

Value-Based Purchasing and Consumer Engagement Strategies in State Employee Health Plans A Purchaser Guide

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Introduction

State Employee Health Plans account for approximately 7 million covered lives nationwide.¹ The nation's largest State Employee Health Plan (SEHP) is CalPERS, with 1.3 million members.² The size and potential influence of SEHPs might best be assessed in terms of the percentage of a state's population that receives health insurance coverage through such a plan. For example, in South Carolina, where state law requires not only state employees and retirees but also public school districts and public colleges and universities to obtain their coverage through the state health plan, nearly 10 percent of the state's population is covered by the plan. Despite their size and potential impacts, these large state-administered programs have drawn less attention than might be expected with respect to efforts to identify and implement successful strategies and innovative concepts that could benefit their purchasing activities and the performance of the broader health care system.

No two SEHPs are the same. Some are self-insured; some use one major carrier; some contract with dozens of carriers; and some represent a mix of self-insured and commercially insured covered lives among their enrollees.

This guide lays out clear and simple descriptions of two principal means for improving the value that states may obtain through the administration of SEHPs: value-based purchasing and consumer engagement. It highlights innovative strategies and focuses on successful programs operated today by SEHP purchasers.

Value-based purchasing is defined here as using a strategy employed by purchasers of health insurance and health care services to maximize the benefits received at the lowest cost.³ It involves the application of a series of prescribed management actions with a contractor(s). For purposes of this

guide, “contractors” may be insurer(s) or third-party administrators (TPAs) as well as direct service providers in cases where a state operates its own health plan.⁴

Consumer engagement strategies, instead of primarily concentrating on carrier/TPA and provider performance, focus on employee, retiree, and dependent behavior. Consumer engagement strategies include the provision of:

- Financial and non-financial incentives for enrollees;
- Support services for enrollees; and
- Strong leadership.

Throughout this guide, the strategies identified as either value-based purchasing or consumer engagement fit primarily into the general definitions provided above. These two strategies are intended as guidelines to help state purchasers think about the differences between strategies focused on changing contractor behavior and strategies focused on changing employee, retiree, and dependent behavior. The categories do not imply mutual exclusivity. A strategy designated as falling within one category (e.g., influencing contractor behavior) could, and likely will, contain aspects of the other (e.g., influencing employee behavior).

While we will describe many successful initiatives throughout this document, we stress that success comes not from one initiative but rather from building and sustaining productive relationships with insurance carriers, medical professionals, state and local governments, private employers, and other important entities and individuals. Change requires a combination of leadership, innovation, and persistence.

The best programs have made progress incrementally over time. Personal behavior change does not happen overnight because people do not change their behavior overnight. Habits become custom and are embedded in the culture of a place. For

example, no individual health purchaser can single-handedly change cultural norms affecting diet, exercise, tobacco use, and other behaviors that are significant drivers of population health status.

Organizational change, as reflected in the practice of value-based purchasing, requires a degree of doggedness to stay with a process and see it through to effective, continuous improvement over time. For example, implementing a process of setting annual performance goals with a contractor supports steady improvement.

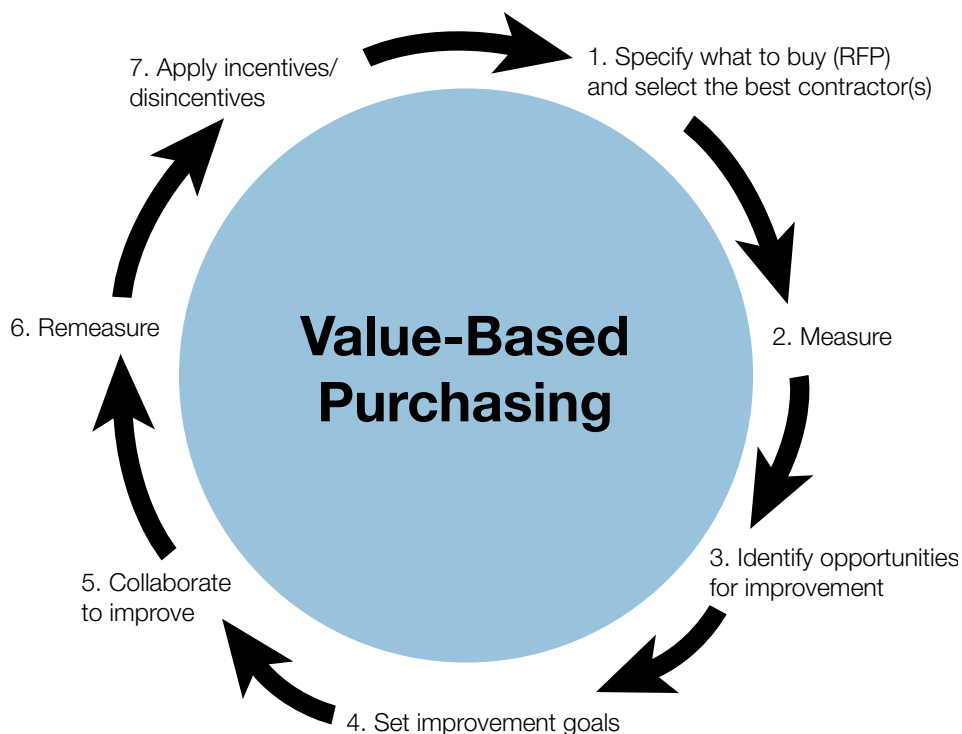
The most successful programs have been attempting to improve health outcomes at the population level for a long time. Such efforts maintain a twin focus on health care market dynamics *and* the cultural underpinnings of society that drive health behaviors. It is these programs that have relentlessly moved forward in incremental steps.

