Cost Management Strategies and Examples for the Pool

Supplement C to the Report:

Challenges and Alternatives for Employer Pay-or-Play Program Design: *An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2)*

For the
California Health Care Foundation
and the
California Managed Risk Medical Insurance Board

Project Team Led by the
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Supplement C:

Cost Management Strategies and Examples for the Pool

Background

The California Health Insurance Act of 2003 (also known as SB 2) adopted a “pay-or-play” mandate aimed at reducing the size of the state’s uninsured population. This law required employers over a certain size to either: (a) “pay” a fee to the state so that their workers and, for employers with 200 or more workers, dependents could be covered through a State Health Purchasing Program established under the Act, or (b) “play” by directly providing health coverage for specified workers and dependents. Although SB 2 was overturned by a narrow margin in a November 2004 referendum, the passage of legislation intended to expand employment-based coverage provides a unique opportunity to assess and to evaluate the implementation issues and challenges presented by a “pay-or-play” program.

The Act directed California’s Managed Risk Medical Insurance Board (MRMIB) to design and operate the program. One of the charges to this board was to “develop and utilize appropriate cost containment measures to maximize the cost-effectiveness of (the) health care coverage offered under the program.” In this supplement, we examine the options available to the board (or other administering body) for controlling costs. Cost-containment is, of course, integral to the broad goal of expanding coverage of the uninsured. In the discussion below, however, we also examine the question of whether the State Health Purchasing Pool (SHPP) could or should have any special advantages in their negotiations with health plans. We also examine the purchasing advantages and strategies of large purchasers generally, and the important distinction between a large purchaser with a significant number of “captive” lives versus a large, but voluntary, purchasing pool that may lack the natural cohesion of the former. Finally, we review some specific cost containment tools such as high deductible plans, negotiating provider discounts, and selective contracting with providers.

The Experiences of Other Large Purchasers

As a purchaser, the pool would want to leverage any and all effective negotiating strategies employed by other large purchasers. In addition, some stakeholders hoped that the pool would have sufficient “clout” to be able to negotiate favorable rates above and beyond those available to larger employers. This section seeks to answer such questions as: What are the negotiating strategies used by other large purchasers and pools? What type of cost savings can be expected vis-à-vis smaller purchasers?

Does Purchaser Size Confer any Market "Clout"?

Large purchasers have been documented as having an advantage over small purchasers in purchasing health insurance in the market place.[1] However, the leverage that large purchasers enjoyed during the 1990s has been somewhat negated in the purchasing environment of the 21 century.[2]

Very large employers are often sophisticated negotiators with their health plans. These employers often use a **structured bidding process** and **standard benefit design** so that they can compare premiums more effectively. In addition, they employ a variety of strategies to enhance their leverage in premium negotiations and justify premium increases. These include:

- reviewing plan rate development methodologies;
- comparing premiums to standards or benchmarks;
- requesting utilization data; and
- examining plan financial indicators.

Using objective criteria to limit the plans selected can effectively encourage competition and reduce administrative costs. The downside to this approach is that eliminating plans can disrupt employees' relationships with their providers.

In a recent survey of CA employers over 500 employees, the JSI Research and Training Institute determined that these employers find the most successful strategies for lowering costs were increasing HMO penetration, selecting regional rather than national carriers, and lowering the employer contribution to individual coverage.[3]

Another cost containment strategy is for the employer to shift the competition down to the employee by pegging their contribution to a "benchmark" plan.[4] The benchmark plan is often the lowest cost plan but it can be the plan that offers the most "value," that is, the combination of cost plus some measure of quality. Employees wishing to purchase other plans must pay the difference in the premium price between their plan and the benchmark plan. Perhaps surprisingly, this is a relatively rare contribution policy. It is estimated that nationwide fewer than 5 percent of insured workers are offered both choice and the ability to retain savings from economical choices.[5] However, when employers have adopted this strategy, employees have generally proved to be extremely price sensitive.

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[1] One study found that the addition of 1,000 enrollees reduced premiums by 1% holding risk mix and benefit design constant. Robinson, James C. "Health Care Purchasing and Market Changes in California," *Health Affairs,* Winter 1995, vol. 14, no. 4, pp. 117-130.

[2] Health plan mergers and hospital consolidation has increased the relative negotiating power of these players.

[3] JSI Research and Training Institute, *Health Care Purchasing Among Private and Public Employers in California,* California Health Care Foundation 2004.

[4] Since employees can pay health care costs using pretax dollars, there are no adverse tax consequences to such an arrangement.

[5] Hal R. Varian, "Controlling Health Care Costs," *NY Times*, November 18, 2004. Plans of this sort are offered by CalPERS, Stanford University and other employers.

Large Purchasers Strategies in other Areas

While the ability of a pool to negotiate extraordinary price discounts may be limited under certain scenarios, large purchasers are uniquely positioned to structure the price negotiation/plan selection process so that it reflects quality and value rather than risk selection. Some of the plan data that sophisticated purchasers include in their negotiations are:

- administrative performance;
- financial stability;
- patient satisfaction; and
- clinical quality.

While employers are very interested in clinical quality, only a handful of large purchasers actually negotiate on this criterion. Some employers require by contract the reporting of performance information and encourage providers to participate in reporting efforts such as the Leapfrog Group initiatives. Less often, employers link plan performance improvement to plan premium payments. For example, PBGH plans put 2 percent of the premium at risk if plans do not meet individual HMO performance targets.

The Experience of Other Large Purchasers

Table C-1 below summarizes the size of some other large purchasers and the activities they engage in.

Table C-1: Plan Negotiating Techniques of Other Entities, by Member Size

Purchaser	Members	Worker Choice of Plans?	Standard Benefit Package?	Rate Negotiation	Do Plans Bear Risk ?	Premium Contribution Strategy	Other
FEHBP	8.5 million (includes dependents and annuitants)	Yes. Any plan willing meeting minimum standard.	No. (Requires a core set of benefits)	OPM gives guidance; Closed door negotiations; Experience rated, multi-year trend can only include reasonable profit.	No	Fixed contribution =72% of weighted average premium of all plans, except will pay no more than 75% of any plan's premium	
Medi-CAL	6.6 million in FY03-04 to 6.7 million in FY04-05;	In selected counties enrollees have a choice of plans.	Yes	Rates for Health Plans and FFS providers determined in large part by the legislature.	Yes, for some plans	Not Applicable.	
CalPERS	1,200,000 (one million active)	Yes.	Yes	RFP w/ subsequent negotiations. Excludes plans whose premiums are too high	Yes, for some plans	Participating ERs decide how much to contribute	Regional pricing and a narrow network
Healthy Families	774,000 children by the end of FY04-05	In all but 7 counties there is a choice of plans	Yes	RFP w/ a chance to rebid. Excludes plans whose premiums are too high. Medical Loss ratio is factored in.	No	Premium incentive to choose the plan that has done the best job of incorporating traditional and safety net providers into its network.	
PBGH Purchasing Alliance	400,000 (active and retired)	ERs choose which Plans to offer	Yes w/ variations	RFP process	Yes, with risk adjustment	Some ERs base contribution on plan quality.	
GM (1.5 million active and retired lives)	49,000 salaried employees in value based purchasing	Yes	Yes	Drops those that don't score well on quality and cost.	Yes	Covers a larger share of HMOs designated as being a better value.	Value Based Pricing
PacAdvantage	150,000	"Paired Advantage" option allows ERs to restrict the plans offered.	Yes w/ variations	Takes Market Rates	No	Employer faces a contribution minimum.	

Large Employers[6]

FEHBP

The Federal Office of Personal Management (OPM) is the largest purchaser of employee health insurance in the country. The Federal Employee Health Benefit Plan provides coverage for approximately 2.2 million workers, 1.9 million retirees and roughly 4.4 million dependents for a total of 8.5 million covered lives.[7]

According to a policy address to a conference of competing health-care carriers on March 6, 2002, OPM Director Kay Cole James told the insurance executives: “If your proposals are consistent with the President’s vision--patient-centered health care, choice, and quality--you will find OPM very receptive. Our job is to provide consumers protection; it is not to dictate choices. We are not going to tell you what to do because the best ideas for helping to contain costs and promote quality are going to come from you in the marketplace. You will have to convince employees that your product is best.”

