals) won't play ball
- Conundrum of exclusive provider agreements
 - Yes, we need the discount, but....

High Performance Networks



- Goal: Tackle unnecessary utilization
 - Avoiding **supply-induced** or provider-driven utilization.
 - Incentivizing members to seek care from high quality, low-cost providers
- Method
 - Related to “efficiency” and quality measures
 - NY AG settlement with CIGNA set parameters for developing network
 - Primary care, specialty care, acute inpatient care
- Concerns
 - Relative or absolute standard?
 - Transparency – and heterogeneity in approach (carriers vs. payers)
 - Provider involvement and obstruction
 - Meaningful communications and consumer tools
 - Are any of these providers accepting new patients?
 - Access, particularly in provider shortage areas

Centers of Excellence (remember Medicare?)



- Goal: Increase use of high volume, high quality facilities
 - Common for transplantation, now bariatric surgery
 - Potential with diabetes, cardiac procedures, orthopedic surgery
- Method
 - Typically related to volume and specified outcomes
- Concerns
 - Margins of procedures in local facilities – and larger impact on access
 - Gravity effect: “Newtonian” preference for local providers
 - Travel and lodging expenses for caregivers
 - Transparency – and heterogeneity in approach (ACS, ASMBS, BCBS, etc.)
 - For how long do the distinctions matter?
 - Additional wrinkle: JCAHO “Disease-Specific Care” certification



Medical Homes (BPHCs' old mantra)

- Goal: Encourage use of integrated medical practices
 - Co-located team of multi-disciplinary providers
 - Health informatics advances
 - Focus on chronic disease care
 - Extension to behavioral health
- Method
 - What isn't a medical home? Does it serve as a gatekeeper?
 - Short-term: changing practice patterns is a hard sell
 - Long-term: must be tied to reimbursement
- Concerns
 - Multiple initiatives with diffuse payer support
 - For employers, where do worksite clinics factor?
 - And the Asheville Project?
 - Continued predominance of small-group practitioners?



Opportunities with Payer Leverage

- Plan administrators of the world, unite!
- Reporting requirements
 - LeapFrog
 - eValue8
- Consistent use of measurement
 - HEDIS report cards: propelling state action
 - All-claims databases and reporting
 - Shaming
- Vital signs
 - Standardized screening tools for depression in primary care
 - Depression screening: required vitals at each primary care encounter?

What Would be Helpful



- Wiki-RFP
 - **LOTS** of concepts, very little in the way of contracts
 - Translation of demos into template contract requirements for use by other payers
 - Operational “best practices” in the form of detailed, prescriptive contract text
- Competition
 - Competition policy for health insurers
 - Vigorous review of alleged anti-competitive practices among providers
- Meaningful Transparency and Information
 - Doctors are not movies or restaurants (i.e., 2.5 stars means what?)
 - Making provider-level cost and quality information available
 - Providing patient decision aids (e.g., DVD on “Is Back Surgery for You?”)

What I Haven't Mentioned



- But should have:
 - E-prescribing
 - Gatekeepers and utilization review
 - Disease management and telephonic care coordination
 - Provider profiling and practice intervention
- Obligatory if reluctant references:
 - Telehealth
 - Electronic medical records
 - Accountable care organizations