Value-Based Purchasing and Consumer Engagement

A. Value-Based Purchasing

Value-based purchasing is a strategy used by both private and public sector purchasers of health care and health insurance services.⁵ It begins with a strategic, focused approach to specifying performance requirements and identifying clear consequences for performance. Contractors and providers are then held accountable not only for standard performance requirements, but also for performance improvements identified and achieved through a collaborative business relationship with the state purchaser. Figure A depicts the ongoing, seven-step cycle that begins with procurement and continues iteratively throughout the term of a contract. State purchasers should focus on the cycle itself and the need to perform and connect the steps.

Figure A: Value-Based Purchasing Cycle



This guide highlights and explains the seven steps. Alongside the individual steps, the guide provides examples from states around the country. Throughout the guide, it is important to note the connectedness, commonness, and overlap of the examples and the steps. The programs have all developed over time and focus on improving both short- and long-term performance outcomes.

Step 1: Specify What to Buy

Draft specific and measurable performance requirements and identify top priorities that the contractor will be required to address during the contract period. Award a contract(s) only to the contractor(s) that best meets the requirements and demonstrates a commitment and ability to be a long-term partner.

Example: The Massachusetts Group Insurance Commission

The Massachusetts Group Insurance Commission (GIC) in its Request for Proposals (RFP) for Pharmacy Benefit Manager (PBM) services first communicated a clear set of priority performance goals and then set forth clear and measurable performance

requirements. The RFP's goals read as follows:

- Full and open disclosure regarding all aspects of the employer/PBM relationship, including disclosure of all revenue received from manufacturers and pharmacies and actual acquisition costs and dispensing fees for drugs purchased through the GIC program;
- Encouraging greater transparency in relationships between PBMs and manufacturers and pharmacies;
- Ensuring that formularies, designation of “preferred drug” and therapeutic substitutions are based on sound clinical evidence and with the members’ benefit and health in mind;
- Working with the PBM to engage the medical community in increasing awareness of members’ utilization and compliance with treatment protocols;
- Quality, safety and efficacy concerns; and
- Service excellence to its employees, and encouraging PBMs to take a greater role in educating the membership as to how to best utilize their prescription drug benefit and improve their overall health.⁶

The RFP then went on to provide 10 areas of “certification,” within each of which the state identified “best practice” standards that the selected vendor had to meet.⁷ The RFP provides an example of procurement design that sets forth a clear vision and concrete, measurable performance requirements, all focused on purchasing value. The following excerpt from the Certification 4–Network Requirements section of the RFP provides a few examples of the requirements in the document:

Requirement 3. Network Access. At least 97 percent of all GIC enrollees should have access to a retail pharmacy within five (5) miles of their home. This metric should be evaluated annually (or more frequently upon GIC request), with remedy within 30 days.

Requirement 4. Mail Order Capacity. Bidder to confirm that their mail service facility can accommodate an additional 50,000 scripts per month. Overall capacity should remain at 75 percent or less.

Requirement 5. Mail Order Professionals. Registered pharmacists dispensing in the mail order pharmacy must be State Board of Pharmacy licensed, in good standing with the Board of Pharmacy (no sanctions or malpractice suits) and have two years of experience in retail or hospital pharmacy. Credentials should be verified on an annual basis.

Requirement 6. Mail Order Accuracy. The mail order facility will maintain a client-specific accuracy rate of over 99.95 percent. This measure should be calculated every two (2) weeks, with a listing of scripts filled incorrectly and the subsequent action taken to inform the member and the physician regarding the error. This goal is to be measured every two (2) weeks and be subject to Performance Guarantee.

Requirement 7. Mail Order Timeliness. For prescriptions requiring interventions or follow-up,

in-house turnaround time will be five (5) business days or less for at least 95 percent of prescriptions. Turnaround time for all other prescriptions will be two (2) business days or less for at least 98 percent of prescriptions. This goal is to be measured every two (2) weeks and be subject to Performance Guarantee.

Requirement 8. Mail Order Stock.

The mail order facility should monitor on an ongoing basis the availability of prescriptions on file to avoid “back-orders” and delays. Less than 0.1 percent of requested prescriptions/refills should be subject to delay due to insufficient medication on hand. This goal is to be measured every two (2) weeks and be subject to Performance Guarantee.⁸

Step 2: Measure

- A. Assess contractor performance at the point of the procurement relative to benchmarks and expectations. This benchmark performance should be provided within the content of the RFP response.
- B. Develop a Performance Indicator Dashboard that: (1) identifies key aspects of performance for which the contractor will be expected to report indicator data; and (2) will be monitored by the purchaser to ensure contractor accountability.

The dashboard should not be an all-inclusive set of performance measures. Rather, it should assemble the performance indicators that assess the most important dimensions of contractor performance. It should include some or all of the measures that may be linked to contractual performance incentives and disincentives. In addition, the purchaser should measure other aspects of contractor performance, as necessary.

A number of states use analytic contracts to review performance of contractors and providers either at the point of procurement or before commencement

of new performance periods or new programs. Iowa and Oregon are discussed below as examples of states assessing performance at the point of procurement and on an ongoing basis.

