GEORGETOWN UNIVERSITY
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CENTER ON HEALTH INSURANCE REFORMS

MIXED RESULTS:

State Employee Health Plans Face Challenges, Find Opportunities to Contain Cost Growth

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Introduction

The high and rising cost of health care is reducing people's access to critical services, suppressing workers' income, and reducing business competitiveness. A primary reason for this cost growth is the prices that hospitals and other health care providers are charging to commercial payers. Many state employee health plans (SEHPs) are the largest commercial health care purchaser in their state, making them uniquely situated to tackle health care costs and exert pressure on insurers and providers. In 2021 we released findings from the first comprehensive, nationwide survey of SEHP administrators regarding plan offerings and states' cost containment strategies. This report assesses these plans' progress in the last two years, as well as the impact of recent federal policy changes.

Background

SEHPs provide health insurance for state and local government employees. Many public sector employees trade lower salaries for more generous health and pension benefits compared to private sector counterparts. That dynamic, combined with union representation for many state government employees, can make SEHP administrators wary of trimming back benefits. However, these plans can also be an attractive target when states need to trim their spending.

In the two years since our last report, states have enjoyed flush budgets and rainy-day funds. Health care utilization has remained below pre-pandemic levels. But these good times for SEHP administrators will not last for long and SEHPs, like other payers, are bracing for cost increases.

SEHPs are also subject to new federal requirements promoting greater transparency of health care transactions under the Consolidated Appropriations Act of 2021 (CAA) and protections for covered workers from unexpected out-of-network billing under the No Surprises Act (NSA).

Findings

SEHPs have developed and implemented a wide range of strategies to constrain cost growth. While only a handful of SEHPs report being able to quantify the savings generated by any of these strategies, a few initiatives emerged as promising candidates for cost savings.

Spaghetti at the Wall: SEHPs Try Multiple Strategies to Constrain Cost Growth

As they did in 2021, SEHPs report that prescription drug and hospital prices are the top drivers of cost growth for their plans. However, as in 2021, SEHPs' strategies remain primarily focused on prescription drug costs and enrollee utilization of services, rather than hospital prices. Of the top five cost containment strategies being pursued by states, only one (Centers of Excellence) has the potential to affect hospital pricing.

Resistance from plan enrollees and providers continues to be the top barrier to SEHPs' implementation of cost containment strategies, although in interviews administrators also flagged provider consolidation as an additional impediment to cost containment.

Only 15 SEHPs could document a return on investment from their cost containment strategies. However, several reported that they have or soon will discontinue certain programs that have not generated hoped-for outcomes. For example, five states report discontinuing workplace wellness programs.

Although no single cost containment strategy was identified as a magic bullet, promising efforts included reference pricing, tiered network plans, and multi-payer purchasing initiatives.

Accountability For Third-Party Vendors

All but four states in our survey use a third-party administrator (TPA) to help with plan and network design, customer service, and/or claims processing. While most SEHPs report that they rely exclusively on their TPA to negotiate with providers and manage plan networks, less than half of states (21) report that they include cost containment targets for TPAs during their procurement processes. Thirty-two SEHPs report that their TPA contracts include accountability mechanisms if their TPAs fail to curb cost growth. However, in interviews a few SEHP administrators reported that they are taking on more network design in-house or have plans to do so, out of frustration with what they perceive as foot-dragging, inability to create customized approaches, or even active resistance to cost containment by their TPA vendors.

Data: More Availability But Limited Capacity To Use It

Since publication of our 2021 report, federal rules requiring plans and hospitals to publicly post price data, as well as a prohibition on gag clauses in provider-payer contracts, went into effect. SEHPs report that these policy changes have somewhat improved their access to claims and price data, but significant barriers constrain translating improved access to data into more aggressive cost containment strategies.

Limited Attention to Limits on Surprise Billing

As plan sponsors, SEHPs are responsible for implementing the federal No Surprises Act. However, 34 SEHPs reported not knowing, as of late 2022, whether any out-of-network providers had filed billing disputes against their TPAs or insurers, and only three SEHPs had a sense of how many disputes had been resolved. No SEHP reported that the NSA was influencing their network design strategies.

Lessons Learned

As they did in 2021, SEHP administrators continue to cite the need to work with providers and communicate clearly with enrollees to position cost containment strategies for success. Additional themes that emerged from our 2022 survey and interviews include:

- **Commitment to affordability for members.** SEHP administrators have implemented and continue to roll out multiple strategies to constrain cost growth and keep health care affordable for their members.
- **Attention to evaluation.** Many SEHPs are not systematically measuring or evaluating the impact of their cost containment strategies, making it difficult to assess what is, or is not, working.
- **Data's unfulfilled promise.** In spite of recent federal policy changes, SEHPs continue to report challenges accessing and using claims and pricing data. SEHP administrators want to use this data to inform network and plan design, but are not yet well-situated to do so.
- **Programmatic tradeoffs.** Cost-containment strategies involve the need to balance competing demands across stakeholders. Mitigating potential backlash often involves injecting greater complexity and administrative overhead into the initiative's design and implementation.
- **Frustration with TPAs.** TPAs and other vendors are necessary to the functioning of many SEHPs, but too often SEHPs cannot rely on them to be agile or willing partners in cost control efforts.