Hence, a broad range of plans can participate in the program. OPM relies on enrollee choice, competition among plans, and annual negotiations with participating plans to moderate premium increases. OPM does use its considerable clout to negotiate heavily with the health plans in unstructured, closed-door sessions. Each year, OPM suggests cost containment strategies for plans to consider and relies on participating plans to propose benefits and premiums that will be competitive with other participating plans. While a core set of benefits is required, carriers have latitude to design their own benefit plan. As a result, the value of the benefit package varies tremendously.[8]

According to a 2002 analysis by the Government Accounting Office (GAO), FEHBP’s premium trends from 1991 to 2002 were generally in line with other large purchasers--increasing on average about 6 percent annually.[9]

The contribution methodology used by the FEHBP is a hybrid of a defined contribution approach and a fixed percentage approach. The government contribution is equal to 72% of the weighted average premium of all plans--subject to a ceiling equal to 75% of the plan’s premium. Hence for more expensive plans, the government requires employees to make up the difference in

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[6] Wal-Mart is likely California’s largest private employer, with about 64,000 workers in California and 1.2 million workers nationally but little has been written about how they negotiate with health plans. On average, less than half of their workers purchase the insurance.

[7] Approximately 245,000 federal workers are based in California—the largest share of any state. Approximately 76 percent of them are enrolled in FEHBP.

[8] Mark Merlis, *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform*, Henry J. Kaiser Family Foundation, May 2003.

[9] GAO. *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits,* GAO-03-236 December 31, 2002. Other analyses also found similar in trends (e.g., Davis, 2003).

premium. However, if an employee chooses a plan that is less expensive than the "average plan," only part of the premium savings (25%) accrue to the employee.[10]

Note that no risk adjustment methodology is employed in setting FEHBP premiums or enrollee premium shares. In light of the fact that they have a large population of retirees and have employees from all over the country, this has caused concern about adverse selection against plans in the system. The evidence of this phenomenon in recent years is inconclusive. Most agree that the potential for adverse selection is mitigated by the policy of (mostly) proportional premium contributions by the Federal Government.

GM

General Motors (GM) is the nations largest private purchaser of health insurance covering a total of 1.1 million lives.

GM is perhaps the leader in value based purchasing. Since 1997, this company has evaluated health plans using data from HEDIS and CAHPS supplemented by additional data supplied by an RFI.[11] This information is used to "score" plans on quality. Plans are also "scored" on their premium costs (after adjusting for age and sex). The total of these two scores is used to assign the plan to one of six bands. The top 15 plans (out of approximately 114) are designated as "benchmark plans." For its 49,000 salaried employees, GM's contribution is tied to these bands with the largest contribution going to the benchmark plans.[12] The strategy has been successful in attracting members to HMOs and moving HMO members into higher quality plans. As a result, the company has seen enrollment in the lowest-ranked plans dropped by 50 percent. Plans have also improved on quality measures in an effort to become a benchmark plan.

It must be noted, however, that despite this aggressive pursuit of value, the company reports that health care costs are contributing to low U.S. profitability. The coverage negotiated with their union workers is extremely generous with GM paying the entire premium for a plan that covers almost all health care at 100%. In addition, 80% of their covered lives are retirees.

The Smart Buy purchasing alliance in Minnesota, a recently announced coalition of large public and private purchasers seeks to develop a joint plan negotiation process and premium contribution strategy that would be based, in part, on the system developed by GM.

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[10] Postal employees—representing approximately 18 percent of all enrollees—have negotiated a more favorable contribution rate (Merlis, 2003).

[11] See *Supplement F* for more information these quality tools.

[12] GM offers 76 health plans to its salaried employees across the country, and 13 of them are designated as Benchmark plans.

California Public Purchasers

CalPERS

The California Public Employees' Retirement System (CalPERS) provides health benefit services to more than 1 million active state and local government workers and about 200,000 retirees. The voluntary participation by local public agencies comprises about 40% of total CalPERS membership. CalPERS is the largest purchaser of employee health benefits in California and the third largest in the nation after the federal government and General Motors.

CalPERS is typically perceived as a tough negotiator and innovator.[13] They were the first to adopt a standard benefit package when contracting with HMOs. While negotiations take place behind closed doors, it is known that they are based on detailed cost figures.[14] In addition, they have used negotiation practices such as freezing plan membership, rejecting bids, and publicly discussing direct provider contracting.[15] Importantly, CalPERS has exhibited a willingness to drop plans that don't have attractive premium bids. Over the course of several years, CalPERS reduced the number of HMOs it offers from 14 in 1997 to 3 in 2005.

Despite its size, the organization has struggled in recent years to manage its costs and keep the offerings attractive in a system that includes voluntary members and a cost of service that can vary by as much as 40% across the state. In recent years, CalPERS has introduced increases in member cost-sharing, but they tend to lag the levels imposed by other large employers.

In 2004, CalPERS entered into a multiyear contract with Blue Shield to dampen the rate of increases, avoiding $125 million in premium costs. The contract incorporated a "re-pricing" mechanism for 2005 and 2006 designed to protect the HMO from potential unforeseen losses while returning excess savings to CalPERS health care program. Finally, the contract commits Blue Shield to contain hospital cost increases and caps the amount of money CalPERS will pay for administrative overhead and "profit" to no more than 7.1 percent.

CalPERS has also moved to restrict the providers in one of its main HMO offerings. In examining these costs in preparation for establishing the 2005 premiums, CalPERS determined - in partnership with Blue Shield - that eliminating certain hospitals from the HMO network for Blue Shield CalPERS members could realize meaningful cost control without compromising access to care.[16]

Also in 2005, the organization moved away from negotiating a single state-wide premium and adopted regional pricing strategy. According to an analysis by Blue Shield of California, this

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[13] James Maxwell, Peter Temin, and Tanaz Petigara. "Private Health Purchasing Practices In The Public Sector: A Comparison Of State Employers And The Fortune 500," *Health Affairs*, Volume 23, Number 2.

[14] The administration of the CalPERS Health Benefits Program by the CalPERS Board is mandated by the *Public Employees' Medical and Hospital Care Act*. This law allows the CalPERS Board of Administration to meet in closed session in order to discuss confidential matters, such as personnel actions and health plan rate negotiations.

[15] See below for further discussion of their exploration of direct contracting in this Supplement.

[16] See below for further discussion of their narrow network in this Supplement.

move may have prevented the loss of 65,000 members which would have increased per member costs.[17]

By law, each bargaining unit negotiates the employer and member premium shares. The Department of Personnel Administration determines the contribution for those state employees that are not subject to collective bargaining. (The contribution for retirees is set by law.) Employer contributions were not restricted to the lowest cost plan. In general, the employer contribution is set at amount equal to a percentage of the weighted average premiums. On average, in 2002 this amount was equal to 85% of the weighted average premium for both single coverage and coverage that included dependents.

Employers are also not restricted regarding which CalPERS plans they offer. They can choose to offer only selected plans and they can offer these alongside non-CalPERS plans. (CalPERS offers two self-insured PPO plans and three HMOs.)

CalPERS also participates in quality improvement activities of the Pacific Business Group on Health (see below).

Medi-Cal

California's Medicaid program, Medi-Cal, covers approximately 6.7 million lives.

The Medi-Cal program uses a mixture of fee-for-service (FFS) and managed care plans to cover its population. The type of managed care plan operated in a county is chosen by the California Department of Health Services and approved by the federal government. The most common type of plan is the **two-plan model**, where counties offer a choice between a local-initiative plan and a commercial HMO (this is the predominant model in use in California). The other two models are **county-organized health system** (COHS), where a county's board of supervisors authorizes the creation of a health-insuring organization (HIO) to contract with the state's Medi-Cal program on a capitated basis and **geographic managed care** (GMC), where the state enters into capitated contracts with multiple commercial plans within a designated geographic area.