Example: The Iowa Department of Human Services

Assessing performance at procurement
In 2008–2009, the Iowa Department of Human Services procured a vendor for managed behavioral health services. During the procurement process, the bidders were scored against RFP requirements. State reviewers noted areas of both strength and weakness relative to RFP requirements. Because even the best proposal had opportunities for improvement, the state reviewers made note of those areas so that subsequent contract negotiation and contract management activity could focus on those opportunities.

Example: The Oregon Public Employees’ and Oregon Educators Benefit Boards

Assessing performance on an ongoing basis
The Oregon Public Employees’ and Oregon Educators Benefit Boards monitor the performance of contracted health plans by using a dashboard to review, among other things, screening for breast cancer, cervical cancer, colon cancer, and prostate cancer. Oregon also tracks Healthcare Effectiveness Data and Information Set (HEDIS) cancer screening measures and compares health plan performance against the national 75th and 90th performance percentiles. On a quarterly basis, Oregon reviews measures for cholesterol screening and preventive care visits. Through this monitoring activity, the state seeks to confirm the achievement of desired improvements over time and to identify areas for improvement.⁹

Iowa and Oregon provide good examples of the specific use of qualitative and quantitative information to assess performance objectively and systematically at the start of a contract and over time in order to identify opportunities for improvement. The review of dashboard

data should occur on a regular basis. The frequency of review is determined by the type of information to be reviewed, when it is available, and the contractual incentives and disincentives that relate to the measures. While more frequent measurement allows for closer tracking of changes in performance, there can be operational and financial constraints to doing so. In most instances, it is desirable and reasonable to review performance against goals or requirements on a quarterly basis.

Step 3: Identify Opportunities for Improvement

Using the information collected as part of Step 2, the purchaser should identify gaps between expected or desired performance and actual performance, prioritizing the identified opportunities for improvement based on the size of the opportunity and the potential impact of reducing or eliminating the gap(s).

Example: California Public Employees’ Retirement System

The California Public Employees’ Retirement System meets quarterly with contracted managed care plans to review performance and identify opportunities for improvement. The quarterly reviews support ongoing performance improvement activities. The reviews have been used to track and improve projects addressing the establishment of high-performance physician networks, e-prescribing, and the proper identification of members eligible for Medicare.¹⁰

Step 4: Set Improvement Goals

Setting performance improvement goals with contractors enhances performance accountability and improvement in areas of high priority to the purchaser. Goal setting should occur annually through the formal establishment of a group of performance improvement goals. The purchaser should contractually require the contractor to make its best efforts to achieve the established goals, with incentives and disincentives

implemented (see Step 7) to increase the likelihood that the contractor will indeed make its best efforts. The goals should number approximately four to eight per contract year, depending on their nature and scope. The goals should be highly specified and measurable. They may be administrative service, access, clinical quality, and cost/efficiency goals and should reflect areas that present significant opportunities for performance improvement. The agreed-upon improvement goals should be incorporated into the contract as an amendment as they are modified from year to year.

Example: The Massachusetts Executive Office of Health and Human Services

The Massachusetts approach to vendor management focuses on the importance of identifying and establishing improvement goals collaboratively with contractors. The state asks each contracted health plan to consider its opportunities for performance improvement and recommend performance goals and attendant measures. The state also identifies high-priority opportunities that it wishes each health plan to address. In these cases, the state either requests a proposed improvement goal or specifies the opportunity it wishes to see addressed. A negotiation takes place between the state and the health plans, resulting in a set of clear goals with measures to confirm attainment during mid-year and end-of-the-year reviews in formal contract management meetings of senior state and health plan managers.¹¹ Two examples of past goals, for which concrete measures were negotiated, include:

- Decrease inappropriate emergency services utilization; and
- Improve access for children and adolescents through linkages with school-based systems of care.¹²

Health plans know that their goal achievement will be measured and reported each year and that goal achievement could influence future contract awards.

Step 5: Collaborate to Improve

A state purchaser and its contractor(s) share one overarching objective: contractor performance that achieves

purchaser-desired levels of performance improvement. State purchasers can enhance the likelihood of contractor success through collaborative activities that facilitate communications and cooperative efforts across insurers, with providers, and/or with other state contractors, such as carve-out vendors. It can even involve the provision of technical assistance to the contractor. Such collaboration can strengthen the partnership between the state and its contractor(s) and help the state achieve its aims.

Example: South Carolina Employee Insurance Program

South Carolina contracts directly with the physicians serving its covered population. The state collaborates with the physicians by providing information that will allow them to identify and intervene to improve health outcomes for members. The state's evidence-based claims monitoring program provides treatment recommendations based on best practice guidelines. The program is targeted at the prevention of adverse events by using claims data and patient-centric records. A software program, Care Engine, reviews the information and forwards recommendations to physicians. The recommendations generated by the program are called Care Considerations and are intended to assist physicians by permitting them to view aggregated patient history, understand treatment delivered by other physicians, benefit from updated medical journal information, and ultimately prevent adverse clinical events. The Care Considerations represent opportunities for improvement identified through a rigorous data-driven process. South Carolina estimates that it has achieved nearly \$14 million in savings based on improved compliance with Care Consideration advice.^{13,14}

Example: Vermont Office of Health Access

The state of Vermont has purposefully co-located several contractors with state staff in order to foster collaboration. This operational design requires contractor staff associated with every major contract for services to be permanently situated on-site in state offices. In addition, regular team

meetings between state staff and contractor staff address progress on activities designed to advance goals aligned with the overall strategies of program leaders. Vermont's approach embeds collaboration into the culture of the office and focuses state and contractual staff on the outcomes essential to strategic success.