Conclusion

Looking ahead, SEHP administrators are bracing for rising prices and a tightening state fiscal picture. Identifying and expanding on cost containment strategies that effectively target principal cost drivers, generate minimal "member friction," and that do not require considerable administrative overhead is challenging for SEHPs. However, several SEHP administrators are demonstrating that it is possible to implement strategies that reduce provider price inflation while also minimizing stakeholder pushback.

Mixed Results:

State Employee Health Plans Face Challenges, Find Challenges to Contain Cost Growth

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Introduction

The high and rising cost of health care is reducing people's access to critical services, suppressing workers' income, and reducing business competitiveness. Health care spending consumed 18.3 percent of the U.S. economy in 2021 and is expected to grow to 19.6 percent by 2030.[1] Average annual family premiums for employer-sponsored health insurance exceeded $22,000 in 2022, an increase of 32 percent over the past decade.[2] Deductibles are rising even more steeply, increasing 48 percent since 2012.[3] These costs are rising not because U.S. workers are getting sicker or using more health care services, but primarily because health care providers and suppliers have been increasing their prices.[4] They are able to do so largely due to significant consolidation among hospitals and health systems, which has given them the market power to demand higher reimbursement rates from commercial payers.[5]

Among those commercial payers are state employee health plans (SEHPs). While they are often operated by state government agencies and deliver benefits to state workers, most pay for health care services at the relatively high rates that commercial insurers pay. Yet, with a proportion of their funding coming from state coffers, they often face pressure from state policymakers to generate savings when the state faces a budget shortfall. At the same time, they are often the largest employer in their state and could, if they choose, exert considerable market power over providers, as well as influence the purchasing strategies of other employer-based plans. SEHPs' cost-containment strategies can have a far-reaching impact.

In 2021, we published findings from a comprehensive survey and in-depth interviews with SEHP administrators.[6] That study provided detailed information about state employee plans across the country, and assessed the opportunities for and barriers to a range of cost-containment strategies. Since then, SEHPs have navigated the COVID-19 pandemic, fluctuations in enrollees' use of health care services, and workforce and supply shortages among health care providers. They have also been charged with implementing several significant changes in federal law designed to protect consumers from surprise medical bills and increase access to critical information about health care costs.

This study updates our findings from 2021 to assess SEHPs' progress on promising cost-containment strategies and how they are impacting the behavior of plan administrators and vendors, plan enrollees, and participating providers. We also assess these plans' experiences with the recent federal law changes.

Background

SEHPs provide health insurance for state and local government employees, including (but not limited to) executive branch employees, municipal employees, legislators, and public school and university teachers, as well as their dependents. Historically, public sector employees have tended to trade lower salaries for more generous health and pension benefits compared to their private sector counterparts.[7] As such, SEHP administrators may be wary of pursuing cost containment strategies that necessitate trimming back benefits. At the same time, their reliance on legislative appropriations can make them an attractive target when a state's fiscal circumstances require belt tightening.

Review of 2021 Findings

In our 2021 report, we highlighted a number of key findings regarding how SEHPs across the country are approaching cost containment. First, although most SEHPs in our survey identified hospital prices and prescription drug costs as the primary drivers of health care cost growth, the primary focus of their cost containment efforts was to limit enrollee utilization of health care services. For example, although only one SEHP identified excess enrollee utilization of services as its primary cost-driver, four of the top five cost containment initiatives pursued by SEHPs aimed to reduce enrollees' use of services.

Second, given that slightly over one-third of state employees are unionized, labor unions have considerable sway in health plan negotiations. While many SEHPs reported pressure from their union to maintain generous benefits, unions also proved to be important allies in pursuing cost containment goals—including pricing and network-based reforms—in a handful of states.

Third, we learned that vendors, including third-party administrators (TPAs) and administrative services organizations (ASOs), play a key role in plan design, but may not always act in SEHPs' best interests. A few SEHPs have used procurement strategies to ensure that their vendors are aligned with and held accountable for meeting cost containment goals. For instance, a competitive bidding process known as a "reverse auction" can help lower prices and improve transparency in vendor contracts. Nonetheless, many states have faced challenges implementing procurement strategies that ratchet up expectations for third-party vendors.