Actuaries in California's Department of Health Services (DHS) calculate payment rates for Medi-Cal's managed care plans based on Federal Guidelines, state policy and available funding.[18] The California Medical Assistance Commission (CMAC) then negotiates payment rates for participating plans within the limits set by DHS.[19] The capitation rates reflect enrollee age, sex and region. While rate data is confidential, the DHS estimates that on average Medi-Cal beneficiaries in a COHS plan are about 81 percent of the cost of FFS beneficiaries.[20] A 2004

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[17] CalPERS press release, August 17, 2004.

[18] Hunt, Sandra et al. *Capitation Rates in the Medi-Cal Managed Care Program*, May 1999.

[19] The goal of the Commission is to promote "efficient and cost-effective Medi-Cal programs through a system of negotiated contracts fostering competition and maintaining access to quality health care for beneficiaries." According to the Commission, their contract negotiation processes currently saves the State General Fund an estimated $900.0 million annually, and has saved the State General Fund more than $7.0 billion since the Commission was established in 1983. California Medical Assistance Commission *Annual Report to the Legislature 2004*.

[20] LAO, 2004.

analysis by Calfornia's legislative Analyst's Office suggests that the rate setting methodology uses outdated mix of service information, resulting in financial difficulties for several COHS plans.

In the remaining counties (which don't have mandatory managed care) coverage is delivered through a mixture of fee-for-service, prepaid health plans, and primary care case management. FFS provider rates are determined as follows:

> ***Hospitals:*** Through the Selective Provider Contracting Program (SPCP), the commission contracts on a competitive basis with those hospitals that desire to provide inpatient services to Medi-Cal beneficiaries at a negotiated per diem rate for all hospital inpatient services. In fiscal year 2002-03, SPCP saved the State General Fund an estimated $683.0 million in Medi-Cal inpatient hospital payments.
>
> ***Physician:*** Physician payment rates in the FFS program are determined as part of the state budget. Physician payments are calculated by applying a "conversion factor" to the relative value units associated with their services. The resulting rates are about 59% of Medicare payment rates. Medicare rates, in turn, are about 80% of the rates paid by private insurers. While these rates are low, it has been pointed out that there are no controls in place to ensure that the health care services patients received were medically necessary.

Healthy Families

California's SCHIP program, called *Healthy Families*, provides comprehensive coverage for about 774,000 children ages 1 to 19 with family incomes up to 200% of the federal poverty level. Applicants must be currently uninsured and *in*eligible for no-cost Medicaid coverage. Unlike Medi-Cal, Healthy Families operates a managed care program in every county and the program model, administration and rules do not vary by county.

In an unusual arrangement for an SCHIP program, Managed Risk Medical Insurance Board (MRMIB) uses a competitive purchasing process to contract with licensed health plans. Plans are invited to bid on a standard benefit package. These bids are compared and the lowest bids are used to establish a premium level called the "Family Value Package."[21] Plans whose bids are too high are invited to rebid. Other factors are also taken into account. For example, each plan's medical loss ratio is examined and, if the ratio indicates too much is spent on non-medical care, the plan is invited to revise its bid.

After determining which plans will be offered, the MRMIB designates one plan as the "Community Provider Plan." This designation is for the plan contracting with the greatest number of traditional safety net providers (clinics, physicians and hospitals). The beneficiaries typically have a choice of plans. Their share of the premium does not vary by plan except that they receive a discount of $3 off their share of the monthly premium if they select the Community Provider Plan.

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[21] The premium levels established as the "Family Value Package" are not simply the lowest bids within a county. A 10% buffer is added to average of the two lowest price plans. Other factors may also be taken into account in determining the criteria for including plans in the program.

MRMIB believes that this system works very well. The emphasis on the inclusion of safety net providers and the choice of plans allows most families to stay with their current provider encouraging a continuity of care. One person familiar with the program felt that the examination of medical loss ratios was particularly effective in terms of soliciting attractive rates from the plans.

As evidenced by the discussion in the main body of the report, if the SHPP could obtain Healthy-Families-type provider discounts for its low income enrollees, it would have a significant impact on the ability of the pool to offer attractive coverage. The cost-savings associated with these rates (vis-à-vis commercial rates) would likely exceed those that can be obtained from other methods discussed in this Supplement. As discussed further in a later section, the ability of the pool to negotiate these savings is unknown and could be difficult to achieve on a state-wide basis.

California's Employer Purchasing Coalitions

Pacific Business Group on Health (PBGH)

Nearly 50 large employers are members of PBGH, representing a wide range of industries and including both private and public sector employers. Together they represent approximately 3,000,000 employees, retirees and their families and nearly $4 billion in annual health care expenditures. The coalition has a heavy emphasis on collecting quality health data from the health plans and surveying enrollees regarding their satisfaction.

About 19 of these member employers purchase their insurance through the coalition's "Negotiating Alliance."[22] The Negotiating Alliance promotes value based purchasing through an annual Request for Proposal (RFP) and a rate negotiating process on behalf of approximately 400,000 active and retired employees. All HMOs in California are invited to submit premium bids on a standard benefit design with variations. After viewing the bids, PBGH negotiators will bargain down on particular HMOs (but without disclosing any bids to competing HMOs). Also, each HMO has to bargain a single premium for the entire PBGH risk pool without knowing which firms would subsequently decide to contract with that HMOs.[23] The alliance has a risk adjustment process in place to alleviate some of the uncertainty associated with these negotiations. In addition, the alliance requires the HMOs to put 2 percent of their premiums at risk if they fail to meet performance guarantees.

Participating employers select which plans and which benefit options will be offered. Employees select from among these options and any self-funded option that the employer may be offering.

In addition to the purchasing alliance, the PBGH membership is evaluating how it can cultivate an improved delivery system by engaging consumers, practicing evidence-based medicine, improving patient safety, and utilizing new health care technology. For example, PBGH threw

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[22] Note that many employer members, including CalPERS, do not participate in the negotiating alliance.
[23] Robinson, James C. "Health Care Purchasing and Market Changes in California," *Health Affairs,* Winter 1995, vol. 14, no. 4, pp. 117-130.

its considerable weight behind the leapfrog survey that was introduced in 2001, which is credited with compelling almost all California hospitals to take part.

PacAdvantage

PacAdvantage is a non-profit purchasing pool offering health insurance plans to small businesses in California with 2 to 50 employees. Membership represents about 1% of the small employer market. Originally operated by the state of California, the pool was transferred to PBGH oversight in 1999. Evaluations of this pool have suggested that the premiums offered by the pool are similar to those available outside the pool but the pool enables small employers to offer their employees a choice of plans (which would otherwise be an administratively costly proposition).[24] In addition, it is believed that its existence may have helped to structure healthy competition by improving the quality of the information available to small employers.[25]

Employers are required to contribute at least 50% to the lowest cost plan.

In 1999, PBGH negotiated performance guarantees for PacAdvantage, meaning that health plans agree to continuously improve their service and quality for small firms, just as they do for their very large customers. Today, the pool requires carriers to put 2% of their premiums at risk.

Strategies for the State Health Purchasing Pool

How Big Would the SB 2 Purchasing Pool Be?

As discussed in the main report, the estimated size of the SB 2 pool varies greatly depending on the implementation scenario.[26] As can be seen in Table C-2 below, for all SB 2 compliant scenarios, the number of potential members does not exceed 480,000. Under the scenarios that introduce subsidies, the pool becomes much bigger commanding up to 15% of the SB 2 eligible population.

Under an SB 2 compliant scenario the pool would be considerably smaller than CalPERS and about the same size as the PBGH negotiating alliance (with many more participating employers, however). In contrast, under scenarios that include subsidies, the pool could become much larger than the CalPERS pool. Their negotiating position would be more akin to that of Healthy Families since it would command a segment of the market that it would be difficult for carriers to reach otherwise.

[24] Note that the rating rules inside and outside the PacAdvantage pool are governed by state regulation and are virtually identical.

[25] Yegian, JM, TC Buchmueller, MD Smith, and AF Monroe. "The Health Insurance Plan of California: The First Five Years," *Health Affairs,* 19:(5) 158–165, September/October 2000.