Step 6: Remeasure

With contractual performance priorities established, the content of a performance dashboard determined, and annual performance improvement goals negotiated, the state purchaser should remeasure performance at least twice a year, if not more often, and review the performance with the contractor. Absent this step, the state has no basis for determining whether its contractor has delivered the desired value specified by the state in both its contract and annual performance improvement goals.

Most state purchasers of public employee health benefits meet with their contractors at least quarterly. In some instances, either the contractor or a separate state analytics contractor provides analysis to support a review of performance trends.

Example: Oregon Public Employees' and Oregon Educators Benefit Boards

Oregon contracts with a vendor to produce a Statewide PPO Plan Dashboard that includes demographic, claims, clinical quality, and utilization metrics.¹⁵ The state uses the dashboard to measure performance directly against established metrics. According to Joan Kapowich, administrator of the Public Employees' and Oregon Educators Benefit Boards (PEBB/OEBB), Oregon approached measurement of cancer screenings with the general knowledge that every health plan could do better. Oregon coupled the tracking of the screenings with a plan design change that removed all member cost sharing for the specified screenings. It is using the dashboard to determine whether the benefit design change and other carrier-specific strategies are achieving desired results.¹⁶

Step 7: Apply Incentives and/or Disincentives

State purchasers should use incentives and disincentives whenever possible to motivate and recognize contractor performance. It should be the state purchaser's objective to create a financial business case for performance excellence and improvement. This can be done with financial rewards or penalties, provision of increased or decreased enrollment or patient volume, and non-financial strategies involving public reporting and recognition.¹⁷ Incentives and disincentives should be linked to some of the measures in the performance indicator dashboard and/or to contractor performance relative to annual performance improvement goals.

Example: California Public Employees' Retirement System

California currently ties reimbursement of its contracted TPAs to contractor performance. While the state keeps the contractual terms confidential, past reports indicate that the TPAs have a portion of their payments put at risk based on performance requirements set forth in the state contract.¹⁸ This is a common practice among many large self-insured employers.

Example: South Carolina Employee Insurance Program

South Carolina contracts directly with the state's 65 hospitals. Several years ago, the state began incentivizing hospitals to focus on quality by tiering reimbursement directly to measures tracked by the Centers for Medicare and Medicaid Services (CMS). The state pays a 0.5 percent higher rate to hospitals that achieve the 90th percentile on at least five of the 23 measures reported by CMS on the Hospital Compare Web site (www.hospitalcompare.hhs.gov). An additional 0.5 percent over the inpatient fixed base rates is awarded for each additional measure when a hospital achieves the 90th percentile. In 2006, the first year of the program, 6 of the 65 hospitals received an incentive. For 2010, based on 2009 reporting, the state will make incentive payments to 18 of the 65 hospitals.¹⁹ For 2010, the South Carolina Employee Insurance Program added

measurement of the reduction in hospital re-admission rates as another factor that can result in bonuses to the base payment rate for hospitals.

Example: Minnesota State Employee Group Insurance Program

The Minnesota Bridges to Excellence (BTE) program is an employer-led pay-for-performance (P4P) program for physicians used by large, self-insured employers and by the state for public employees. A modified version of the national BTE program, Minnesota's program uses locally developed measures to reward physicians for optimal diabetes care. In 2006, physicians at nine of 53 medical groups received \$100 bonuses for each diabetic patient who met five specific clinical measures: blood sugar count under control; LDL cholesterol under 100; blood pressure less than 130/80; no smoking; and daily aspirin for patients over age 40. In 2007, the number of clinics receiving bonuses tripled, and BTE added cardiovascular disease metrics.²⁰ The cash bonuses paid for achieving specific, measurable outcomes is an example of P4P and a clear example using incentives after establishing goals and measuring performance. BTE uses the same metrics used by the Minnesota health plans to reward physicians in its networks, thereby promoting uniformity and minimizing providers' data collection burden.²¹

B. Value-Based Purchasing: Summary

Value-Based Purchasing in State Public Employee Health Benefit Programs

Interviews with the administrators of leading state public employee health benefit programs reveal that few states apply value-based purchasing strategies; those that do so often apply only selected steps. Some strategies (e.g., annual performance improvement goal setting) see little if any use. In addition, of the states that focus on value-based purchasing as a strategy to improve purchasing value, just a few have followed a continuous process over several years.

The challenges constraining state efforts to implement value-based purchasing are several. Some of the apparent challenges include the following:

- Value-based purchasing produces steady results over time and therefore requires a longer time frame. States sometimes find themselves pressed to produce immediate results, resulting in a focus on the short term to the exclusion of long-term goals.
- Value-based purchasing is a human resource-intensive activity, and many states are not staffed at adequate levels to devote scarce resources to the activity.
- Value-based purchasing requires state employees with high levels of technical knowledge (e.g., clinical quality, performance measurement) and highly developed negotiating skills; states may experience difficulty in attracting and retaining such employees.
- Health insurer and health care provider performance improvement is not always a high priority for state government relative to other competing priorities.

