Who are employer purchasers?

- Purchasers of public and private health insurance have a major role in shaping health care delivery.
- Employer purchasers include:
  - Self-insured large employers, often multi-state
  - State and other public employee purchasing groups
  - Mid-sized fully and self-insured employers
  - Fully insured small employers
  - Employer coalitions
## What concerns employer purchasers?

- Cost, cost, cost, cost, access, cost, quality, cost, cost and cost.
- Why? Employers have had their premiums annually grow by two-to-three times the rate of inflation *for decades.*

## How have purchasers been reacting to cost growth?

- **Most Employers**
  - Cost-shifting to employees
  - Moving to “defined contribution”
  - Dropping coverage
- **Leading Employer Purchasers**
  - Incenting and supporting health behavior change
  - Advancing payment and delivery system reform
- Employers have generally been acting on their own or through coalitions without state involvement, although some states have tried to support efforts through insurance regulation and transparency investments.
Incenting and Supporting Health Behavior Change

- State of Tennessee Employee Benefit Program
  - Allows members to choose from two different insurance options, with a significant financial incentive to choose a plan that requires member engagement (Partnership PPO).
  - About 80% of members chose the Partnership PPO and are required to:
    - Complete a biometric screen every two years
    - Complete a Health Risk Assessment
    - Engage in one wellness activity
      - Age and gender-appropriate wellness activity (e.g., mammogram)
      - Wellness challenge (e.g., work-based weight loss program)
      - Create a well being plan
  - In addition, tobacco users must enroll in a cessation program
  - At-risk members must:
    - Complete a biometric screen annually
    - Enroll in a disease management or case management program

Incenting and Supporting Health Behavior Change

- Incentives for health behavior change can also be built into the plan design.
- For example, the employee earns contributions to a health investment account (or HSA) for:
  - Completing an HRA
  - Participating in a wellness program
  - Participating in a care management program
  - Achieving a health improvement goal
Four Purchasing Strategies

1. Tiered and select networks
2. Value-based benefit design
3. Empowering employees with information
4. Risk-based contracting with providers

Tiered and Select Networks

- **Tiered Networks:** providers are classified into tiers, usually based on measures of efficiency and quality. Consumers pay a higher cost share for providers deemed to be less efficient (or costly) and/or of poorer quality.

- **Select or “Limited” Networks:** providers are classified as “in” or “out” of a network usually based upon on measures of efficiency (or cost) and quality.
Tiered Networks: Massachusetts Group Insurance Commission

  - hospital-tiered networks created in 2004
  - physician networks created in 2007
  - additional physician specialties were tiered in 2009
- Each plan allowed to design its own tiering methodology based on aggregated GIC data.
- Tier copay differentials across all plans are (too) modest (i.e., $10-$15 differential between tiers).

Select Networks: Massachusetts Group Insurance Commission

- The GIC has had select networks for many years, but enrollment was historically low.
- In 2011, the GIC required re-enrollment and offered a 3-month premium holiday to any worker who elected one of six select networks.
  - The GIC estimated savings of $800 for individuals and $1,700 for families.
- 31% chose a select network
Value-Based Benefit Design

- Guiding concept is varying member financial incentives to services based on the “value” of the service.
- Primarily implemented with pharmacy co-pays for chronic illness medications
- Less common examples: health education classes, minimally invasive procedures, “medical step therapy”

Empowering Employees with Information

- Some insurers are introducing tools to aid employees with high deductibles.
- For example: United’s “My Healthcare Cost Estimator”
  - Provides enrollees with comparative cost information for treatments and procedures as provided by different providers in different settings
  - Provides side-by-side quality data for providers.
  - The member can see the total cost of the procedure by provider, his or her out-of-pocket costs associated with each alternative, the components of the out-of-pocket costs, and how much of his or her deductible remains. The deductible information is current as of claims paid the day the member is accessing the website.
Risk-based Contracting with Providers

- Risk-based contracting allows a purchaser to contract directly with a provider and pay one fee for a set of services for a covered population.

Risk-based Contracting with Providers: CalPERS Pilot

- ACO-like program with Hill Physicians, Catholic Healthcare West and Blue Shield of California for state employees in Sacramento.
- Providers and Blue Shield jointly committed to zero cost increase between 2009 and 2010 for ACO-based HMO product.
- A three-way shared-risk global payment was instituted to encourage coordinated care between the physicians, hospitals and the health plan.
- 2010 results: $15.5M in savings shared with state (17% reduction in readmissions; 14% in total IP days)
Risk-based Contracting with Providers: Maine SEHC

- Maine State Employee Health Commission (SEHC) negotiated a risk agreement with one large hospital provider and its affiliated physicians – at the provider’s initiative after the state told the provider it would be removed from the preferred tier in the state’s tiered network. SEHC has since added a second memorandum of understanding with a second health system.
- $1 million dollars was placed at-risk by the provider
- Savings will be calculated by comparing the trend rate to a control group defined using statewide data

Questions