[26] *Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2)* by the Institute for Health Policy Solutions and the RAND Corporation (available from the California Health Care Foundation, www.chcf.org).

Table C-2: Estimated Purchasing Pool Size under Various Scenarios

	Implementation Scenario			
	C. Fee based on: Health; Age; Geography (no new subsidies)		**D.** *Low-income:* Subsidies available for Healthy Families Rates *Non-low income:* Fee based on age & geography	**E.** Subsidies available for to support Employer and Employee Fee based on percentage of payroll
	Lean Plan	***Generous Plan***	***Lean Plan***	***Lean Plan***
% SB 2 Eligible Workers and Dependents in Pool	2.6%	2.7%	15.1%	13.5%
Estimated Total Enrollees in Pool	460,200	477,900	2,672,700	2,389,500

Note: Total eligible workers and dependents are estimated to number 17.7 million in 2007.

Source: RAND analysis

The "Clout" of the Pay-or-Play Pool

Based on the experiences of other large purchasers, it appears unlikely that the SHPP could command price discounts over and above those already available to large employers under the SB 2 compliant scenarios. For one, the pool (as envisioned by SB 2) simply would not have that large a geographic concentration of employees. In addition, it has been observed overtime that the rate of premium increase realized by extremely large purchasers such as CalPERS and FEHBP has more or less mirrors that of other large employers.[27] The rates offered by PacAdvantage, a small employer purchasing pool, also mirror those that can be commanded by other small employers in the market.

Importantly, a pool of a given membership size is not the same as a single purchaser of a given membership size. Two features in particular limit the negotiating power of the pool. First, under the SB 2 compliant scenarios, plans have the ability to compete for employer lives both in the pool and outside the pool, limiting their incentive to give the pool their best rates. Second, under SB 2, the pool is prohibited from self-insuring. This reduces the negotiating leverage of the pool vis-à-vis plans. In contrast, large employers can always threaten to put their lives into a self-insured plan if they are unable to negotiate attractive rates.

On the other hand, the non-compliant scenarios--which introduce pool-only subsidies--greatly change the negotiating position of the pool. Under these scenarios, not only is the pool much

[27] Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace, 2004 update*, Exhibit 3.6.

larger (up to 15% of the SB 2 eligible lives) but it now contains lives that the plans are unlikely to access outside of the pool. In some ways, this is more akin the negotiating position of Healthy Families and opens up the possibility of negotiating rates that are truly "below market."

Could/Should the Pool be a "Market Maker?"

During interviews, some stakeholders suggested that the pool should function as a "market maker" imposing cost-discipline on the market and determining trends in benefits and cost-sharing.[28]

Because the health care market is highly fragmented, it is extremely difficult for a single purchaser to function as a "market maker." Owing to their smaller numbers, the relative market power commanded by plans usually outweighs that commanded by purchasers. For example, CalPERS, the purchasing behemoth, commands just 6 percent of the market for employer-sponsored coverage in California. As a result, even though 34% of CalPERS lives enroll in Kaiser, they still represent just 6% of Kaiser's total lives.

This fragmented nature of the market means that the ability of individual purchasers to influence provider behavior through a managed competition model (like BHCAG), a consumer directed plan, or through value-based purchasing (like GM) is very low. The share of patient volume that any given purchaser contributes to a provider is tiny. As a result, private purchasers operating individually face very little incentive to use these schemes.

In addition to insufficient numbers, in many markets the relative market power between providers and plans is such that plans are limited in their ability to squeeze out savings. Increasing hospital consolidation in many markets has resulted in many plan-hospital disputes being resolved in favor of the hospital.[29]

Nonetheless, purchasers have not been without impact. For example, Medicare influences the market through its administrative requirements. The adoption of hospital prospective payment in the 1980's reverberated through out the industry and dramatically changed the way hospitals managed care and the recent adoption of the DxCG risk adjustment mechanism can be expected to reverberate in a similar fashion. The fact that CalPERS conducts plan negotiations in the public spotlight provides a benchmark against which other large purchasers can measure their negotiations.[30] GM has successfully had a direct impact on how health care is delivered for its employees by focusing narrowly on improving the quality of selected procedures.

As a public purchaser, the SHPP would need to be cognizant of its (albeit limited) influence on the market. As other large purchasers have demonstrated, promoting innovation, encouraging information flows and operating in the public spotlight can all have positive spillover effects in

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[28] See *Supplement G: Stakeholder Interview Report*.
[29] The "market forces" to which economists ascribe the ability to motivate improvement in quality and efficiency are largely nonexistent in U.S. health care according to Alain C. Enthoven. " Market Forces And Efficient Health Care Systems," Health *Affairs*, Vol. 23, Issue 2, 25-27.
[30] Actual rate negotiations are determined behind closed doors. The strategies employed, however, and their success or lack thereof, are well documented in the press and, at times, used to the advantage of one or another of the negotiating parties.

the market. Plan designs which make use of provider "tiering" and produce publicly available provider comparison data may not yield significant savings but may serve to expose underlying cost variation which has been known to incent changes in providers practice patterns and costs.[31]

It must be noted that the pay-or-play pool does not need to operate unilaterally if it pursues these efforts. Joining forces with other initiatives, such as California's "Pay for Performance," will yield considerably more "bang" for the buck.

Finally, if influencing the market is to be a role for the pay-or-play pool, the governing legislation would ideally explicitly address this and acknowledge that some of these "best practices" may represent an expense, and not a savings, to the pool yet may improve the functioning of the market overall.

Patient Cost-sharing/High Deductible Plans

The Use of Health Savings Accounts under SB 2

If it is determined that pool will offer a high-deductible plan, then MRMIB may want to ensure that this high-deductible offering qualifies for a Health Savings Account (HSA). These accounts can be funded with money contributed by the employer, the employee or both. The funds may be used to pay for unreimbursed medical expenses on a pre-tax basis.[32] Unlike the (closely related) Flexible Spending Accounts, unused monies in Health Savings Accounts can be rolled over into the following year.[33] However, to qualify for this treatment, the account must be used in conjunction with a high-deductible insurance policy. Federal law requires that the policy have minimum annual deductibles of $1,000 for an individual or $2,000 for a family, and sets maximum out-of-pocket expenses—such as deductibles and co-payments—of $5,000 per year for an individual or $10,000 for a family.[34] The amount which can be contributed to the Health Savings Account is the lessor of (a) the plan's deductible or (b) program limits of $2,650 for individuals and $5,250 for families.[35]

Structuring the pool's high deductible offering in this way preserves the employer and/or employee's option to set up an accompanying health savings account--thus increasing the utility of the pool offering for some participants.

Importantly, the pool operator (such as MRMIB) cannot fund the health savings account. This account can only be funded by an individual, an employer or both. Further, it is unlikely that

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[31] See discussion later in this Supplement.

[32] Any monies contributed to the account by the worker or the employer from FICA. Both the contributions and any earnings made on the account are exempt from Federal income tax. California's tax law does not yet provide a tax deduction for these accounts but a bill has been introduced. Account contributions are subject to California's state disability tax and both the contributions and earnings are subject to state income tax.

[33] For a detailed comparison of HSAs, FSAs and the closely related HRAs, please see Appendix B of *The Health Insurance Market Context and Demographic Profile* report.

[34] Note that the "lean" plan modeled in our scenarios meets this standard. The impact of an accompanying savings account, however, could not be modeled.

[35] These federal limits will be raised annually.

MRMIB could *require* employers to offer such an account in conjunction with the high deductible plan if they want to forestall ERISA preemption. If the pool design features multiple plan designs, employers might be *incented* to contribute to such an account if the fee structure passed the premium savings associated with a high deductible plan through to the employer in the form of a lower fee.[36] However, as discussed in sections 3.2.2 and 3.6.1 of the main report, this type of fee structure, which varies depending on the plan selected, could invite ERISA challenges.

Importantly, even if legislation or fee structure ensured that such accounts would accompany the high deductible plan, the potential for cost savings may be minimal. First of all, because most enrollees spend far less than $1,000 annually on health care, the premium savings can amount to less than 10% of the cost of a mainstream plan. As shown in the example below, the lean plan in our simulation scenarios is only 8% (or about $200 annually) less expensive than the mainstream plan. This suggests that less than $200 would have to be contributed to the Health Savings Account in order to realize any program savings vis-à-vis the mainstream plan.