With so little adherence to the value-based purchasing cycle of goal setting, measurement, collaboration, remeasurement, and application of incentives and disincentives, little evidence is available on outcomes achieved as a result of such efforts. In states where adherence has been more normative, some evidence points to the impact of value-based purchasing. Some of the lessons that can be drawn from these state efforts follow:

- Benchmarking with national averages and publicly available data sources represents one approach to goal setting and development of performance incentives.
- Advances require a systemic approach, statewide leadership, ongoing attention to the change process, and a dogged approach to each activity.
- Building partnerships with other purchasers can enhance the effectiveness of purchasing activities but requires a time commitment spanning years.

Relationship between State Public Employee Health benefit Programs' Purchasing Activity and State Health Care Reform Goals and Related Activity

While not extensive, there are some state examples of efforts to align, if not integrate, overall state health care reform goals and state public employee health benefit program activities. One approach calls for aggregating covered lives to enhance the state's purchasing power. Some states have in some fashion combined their two primary state purchasing programs—state employee health benefits and Medicaid—by either creating a combined health care purchasing agency or formulating shared purchasing goals and strategies across public programs.

For example, the first recommendation of the January 2007 final report of the Washington Blue Ribbon Commission directed the state to use its purchasing power to improve health care quality.²² Governor Chris Gregoire's 2010 priorities include the transfer of the state's Medicaid program from the Department of Social and Health Services to the Health Care Authority. The transfer would place under one management structure the state's Medicaid program and State Employee Health Plan, thereby combining the state's purchasing power.

Other states have already moved in this direction with the creation of the Oklahoma Health Care Authority in 1993²³ and Georgia's 1999 creation of the Department of Community Health, which brought together four state agencies.²⁴ In 2005, Kansas state law created the Kansas Health Policy Authority to combine the state employee health plan and the state's Medicaid operations.²⁵

Minnesota took a collaboration-focused approach when Governor Tim Pawlenty created the Health Cabinet in November 2004. The cabinet brought together the heads of several state agencies with responsibility for running public health care purchasing programs. The governor directed the cabinet to “[u]se the buying power of the state (and) partner with the

private sector to make substantive changes to Minnesota's health care purchasing.”²⁶ The following are a few initiatives that demonstrate a focus on collaboration.

- **Bridges to Excellence.** A pay-for-performance initiative that combined the Minnesota Medicaid program, state employee health benefits program, and nine private sector employers. Under the program, health care providers that demonstrate excellence in outcomes among patients with certain chronic conditions receive both recognition and financial incentives.²⁷
- **Smart Buy Alliance.** A coalition among state government, private employers, and labor groups to focus on quality improvement in the health care system by agreeing to uniform performance standards, cost and quality reporting requirements, and technology achievements (e.g., tools to monitor personal health status such as blood pressure, blood sugar, body mass index, and other biometrics; online health screening and education; and secure online communication and telehealth services among health plans and providers).²⁸
- **Minnesota Health Information Web Site.** Under the Health Cabinet, a clearinghouse for health care information, a central Web site, provides all Minnesotans with a place to access health care information of all types (www.minnesotahealthinfo.org/).

In August 2009, Governor Pawlenty launched a new Web site that provides Minnesotans with enhanced information on clinical quality and costs (www.mnhealthscores.org). The non-profit Minnesota Community Measurement established the site in 2004. The addition of new quality and cost information over time is the result of the concerted and ongoing efforts of private and public entities working together.

Increasingly, many states are recognizing that state coordination efforts must go beyond achieving consistency between

state programs and instead must encourage coordination within the entire payer community. As a result, several states have begun to lead multipayer reform efforts that often require state payers to serve as convener and facilitator *and* as a partner purchaser. Minnesota and select other states are demonstrating this new form of leadership.

Best Opportunities for States to Improve Purchasing Effectiveness

States have an excellent opportunity to improve the effectiveness of their purchasing activity related to employee health benefits by applying value-based purchasing concepts comprehensively and consistently over time. Partnerships with other purchasers, such as those pursued by Minnesota, can be the source of support and enhance purchasing leverage. Specific suggestions for the application of value-based purchasing follow:

- Apply a structured and disciplined value-based purchasing process that, from the outset, transparently specifies goals and requirements. Identify the specific measurements to be used, and establish a monitoring and feedback mechanism to ensure communication and promote collaboration with contractors.
- Adjust goals and remeasure to take into account actual events.
- Review data from the current plan and determine where current performance stands in comparison to that of other plans within the state (e.g., commercial carrier data, Medicaid data, and Medicare data).
- Create a dashboard to monitor changes in measures against established incentives and disincentives for contractors.
- Use national data to benchmark plan performance.
- Meet with contractors on a regular basis. Develop meeting agendas that are specific and focus on activities intended to affect goals and permit tracking on the dashboard.

- Collaborate to improve. Make adjustments in activities as necessary to drive achievement of goals.
- Develop a multipayer approach to measurement that is statewide and collaborative.

C. Consumer Engagement

The health behaviors of employees and their dependents have a significant impact on health benefit costs and on productivity. Employer purchasers are well-situated to promote and support desirable employee health behavior. In fact, many private purchasers have been adopting such strategies, including substantial use of health risk appraisals, disease management, and provision of on-site health care services. Research evidence indicates that such strategies reduce medical costs by approximately \$3.27 for every dollar spent and absenteeism costs by approximately \$2.73 for every dollar spent.²⁹

Within the context of employer-provided health care coverage to employees, retirees, and dependents, consumer engagement strategies include the following:

- Financial and non-financial incentives that encourage enrollees to access care in a manner that maximizes their health and financial benefits and make lifestyle choices that result in a reduced health-risk profile.
- Support services, including educational, disease management, and wellness programs, that complement the above incentives and enhance the likelihood that enrollees will maintain their good health status, reduce health risks, or effectively manage chronic condition(s).
- Strong leadership within the organization to create a culture of wellness by changing expectations about how enrollees care for themselves.