HSA Math

Average worker health care expense	$ 2,829

	Mainstream plan	**Lean plan**
Average Percent of Spending Covered Overall	91%	84%
Implied Premium Cost (before admin)	$ 2,574	$ 2,376

Amount available for HSA if cost-neutral:	$ 198

Amount available for HSA if cost-neutral and 15% reduction in service use assumed:	$ 233

Proponents of this arrangement feel that the accounts "encourage" employees to not spend their funds on "unnecessary care" and hence can generate savings to the system. Even if we assume service use is reduced by 15%, this suggests that the accounts must be funded at less than $233 for program savings to be realized. Compared to the mainstream plan, the net effect will be to redistribute coverage to those with annual expenses below $232 from those that have expenses

[36] If, however, "play" employers are restricted to choosing one plan for their employees, far fewer will likely avail themselves of a high-deductible option because most employers are unwilling to place all their employees in this type of a plan.

that fall between $232 and $1,000. Some dollars will, in fact, not be used for care in the current year and will, instead, be "saved."

It is important to note that the available evidence suggests that consumers will cut back on necessary and unnecessary care equally.[37] Hence, "crude" cost-sharing incentives such as high deductibles have only limited ability to ensuring that only "appropriate" levels of care are consumed. This reflects the fact that the typical consumer is limited in their ability to make informed decisions about an appropriate course of care or which health care provider to use.

A related concern is that workers in these arrangements will spend too little on health care. There is evidence that forgoing certain preventive care or chronic condition treatments can have higher costs in the long run. To a certain extent, this type of outcome can be avoided by exempting certain treatments from the deductible to ensure that cost-effective treatments are not under-consumed. Exempting preventive care from the deductible falls under the definition of plans that qualify for an HSA. Treatments for an existing chronic condition do not.[38]

Lastly, the approach does nothing to target the high-cost cases that contain the most potential for cost savings.

To date, few employers have exhibited a willingness to offer this type of arrangement exclusively. In the absence of total replacement, many analysts feel that these types of accounts would attract healthier employees.[39] If only the young and healthy are attracted to these types of plans, their impact on health care cost trend may be minimal.

Under most scenarios, a high-deductible health plan would create an access problem for low-income workers. Paying out-of-pocket for medical services that fall into the "coverage gap" would be difficult for the low-income worker. Low-income workers are not in a position to fund a Health Savings Account themselves and, even if they could, the tax benefits from such a design may be minimal for the low-income employee.[40] Even if the employer funds the account at a level that leaves only a small coverage gap, the temptation to use HSA funds for non-medical purposes could prove great.[41]

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[37] See *Supplement B: Benefit Design Considerations* for further discussion.

[38] The IRS has issued guidance clarifies that medications are considered preventive if they are used to prevent the recurrence of a disease, or if the drug is taken by someone who has risk factors for a disease that has not yet become clinically apparent. However, those same drugs aren't covered below the deductible if they're used to treat an existing injury, illness or condition. For example, statins used to treat patients with high cholesterol, and ACE inhibitors for stroke patients as examples of drugs that could be considered preventive if not used to treat a chronic condition.

[39] The limited evidence to date is inconclusive regarding this outcome.

[40] To the extent that an employer-funded account substitutes for employer funded premium, there is no tax impact for the worker (both are tax-free compensation). To the extent that the employee funds the account, greater tax savings accrue to higher income workers. The HSA is "above the line" (like the IRA deduction) so taxpayers don't need to itemize to receive the deduction but the nominal tax rates faced by lower income workers lead to much lower savings. The deduction reduces adjusted gross income but not "earnings" so they do not receive an increase in their EITC in connection with taking the deduction the way they would if the expenses were run through a Flexible Spending Account.

[41] HSA monies can be withdrawn for non-medical purposes but they are subject to income tax and a 10% tax penalty.

Using Health Families Provider Rates

The main report, *Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2),* discussed a pay-or-play design which assumes the SHPP could obtain Healthy-Families-type provider discounts for its low-income enrollees. Among other attractive outcomes, this design would enable the pool to offer coverage attractive rates thus greatly increasing pool "cohesion."

It is important to note that the cost-savings associated with these rates (vis-à-vis commercial rates) would likely exceed the savings that can be obtained from other methods discussed in this report. However, the ability of the pool to negotiate these savings is unknown and may be difficult to achieve on a state-wide basis. See the main report for further discussion.

Selective or Direct Contracting with Providers

Provider Contracting Strategies

Practice and cost variation among health care providers in the United States is a well-documented phenomenon. One approach to cost containment attempts to sensitize consumers to this variation by identifying low-cost/high-value providers and providing an incentive for patients to use these providers.[42] In addition to influencing consumer purchasing behavior, the process of classifying cost-effective providers can also lead to changes in provider practice patterns.

There are several variations to this approach. A *tiered* network approach keeps all providers in the plan but uses cost incentives to steer patients to the cost-effective providers. These cost-incentives can be structured so that they are only reflected at point of service or also reflected in the plan's premium.[43] A plan with a *narrow* network restricts coverage to just the cost-effective providers. Under this scenario, cost-sharing would not vary according to which provider the patient chooses because only the cost-effective providers have been included in the plan. The premium, however, should reflect a discount vis-à-vis plans that don't restrict their network.

In practice, the sophistication of the system used to identify "cost-effective" providers varies. As the examples below show, hospitals, specialists, physicians or "systems of care" are all types of providers that have been subject to this scheme. Provider cost weighs heavily in all these determinations but most plans attempt to incorporate other measures as well. As discussed

[42] In addition to the approaches discussed here, some plan sponsors will provide comparative information on providers in an effort to sway consumer behavior without using financial incentives. Purchasers are mixed in terms of their perception of the effectiveness of an information-only based approach. MedPAC, *Report to Congress: New Approaches in Medicare*, June 2004.

[43] The distinction vis-à-vis PPO/POS plans (which already distinguishes between network and non-network providers in their point-of-service cost-sharing) is subtle. The introduction of a "preferred" tier of providers into this type of plan seeks to differentiate between those in-network providers that are most cost-effective and in-network providers that are less cost-effective.

below, typically it is the *plan* that categorizes the providers. Rarely, a *purchaser* bypasses the plan and contracts directly with providers.

Plans featuring tiered or narrow networks claim to save 10%-20% compared to offerings featuring unrestricted networks. According to some analysts, however, these "narrow" networks are still too broad to be very cost-effective.[44] One interviewee speculated that the tiered/narrow networks served more as a tool to negotiate with providers rather than a real strategy to influence consumer behavior (reflecting the fact that some of the cost incentives are quite small).

Looking forward, the use of restricted or narrow networks is expected to have broad appeal to both medium and large employers as a means of muting the significant cost-shifting to enrollees that would otherwise be adopted to counter ongoing premium increases.

[44] Mays, Glen P., Gary Claxton, and Bradley C. Strunk. *Tiered-Provider Networks: Patients Face Cost-Choice Trade-Offs*, Center for Studying Health System Change, November 2003, Issue Brief No. 71.

Table C-3: Examples of "Reaching Through" to Providers

	Blue Shield of California *Network Choice*	**Blue Cross of California** *Power Select HMO*	**Aetna** *Aexcel*	**PacifiCare** *SignatureValue Advantage*	**BHCAG** *Choice Plus**
Tiered or Narrow?	Tiered	Narrow	Employer Option	Narrow	Narrow
Type of Provider Targeted	Hospitals	Physicians	Specialists	Hospitals & Physicians	Integrated Care Systems
Tiering Reflected in …	Copay At Point of Service (BS also absorbs some of the hospital cost difference)	Premium	Copay At Point of Service	Employer option (premium and/or copay)	Premiums ("Care Systems" expected costs for a standardized benefit package just passed through)
Tier placement reflects…	Mostly hospital cost; some quality taken into account	Financial stability, administrative efficiency, accessibility for new members and cost efficiencies	Rate of hospital readmissions, rates of unexpected adverse events, and total cost of care.	Clinical Performance, patient satisfaction (CAHPS);safety	Cost
Cost Adjusted for:	severity, mix of businesses and geography			Clinical performance adjusted for severity	ACGs
Quality?	Leapfrog participant, JCAHO			Leapfrog	

*Renamed *Patient Choice* in 2004.