The importance of consumer engagement in managing health care costs is clear. An estimated 75 percent of health care costs are associated with chronic diseases,³⁰ such as diabetes and cardiovascular disease, which are linked to poor lifestyle choices.

Figure B: Consumer Engagement



Examples: Minnesota, Washington, Arkansas, and Alabama

Financial and non-financial incentives can motivate and support health behavior change. Minnesota and Washington operate state employee health benefit programs that offer cash incentives to members who complete a health risk assessment (HRA). The programs are designed differently, and the states report different degrees of success as measured by overall participation.

Minnesota has obtained a 70 percent completion rate of its enrollee self-reported HRA instrument. As an incentive for HRA completion, the state offers a \$5 discount on office visit co-payments for both employees and their dependents.³⁴

Washington offers a \$30 gift card for completing an initial HRA online and has obtained a completion rate of 19 percent among all members, 25 percent among employees. Enrollees who identify themselves as smokers in the initial HRA and then enroll in a tobacco cessation program receive an additional \$30 gift card. This incentive applies to other disease management programs as well as to members who exercise at least 2.5 hours per week.³⁵

Arkansas provides premium discounts of \$25 per month for members who complete a self-reported HRA; it reports a 70 percent participation rate. Arkansas has tied HRA data to claims data to quantify the costs associated with risks attributable to unhealthy behavior. The state found increased health care costs associated with individuals who reported use of tobacco, obesity, and physical inactivity, with costs rising steadily as the number of health risks increased.³⁶ Specifically, in a 2009 study published in the *American Journal of Preventative Medicine*, the authors found that individuals in Arkansas who scored 'no risk' (\$2,382) on the HRA cost less than average (\$3,205) and that those who scored 'high risk' (\$4,432) cost above average (Figure C).

Alabama operates two related premium discount programs. One is a self-reported non-tobacco user discount; the other is a discount based on an acceptable HRA result that includes a body mass index (BMI) screening. In Alabama, if employees self-report that they do not use tobacco, they receive a \$30 per month discount on their premium. Currently, 82 percent of members report that they are non-tobacco users. More recently, Alabama instituted a body mass index (BMI) screening that is part of the HRA used at worksite locations and public health clinics around the state. The HRA, conducted by nursing staff, screens for blood pressure, cholesterol, and blood glucose and calculates BMI.³⁸ If the employee has no risk factors, he or she receives a premium discount of \$25 per month off the regular premium.

In Alabama, if the HRA places an employee in a higher risk category, he or she must do one of the following:

1. Follow up with a physician (co-payments waived for the consultation);
2. Participate in an offered wellness management program (such as Weight Watchers, with the state splitting the cost 50/50 with the employee); or

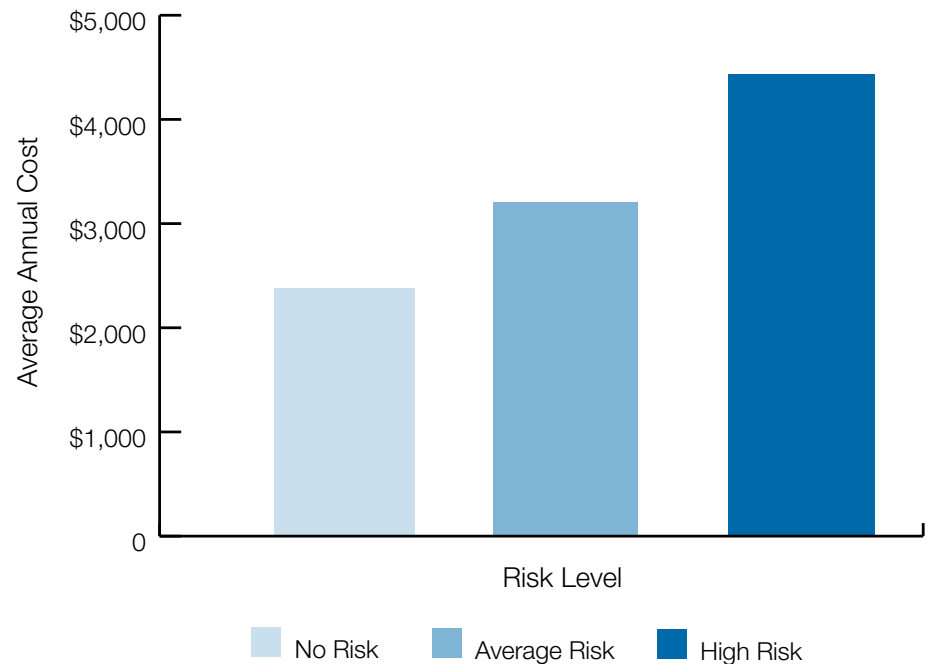
3. Reduce risk factor(s) through self-management (requires remeasurement by the state within one year).

There is no requirement that the employee correct the health condition.