Experience with Tiered Networks

The vast majority of enrollees in employer-sponsored insurance face tiered drug pricing arrangements. Substantially fewer face differential pricing reflecting the cost of the provider they go to for service.[45] California, however, is a leader in the use of this type of product.

Blue Shield of California introduced a tiered product, dubbed *Network Choice*, in early 2002, and it has grown to become one of the largest plans of its kind, with approximately 1.2 million members – in part because this tiered product is integrated into all of the carrier's individual, small employer and mid-sized employer products. The same hospital network is used for its HMO and PPO products.

Initially, Blue Shield assigned hospitals to tiers based on cost, after adjusted for severity and mix of businesses. About 80% of contracted hospitals are in the low-payment tier.[46] In 2003, Blue Shield incorporated quality measures into their methodology including participation in leapfrog patient safety initiatives, JCAHO accreditation, and Patient's Evaluation of Performance.[47] In addition, they increased the number of rating regions and incorporated more information on the severity and complexity of cases.

According to a Blue Shield spokesperson, the *Network Choice* product was created primarily as a means of introducing some transparency into the patient's hospital selection decision. Premium savings were a secondary consideration. Because the differential is modest--typically a 10% differential in the copay—the savings are not large. Nonetheless, Blue Shield believes there have been some shifts in the patterns of hospital usage.

The *Network Choice* product is an option for employers with 299 employees or more but few of them have taken it up. One Blue Cross official said that main reason is that the premium savings are too small. Larger savings can be realized with other benefit design options. Another consideration is the fact that for certain areas of the state there is no "choice" hospital designated and large employers with diffuse populations don't want to penalize employees for living in the wrong place.[48]

In 2004, **Aetna** rolled out a variation on the tiered approach that targeted specialists. They called this product the *Aexcel* plan.[49] This product identifies low-cost, high quality physicians in six key specialties: cardiology, cardio-thoracic surgery, general surgery, orthopedic surgery, gastroenterology and obstetrics and gynecology.[50] Unlike Blue Shield, Aetna hopes that

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[45] The KFF/HRET survey finds that just 6% of HMO, PPO and POS participants are in plans using tiered provider networks, while 19% of plans are "considering" tiered network arrangements.

[46] Robinson, James C. "Hospital Tiers In Health Insurance: Balancing Consumer Choice With Financial Motives," *Health Affairs* Web Exclusive, March 19, 2003

[47] See *Supplement F: Quality Considerations* for more information on these initiatives. Note that providers receive their contracted rate; there is no increment for being in the preferred tier. The reward for performing well on these quality measures is the increase in patient volume.

[48] Employee Benefit News, June 15, 2004.

[49] This product was launched in three markets in 2004 and will be expanded to nine markets in 2005.

[50] This list of specialties will be expanded to 12 in 2005.

targeting specialists will prove to be a powerful weapon in the fight against health care inflation. Doctors are placed in the high-quality, high-efficiency tier based on patients' hospital readmissions rates, rates of unexpected adverse events experienced by patients during hospitalizations, and total cost of treatment (in and out of the hospital). Employers have the option of directing their workers to use only the *Aexcel* physicians for the six specialties or offering the *Aexcel* physicians along side Aetna's broader network of specialists at a reduced copayment rate. The physician gets no additional pay, only the opportunity to attract more patients. According to a June 2004 press release, 10 customers have implemented *Aexcel* for more than 64,000 members. The product is currently only available to self-insured employers.

Experience with Narrow Networks/Exclusive Contracting

PacificCare developed the original tiered offering in late 2001 with their "Selected Hospital Plan." In October of 2002, however, PacifiCare replaced this product with a new "value HMO," which offered a restricted choice of doctors groups and hospitals in exchange for a significantly lower premium. In 2003, this product was renamed *SignatureValue Advantage.*

Originally the selection criteria only looked at hospital cost but it evolved to include physicians and quality measures. PacifiCare estimates that approximately 70 percent of PacifiCare's standard HMO network participates in the plan in the counties where it is offered.[51]

In order to qualify for the *SignatureValue Advantage* network, providers must meet established cost and quality targets. In 2002, quality measures included 10 indicators of physician group performance and 6 measures of hospital performance. Physician performance included five clinical measures (breast cancer and cervical cancer screening rates, childhood immunization rates, diabetic and coronary artery disease care metrics) and five service/satisfaction measures (all derived from CAHPS). Hospital performance was based on a subset of patient safety measures and one patient satisfaction measure.

According to PacifiCare, healthcare costs are approximately 20 percent lower and quality is approximately 20 percent higher than their standard plan.[52] Annual premium savings are 8-10%.[53] By August of 2004, 16 large employers (including AT&T, Pitney Bowes, Wells Fargo and Ross Department Stores) have offered the limited network product to their employees.

Blue Cross of California (Wellpoint) also offers a narrow network product, *Power Select HMO*, that includes just 50 percent of their full physician network. Medical groups must demonstrate financial stability, administrative efficiency, accessibility for new members and cost efficiencies related to physician, hospital and pharmacy charges.[54] When the plan was introduced in October of 2003, the premium was 15% lower than their "regular" HMO product. The product is offered to employers with 51 or more employees in 22 California counties.

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[51] Ho, Samuel M.D., Senior Vice President and Chief Medical Officer, PacifiCare Health Systems, Inc., Cypress, California , Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 18, 2004.

[52] *Ibid.*

[53] May, Troy. "Blue Shield: Two hospitals too expensive," *Silicon Valley /San Jose Business Journal*, August 2004.

[54] Edlin, Mari. "Tiers Keep Costs in Tow," *Managed Healthcare Executive*, May 1, 2004.

CalPERS adopted a similar strategy in 2004 by choosing to narrow the hospital network used by its Blue Shield administered HMO.[55] To select the providers for inclusion, CalPERS used an analysis done by Blue Shield that took into consideration cost and a dozen quality indicators. Originally, CalPERS identified 39 hospitals for exclusion but 10 were reinstated after they reduced their charges and another five were restored by the Department of Managed Health Care to address patient-access issues.[56]

The new plan began in 2005. About 12 percent of this plan's 400,000 enrollees had a provider who was no longer associated with the network.[57] Approximately 7 percent of enrollees choose to switch plans during 2004 open enrollment. (Note that some of these "switchers" changed plans for reasons other than the change in their provider status.) Only 20% to 25% of the switchers appeared to have changed plans in order to keep their doctor, according to CalPERS estimates. CalPERS estimates that the move to the smaller network saved 4 percent off the premium.

Direct Contracting with Providers

Direct contracting takes the idea of selective contracting with providers one-step further. There are different reasons why a purchaser might consider this approach. An employer might want to cut out the insurer to encourage meaningful competition at the provider level. Such a move might serve to counter HMOs with too much market power or whose provider networks overlap extensively with those of other HMOs. If such a system creates or improves accountability between the patient and the provider, it could drive changes in practice patterns or in the fees charged. It has also been suggested that by cutting out the insurer, a purchaser could save on administrative costs, which can represent 20% of each health care dollar. Many administrative functions still need to be performed, however, so the ability to realize savings (if any) may be limited.

Only a few purchasers have tried direct contracting. The most recognized example is the **Buyers Health Care Action Group** (BHCAG) in Minneapolis. In 1997, this large employer purchasing alliance introduced a program featuring direct contracting arrangements with hospitals and doctors aligned into approximately 20 "care systems." It should be noted, however, that the goal of this system was not cost-savings. Rather, BHCAG hoped this innovation—by making providers more accountable to their patients—would foster competition among providers on price and quality, with consumer's choices driving the process.[58]

In this plan, dubbed *Choice Plus*, the provider "care systems" submit a "claims target" based on a standard benefit package and standard enrollee mix, i.e. an estimated "per member per month" amount needed to provide all covered care. The systems are then grouped into premium "cost

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[55] Note that CalPERS adopted a variety of other measures to contain premium increases and preserve membership, including the adoption a regional rating system.

[56] May, op. cit.

[57] While hospitals were the providers evaluated for inclusion or exclusion, the status of physicians was affected if the hospitals where they have admitting privileges were no longer in the network.

[58] As such, BHCAG's model shares a similar goal--but a different implementation--with the "consumer driven health care" approach currently receiving a lot of press.

tiers" based on that bid. Prior to be classified into these cost tiers, the bid is risk-adjusted to reflect the care system's prior year case-mix of patients. [59] Providers are actually paid based on fee-for-service. Their bid is used to develop a fee schedule "conversion factor" that determines level of payment to the "care systems." The ability to set your own price has been reported as being especially attractive to physicians participating in the system.[60] Furthermore, unlike full capitation, physicians in this system are not at risk of taking a large loss on an unhealthy patient. Instead, they are at risk of losing the patient if patient's expectations are not met. Originally, if the "care systems" actual expenditures was determined to be too far off of their original bid, their "conversion factor" might be adjusted up or down. This adjustment was dropped in 2000 because it was difficult to administer.

Employers contribute no more than the cost of the lowest cost plan and employees bear the burden of choosing a higher cost plan.[61] Importantly, providers can participate in only one system of care while hospitals and specialists can affiliate with multiple systems of care.

The BHCAG model could not be implemented under SB 2, because the pool is prohibited from bearing risk. (A discussion of direct contracting arrangements whereby the providers bear the risk is discussed below.) Nonetheless, it offers several useful lessons regarding direct contracting with providers

The experience of BHCAG confirms what has been observed in cases of tiered health plan pricing, namely, that workers will select lower cost providers when given an incentive to do so. It has also be observed that workers are more sensitive to tiered pricing when it is associated with a plan compared to when it is associated with a provider system.[62] In the case of tiered plan pricing, overlapping provider networks often mean that a pre-existing provider relationship can be preserved when the lowest cost plan is selected. The mutually exclusive "care systems" under *Choice Plus* preclude this.

One study examined the impact of *Choice Plus* on provider behavior and concluded that, after adjusting for case mix, most care systems seem to be competing more on price and less on efficiency. The "care systems" in the highest cost tier were only moderately more resource intensive compared to those in the lowest cost tier.[63]

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[59] This adjustment is made using Ambulatory Care Groups (ACGs). (See *Supplement E: Risk Adjustment and Mitigation*.) It is up to the individual care system whether or not to risk adjust the individual provider's payment. Studies have shown that the risk taken on by these care systems ranges 25% above and below the Choice Plus average.

[60] Jon B. Christianson and Roger Feldman, "Evolution in the Buyers Health Care Action Purchasing Group Initiative," *Health Affairs*, Vol. 21, no. 1, pp. 76-88. Note that a similar arrangement exists at Blue Cross and Blue Shield of Florida: hospitals select their own tier based on the level of reimbursement they want, and their placement does not change during the life of the contract

[61] Employers decide which plans, if any, will be offered alongside *Choice Plus*. Note that these employers are self-insured and ultimately bear the insurance risk for their employees under this system.

[62] Harris, K. et al. "Measuring consumer perceptions of quality differences among competing health benefit plans," Journal *of Health Economics*, 21 (1): 1-17 (Jan 2002).

[63] Lyles, Alan et. al. "Cost and Quality Trends in Direct Contracting Arrangements," *Health Affairs*, January/February 2002, pp. 89-201.

Ann Robinow, the vice president of Patient Choice, notes that a large membership base is required in order to contract with providers.[64] While a *plan* would be happy to get 50,000 member group, this same membership—divided among many *providers*—represents a relatively small amount of patient volume. In addition, providers face higher administrative costs in direct contracting arrangements. Patient volume has to be sufficient to justify these costs.

Importantly, Robinow believes that a differentiated provider network can also be used to change patient behavior in the context of a health plan (like the tiered network plans described above). In other words, direct contracting does not need to be used to realize some of these benefits. Patient Choice intends to roll out such a plan (featuring tiered provider pricing) in early 2005.

There is a limited amount of evidence suggesting that the BHCAG program has successfully contained cost trend. One early study analyzed the cost and usage of health care resources from 1996 to 1998.[65] The study found that the cost of hospital care, which is the most expensive form of health care, dropped over the three-year period, while the cost of ambulatory care rose slightly and the cost of pharmaceutical care increased more sharply. Overall, the BHCAG spent an average of $120 per month for each member, while the average Minnesota HMO spent $152 per month for each member. The study also looked at several quality measures and found no loss of quality. A later analysis found that over four years, the *Choice Plus* trend was in line with the average for Minnesota HMO plans—despite an increasingly sicker population overall.[66]

As with any voluntary purchasing alliance, BHCAG struggles to keep its members from being enticed out of the alliance by attractive offers from plans. From a high of about 150,000 members, BHCAG has only about 80,000 members today.

Despite the limited savings and administrative difficulties faced by the program, the *Choice Plus* model continues to attract interest around the country. Several state agencies, including Minnesota, Wisconsin and Washington, have introduced benefit programs for state employees that include mutually exclusive, cost-differentiated provider groups. For example, Washington State initiated a pilot project in three counties that mirrored many aspects of Choice Plus dubbed *UMP Neighborhood*. In this plan, care is provided by a limited choice of network providers ("care systems”). Enrollees can self-refer to anyone within the care system they choose. Unlike *Choice Plus*, in this plan enrollees can also use providers outside their “care system” but at a higher coinsurance. The monthly premium difference for an employee choosing single coverage was about $10 in 2004. Minnesota state employees pay the same premium for a plan that includes multiple care systems but face very different copays and deductibles depending on the “care system” they use.

[64] Patient Choice is a group that was “spun off” of BHCAG in 2001 in order to permit the alliance to focus on other areas. In keeping with the goal of bring sufficient capital into the new enterprise, Patient Choice was acquired by Medica (a large regional health plan based in Minnesota) in 2004.

[65] Lyles, op. cit.

[66] Lo Sasso, Anthony T. et al. “Tales from the New Frontier: Pioneers’ Experiences with Consumer-Driven Health Care,” *Health Services Research* 39:4, Part II (August 2004).

Other Models of Direct Contracting

Other models of direct contracting exist. There are limited cases of stand-alone employers contracting directly with individual providers. For example, in 1997 an IPA in Houston began contracting directly with Randall Supermarkets, offering health services to the company's approximately 5,000 area employees. (This arrangement ended when Randall was purchased by Safeway a few years later.)

More recently, in 2002, Sprint began purchasing health care services for its SprintChoice Healthcare PPO directly from Health Midwest Comprehensive Care, a PHO affiliated with one of the two major health systems in the city. A third-party administrator administered claims for the Kansas City PPO.

Direct Contracting Arrangements whereby Providers Bear the Risk

While it is common for HMOs to fully or partially capitate their providers, it is extremely rare to have a purchaser enter into a direct contracting arrangement in which the providers bear all the risk. In large part, this is because an employer typically would not want to lose the liability protections afforded by ERISA by transferring too much risk to providers.

Under SB 2, the pool is prohibited from bearing risk so any direct contracting it might consider would have to take the form of having the providers bear the risk. (This type arrangement was studied by purchasing coalitions in the early 1990s but not successfully put into place.)

As with HMOs that globally transfer risk to providers, it is important ensure that providers have the financial resources and administrative structures in place to handle this risk.[67] States vary in their regulation of risk bearing provider groups. In Minnesota, for example, providers are not permitted to bear risk (i.e., accept capitation from self-insured plans) without licensure as an HMO.