After instituting the premium discount tied to HRA completion in 2009, Alabama has seen an increase from 8,000 completed health risk assessments in the previous calendar year (2008) to nearly 36,000 completed through November 2009. The participation rate through November 2009 exceeded 95 percent.³⁹

The use of nurses to obtain blood pressure, cholesterol, blood glucose, and BMI levels provides Alabama with values that cannot be obtained via a telephonic, mail, or electronic HRA. This approach is more time-consuming and costly to implement on the front end, but it provides quantitative baseline measurements that then may be tracked over time. A state embarking on this type of program must assess the value of obtaining the clinical measures against the associated time and cost.

Figure C: Arkansas HRA Cost Analysis³⁷



Support Services

The private employers who spearheaded development of value-based benefit designs realized that incentives alone would not result in the desired degree of behavior change. Research conducted with a consumer panel of 481 individuals with chronic conditions, for example, appeared to support the finding that people with chronic conditions often know what they are supposed to do but do not know how to start making needed lifestyle changes; they lack self-management skills and necessary support.⁴⁰ With disease management and wellness programs, health coaches often provide the guidance and encouragement that many people need to undertake and sustain difficult behavior changes.

The way in which employers offer support services influences the success of engaging the consumer. Several commercial employers and at least one municipality have found that on-site provision of health care services, including health coaching such as nutrition counseling, is the single most effective way to reach and engage enrollees.⁴¹ However, the success of on-site programs is predicated on a large geographic concentration of employees. Messaging from the individual's physician or health care team can also be highly effective. Insurer-based telephonic health or disease management coaches are likely to be less effective.^{42, 43, 44}

Example: West Virginia Public Employees Insurance Agency

West Virginia offers a statewide diabetes disease management program targeted at the plan's 13,000 diabetic enrollees. Of these, 5,141 participate in the program, which offers consultative services provided by specially trained pharmacists throughout the state. The pharmacists receive payment for scheduled appointments as part of the diabetes disease program. Enrollees receive free diabetes drugs and supplies but must meet with their participating pharmacist a minimum of once per month during the

Figure D: Lifecycle Approach to Wellness in King County, Wash.



first quarter and once per quarter for the rest of the first year. Enrollees must also establish goals related to exercise or diet, with two goals per month required.

During its first three years, the program reduced emergency room utilization but increased the state's pharmacy costs. In 2009, for the first time, the program showed an aggregate cost savings, which resulted from decreased emergency room visits and hospitalizations but increased pharmacy and outpatient costs.⁴⁵

Example: King County (Washington)

In King County, Wash., the county employee health plan has annual lifecycle for wellness supports that provide continuous encouragement and reminders on issues of importance to members (Figure D).⁴⁶

Example: Minnesota State Employee Group Insurance Program

Minnesota's State Employee Group Insurance Program supports a different type of behavior change. It helps members select high-value providers by linking them to information provided by Minnesota

Community Measurement, which is a non-profit organization involving medical groups, clinics, physicians, hospitals, health plans, employers, consumer representatives, and quality improvement organizations. The organization's mission is "to accelerate the improvement of health by publicly reporting health care information."⁴⁷ Minnesota's program "encourages its members to use this resource to help select a health care provider. Members are provided a link to the organization's annual Health Care Quality Report. This report provides members comparative data on provider group performance in the areas of preventive care screenings and immunizations, basic ambulatory care tests and treatments, and treatment of selected chronic conditions, as well as cost, locations and past history."⁴⁸

The West Virginia, King County, and Minnesota programs all provide members with substantial and ongoing supports focused on adopting permanent lifestyle changes and improvements in overall health.

Leadership

Any initiative aimed at changing the culture of an organization requires strong leadership and commitment at all levels of the organization. Consumer engagement initiatives cannot be viewed as adjunct initiatives; they must be central to the organization's mission. Leadership at the top of the organization, including managers and informal opinion leaders, is essential. Given that change takes time and must address obstacles, it requires a sustained multiyear leadership commitment to consumer engagement.

Example: Oregon

Oregon provides a model of strong leadership and a commitment to transforming the state's organizational culture to a culture of healthy behavior. Governor Ted Kulongoski launched a wellness initiative in October 2008 that involved the placement of "Stay Well Coordinators" in 34 state agencies. These individuals assumed responsibility for work-based wellness programs. The governor asked each agency director to:

- Model healthy behavior by holding "walking meetings" and serving fruit or other healthy options at gatherings;
- Ensure that the physical environment is conducive to healthy choices by making sure that stairwells are clean and attractive and by placing bicycle racks in convenient locations to encourage cycling;
- Support healthy choices through policies that permit flexible work schedules for physical activity breaks, participation in worksite health screenings, and annual flu shot clinics;
- Negotiate contracts with cafeteria vendors offering nutritious menus;
- Sustain these efforts through communication; and
- Promote community wellness efforts.⁴⁹

Oregon's Healthy Worksites Initiative Checklist for state agencies allows for follow-up of the governor's initiative.⁵⁰

Oregon's Public Employees' Benefit Board (PEBB) wellness programs include a diverse and comprehensive slate of activities organized into four categories related to:

- Public health;
- Other employers;
- Health plans; and
- Members.