California does not prohibit this type of contract but, under Knox-Keene, licensed health plans that have capitated contracts are responsible for ensuring that each contracting provider has the administrative and financial capacity to meet its contractual obligations. In addition, in 1996, the state began requiring providers who wanted to take on full capitation obtain a “limited license” from the Department of Corporations. These groups were held to the same financial viability standards as fully-licensed health plans (although were not required to meet other standards). However, in the wake of some highly visible failures of certain provider groups in 1999, existing safeguards were deemed inadequate and the legislature sought to establish more clear-cut standards for financial solvency for these groups. It created the new Financial Solvency Standards Board (FSSB) as part of the new Department of Managed Health Care (DMHC). In addition, the state suspending the issuing any new “limited licenses.” In March of 2001, the FSSB issued its initial regulations specifying the financial information that HMOs were to provide to physician groups prior to negotiating a contract and the financial data that the 250 or

[67] The Balanced Budget Act of 1997 established regulations that allows provider sponsored organizations (PSOs) to bypass HMOs and obtain independent Medicare risk contracts. Very few PSOs have sought Medicare contracts however.

so risk-bearing groups were to provide to the DMHC.[68] The FSSB posted the extent of compliance for these groups on its website. The board wanted to post more detailed financial data on these physician groups but was successfully sued by the California Medical Association to prevent this public disclosure. The court declared that the sections of the law dealing with the collection of financial information were invalid. Since that ruling, the requirement that "risk-bearing organizations" submit financial information to the DMHC has been suspended. The Department expects to issue new regulations "in the near future."

CalPERS Evaluation of Direct Contracting

In 2000, CalPERS studied direct contracting as a cost-saving option for its membership—particularly in rural areas that were plagued by HMO withdrawals. After commissioning a study and issuing an RFI, CalPERS decided not to pursue this option. There were several reasons. For one, CalPERS already had significant leverage in the negotiation of purchasing discounts; the savings would have to be significant to improve upon this. Second, the strong presence of Kaiser, which transfers risk to providers, accomplishes some of the same goals. Thirdly, the organization had other options for eliminating some of the network redundancies in the current plan offerings (see the narrow network discussion above). Finally, after examining the experience of BHCAG, CalPERS concluded that it would require significant start-up costs to introduce direct contracting and that savings from reduced layers of administration would not be enough to justify that investment.

One of the original study authors emphasized that a lot has changed in the California health insurance market since this topic was studied and its conclusions should not be assumed to still apply.

Implementation Issues

Purchaser Size

Regardless of the exact type of selective contracting, the plan (or the purchaser in the case of direct contracting) needs to command a sufficient number of lives to impact the patient volume of providers. Ideally, the arrangement would affect 20-30% of the provider's patient mix. If the purchaser/plan commands a larger share than that, the provider may feel that their relative market power is too unbalanced to enter into any selective contracting arrangements.

Identifying Cost-Effective Providers

To date, most attempts to classify providers for this purpose have focused on hospitals. Not only is hospital claims data more readily available, but hospitals also are responsible for a larger share of total health care costs than physicians. According to an analysis by Blue Shield of California (for CalPERS), there are wider cost discrepancies among hospitals than among physicians.

[68] This includes groups with limited licenses and those taking partial capitation. As of April 2003, only five limited-license plans were still active in California. Baumgarten, Allan. *California Health Care Market Report*, California Health Care Foundation, 2004.

In the past, cost has been the only criterion used to classify these providers. However, in an attempt to bring "value" into the equation, several insurers are now incorporating quality measures. However, a large volume of claims data is necessary in order to evaluate providers using these criteria. Some purchasers require their third party administrators to share claims data for their full book of business in order to do these assessments. Importantly, claims data is also needed to adjust the cost data for case-mix so as not to penalize providers who take on sick patients

While the number of purchasers/plans using hospital performance data is relatively small, rarer still is data on physician performance.[69] This data is generally regarded as being of poorer quality than hospital data. In addition, the volume of data available for an individual physician is considerable less than that available for a hospital. Analysts question whether examining that small amount of data can provide a fair assessment of a physician's performance.[70] As a result, some analysts believe tiering works better in the hospital setting because the volume and quality of inpatient data allow plans to make more accurate assessments about the quality and efficiency of care.

Another physician profiling issue concerns the fact that available data will often identify only the group practice and not the individual physician. For example, in the case of group practices where Aetna can't be sure which physician directed patient care, entire groups and not individual doctors will be assigned to, or excluded from, the *Aexcel* tier.

Significantly, many of the plans that do tier physicians are fairly liberal with their criterion for inclusion. A plan operated by Premera in Washington state includes 80 percent of the doctors it contracts with, while PacifiCare's *SignatureValue* network embraces 70 percent. The *Aexcel* networks include between 40% and 70% of the physicians in Aetna's existing specialist network in a given region.[71] In contrast, Blue Cross of California has placed just one-third of its doctors in its *Power Select HMO* network.[72]

Some providers may be less interested in being in the preferred tier than others. If their practices are full, for example, they may not value the increased patient volume associated with being in the preferred tier.

New Administrative Roles

For the direct-contracting approach, payers or providers would take up HMO functions such as eligibility processing and data tracking and analysis. These startup costs can be high.

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[69] Insurers typically decide which community-based physicians can join their narrower, tiered network by looking at how physicians treat certain conditions. In some cases, health plans analyze all the care physicians provide for a given condition to create what is called "episode treatment groups" or "episodes of care."

[70] Aetna, for example, decides who can participate in its Aexcel network by measuring physician groups who care for a minimum of 10 "episodes of care" over a two-year period.

[71] Bonnie Darves. "Tiered physician networks spark controversy," *ACP Observer*, American College of Physicians, September 2004.

[72] Terry, Ken. "What 'tiered networks' will mean to you." *Medical Economics* Sep. 17, 2004;81:4.

Local Market Conditions

In some areas, hospitals and/or provider groups have market leverage that makes it difficult to implement a tiered system. In Boston, for example, the Partners system has been successful in its refusal to contract with any plan that would place them in a tier other than the preferred tier.

In other areas, like rural areas, a dearth of providers makes impractical to implement such a system. As Robinson (2003) points out:

> *To be effective, tiered products require multiple independent facilities within reasonable travel distances as the basis for the cost-conscious consumer choice. The hospital cost problem is most acute, however, in precisely the urban cartel and rural markets that lack those characteristics. Tiering may be most effective in fragmented markets such as Los Angles, where it is least needed, and least effective in consolidated markets, such as Sacramento, where it is most needed.*

BHCAG is successful, in part, due to the integrated structure of its providers and the fact that all its members are self-insured and thus exempt from state regulation. Many markets have not developed the integrated, sophisticated provider organizations needed to make this strategy work. In Des Moines, for example, the Community Health Purchasing Coalition, consisting of about 22,000 covered lives, tried unsuccessfully to introduce direct contracting. Historically low managed care enrollment created an infrastructure with less provider integration and managed care acceptance than Minneapolis.

Conflicts with other goals

The criteria used to exclude hospitals from the preferred tier can have ramifications for hospitals that provide public safety net services. For example, as of June 2004 the University of California at Davis Medical Center (UCDMC) was not on PacifiCare's preferred list, nor was it on Blue Shield's preferred list.[73] The UCDMC provides the largest share of county indigent care in the area.

Blue Shield of California's tiering methodology stratifies hospitals by their status, i.e., comparing teaching hospitals with other teaching hospitals and community hospitals with other community hospitals. By design, of course, some hospitals in each group end up in the high-cost tier. However, teaching and safety-net hospitals raise a valid—and familiar— question about the sustainability of their burn units, trauma services, and twenty-four-hour "standby" capabilities in an era of declining public reimbursement.[74]

Subsequent negotiations resulting in Blue Shield reversing its decision regarding the UCDMC's tier, in part by incorporating additional quality measures into their equation. UCDMC claims they did not lower their costs (which are expensive since they have an all RN staffing system).

[73] Baumgarten, op. cit.

[74] Yegian, Jill M. "Tiered Hospital Networks--Reflections from the California HealthCare Foundation/Health Affairs Roundtable," *Health Affairs,* web exclusive, 19 March 2003.

In summary, consumers still prefer broad networks and many employers want them in their product offerings. Nonetheless, the tiered or narrow network may be preferable to other cost-containment options, particularly if it can be demonstrated to drive improvements in quality or practice patterns.