Some examples of specific activities in the above four areas include:

- *The Healthy Worksite Initiative (HWI)*. A program in which PEBB partnered with the Department of Human Services Public Health Division to promote health and wellness in the workplace by developing a toolkit for use in the workplace (www.healthoregon.org).
- *The Stay Well Program*. An initiative that brings together wellness coordinators from 35 agencies to participate in training, attend talks on wellness topics, and discuss best practices.
- *Worksite Health Screenings and Flu Shot Clinics*. A series of initiatives that are required by participating health plans and provide screenings for blood pressure, glucose, triglycerides, cholesterol, BMI and waist circumference, and offer flu shots in the workplace.
- *The Physical Activity Program*. An initiative to encourage physical activity by providing eligible employees with pedometers, access to health and nutrition information, and information on walking programs.

Finally, every February, the governor sponsors a food drive involving state employees. To show the connectedness between community action and good health, health plans make a donation to the food drive for every HRA completed during the month. The largest carrier, Regence Blue Cross, saw 773 members complete HRAs in February 2009, surpassing the number completed for all of 2008.⁵¹

D. Consumer Engagement: Summary

State public employee health benefit programs are focusing on consumer engagement in order to change health behaviors and encourage consumers to select high-value health providers. Current trends include the following:

- Offering consumers a range of financial incentives that are integrated into plan design (e.g., lower co-payments or lower premiums for completing a Health Risk Assessment);
- Differentiating premium levels based on compliance with requirements to complete an HRA and follow-up steps (e.g., a visit to the doctor);
- Using financial incentives and disincentives to provide differential rates based on health status; for example, if employees in Alabama self-report that they do not use tobacco, they pay a lower premium (premium differential may be extended to other health status categories); and
- Supporting services that go beyond single interventions and focus on continuous engagement to affect permanent lifestyle changes.

Summary Observations

For state public employee health benefit programs to manage cost growth and improve quality, they must focus their management strategies on changing both the performance of the delivery system and the health behaviors of the covered population. States are often engaged in one area or the other but rarely maintain sustained efforts in both. In addition, when a state does undertake an effort that engages consumers or focuses on the delivery system, it seldom uses all of the value-based purchasing steps identified in this guide. To produce a transformational change, states must deliberately combine value-based purchasing and consumer engagement strategies and commit to the strategies over several years.

This guide includes several examples of how states are using strategies to effect change in the health care delivery system while improving the health behaviors of members. Building from the strengths evident today in every state will allow each discrete system to move forward in challenging times. Minnesota's leadership in transparency and public quality reporting is a good example of one approach to improving health care quality. Alabama's effort to tie premium discounts to health risk assessments represents a new area for other states to explore. South Carolina bases payment incentives on publicly available benchmark data, providing an excellent example of how a state can link quality reporting and payment. Other states should examine what they do well and search for ways to improve what exists today. At the same time, states may find ideas herein that could provide the inspiration for new programming in the coming years.

Endnotes

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P.O. Box 304900
Montgomery, AL 36130-4900

HealthWatch

State Employees' Insurance Board

Screening Form

7625258601

1-866-838-3059
FAX: 334-263-8631

Section 1 (To Be Completed by Employee) PRINT CLEARLY WITH A BLACK INK PEN. DARKEN BOXES COMPLETELY. <input type="checkbox"/> << Not This <input type="checkbox"/> << This <input checked="" type="checkbox"/> << Not This		
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Screening provided by: <input type="checkbox"/> ADPH <input type="checkbox"/> HealthMed <input type="checkbox"/> CMS <input type="checkbox"/> SEIB <input type="checkbox"/> County HD		

I acknowledge that I have been counseled today by the below listed HealthWatch Coach regarding the health risk(s) associated with my screening results recorded on this form.

Wellness Coach Signature	Member Signature

Healthy Worksites Initiative Checklist

Please fill out this form to the best of your abilities to reflect your worksite's Healthy Worksites Initiative activities.

WORKSITE & CONTACT INFORMATION			
Worksite name:			
Your name:			
Your phone number:			
Your e-mail address:			

INFRASTRUCTURE				
	Yes	Working on this	No	Not applicable
Does your agency have a wellness coordinator?				
Does your worksite have a written overall wellness plan or policy?				
Is there a wellness committee for your worksite?				
If yes: Does it meet regularly?				
Is the committee required by worksite policy?				
Is support for the wellness policy demonstrated by leadership?				
Are enough resources (budget, staff and time) allocated for the wellness committee?				
Are a broad cross-section of employees involved?				

NUTRITION				
	Yes	Working on this	No	Not applicable
Does your worksite have written policies in place to make fruits, vegetables, and other healthy foods available in cafeterias, vending machines and break rooms?				
Does your worksite have written policies in place to make fruits, vegetables and other healthy foods available at meetings and events?				
Are campaigns to promote healthy foods conducted at your worksite?				
Does your worksite offer reimbursement or some other cost support for an evidence-based weight loss program (such as Weight Watchers)?				
Does your worksite provide meeting space for an evidence-based weight loss program (such as Weight Watchers)?				
Does your worksite have a private room that locks and a refrigerator available for breastfeeding mothers who express milk during the workday?				

REDUCING TOBACCO USE AND EXPOSURE TO SECONDHAND SMOKE				
	Yes	Working on this	No	Not applicable
Is there a 100% smokefree campus policy in your worksite?				
If yes: Is it promoted?				
Is it enforced?				
Is the Statewide Indoor Clean Air Act enforced, including enforcing the 10 foot smokefree zone in front of doorways, windows and air intake vents?				
Are smoking cessation benefits available to employees for free or at a low cost?				