Fourth, reliable data is critical to implementing and evaluating cost containment reforms. In 2020, while most SEHPs surveyed had access to some claims data, their ability to meaningfully analyze data—particularly without relying on their TPA—varied. Many SEHP administrators pointed to limited in-house capacity to analyze and use the data to inform cost containment initiatives.

Fiscal and Policy Changes Affecting SEHPs

Numerous contextual and policy changes have impacted SEHPs in the last two years.

States have enjoyed unexpectedly high revenue, buoyed by federal pandemic aid, increased sales tax receipts, and wage growth-fueled income tax collections, resulting in flush state budgets and rainy-day funds.[8,9] At the same time, health care utilization remains below pre-pandemic levels; this low utilization is likely responsible for lower-than-expected growth in health care spending.[10,11] But this halcyon period for SEHP administrators is unlikely to last for long, as increasingly monopolistic provider systems seek rate hikes to accommodate higher labor and supply costs, and as health care utilization rebounds. SEHPs, like other payers, are likely to face increased premiums in fully insured plans and increased costs passed along by TPAs.

In addition, SEHPs are now subject to new federal requirements under the Consolidated Appropriations (CAA) and No Surprises Acts (NSA) of 2021. The NSA protects plan enrollees from receiving out-of-network balance bills in certain situations when they have limited control over who provides their care, such as emergencies. It also requires health plans and out-of-network providers to resolve payment disputes through a federal independent dispute resolution (IDR) process (provided states do not already have their own process for resolving payment issues in place).[12] Other provisions in the CAA boosted transparency in the employer-sponsored insurance market—for instance, health plans and insurers are no longer allowed to include gag clauses in their contracts with providers. Finally, as of July 2022, both hospitals and health plans are required under federal rules to publicly post data on their negotiated rates for in-network providers as well as allowed amounts for out-of-network providers.[13] Access to this market-wide data can potentially help payers identify the drivers of health care cost growth and target strategies for lowering health care spending.

Methodology

In this update to our 2021 report, we first captured new information relevant to each state's SEHP and the cost containment initiatives they have undertaken through an environmental scan of relevant scholarly publications, media coverage, and SEHP websites. We then developed a survey for SEHP administrators that would capture relevant changes since our 2021 report, as well as additional information about the implementation of recent federal policies (for the list of survey questions, see Appendix I). We fielded the survey between October 17 and December 16, 2022. We received survey responses from 49 states and the District of Columbia (D.C.). The only non-responding state was New Jersey.

We then reviewed survey responses to identify 11 states for in-depth follow-up interviews. Criteria for selection included the number and mix of cost containment strategies initiated, geographic and political diversity, presence or engagement of public employee unions, and reported experience using data to manage cost-containment efforts. Six SEHPs—in South Carolina, California, Connecticut, Washington, Tennessee, and New Mexico—were among those we interviewed for our initial report, allowing us to ask about the status of cost containment initiatives they identified in 2021. The remaining five (Minnesota, Georgia, Oklahoma, Colorado, and Maine) were SEHPs we had not interviewed before. The interviews were conducted between February 17 and March 10, 2023.

Study Limitations

Our study has several limitations. First, we limited our focus to cost containment strategies targeting hospital and ambulatory care services; strategies concerning prescription drug costs, while critical to SEHPs' cost containment efforts, were generally outside the scope of our research and merit separate study. Additionally, some answers to the survey questions were qualitative and thus required subjective interpretation. As SEHPs have varying capacity to evaluate cost savings and other metrics relevant to cost containment measures they have implemented, the information available to us was not uniform across all states.

Findings

SEHPs have developed and implemented a wide range of strategies to constrain cost growth in their plans (for a glossary of cost containment strategies, see Appendix II). While only a handful of SEHPs report being able to quantify the savings generated by any of these strategies, a few initiatives in survey and interview responses emerged as promising candidates for cost savings. As they did in 2021, many states report that resistance from key stakeholders, such as providers, TPAs, and enrollees, remains a top barrier to implementing these and other programs. Further, although recent federal requirements for greater hospital and health plan price transparency have opened up greater access to price data, most SEHPs have yet to leverage the information to inform or assess their cost containment strategies.

Spaghetti At The Wall: SEHPs Try Multiple Strategies To Contain Cost Growth

As they did in 2021, SEHPs report that prescription drug and hospital prices are—by far—the top drivers of cost growth for their plans (see Table 1).

Table 1. Single Highest Cost Driver Identified by Number of States in 2020 and 2022

Cost Driver	Number of States 2020	Number of States 2022
Prices of prescription drugs	20	22
Prices of hospital services	22	20
Prices of physician or other ambulatory services	1	4
Excessive or inappropriate utilization	1	2
Other	1	1

Source: Authors' analysis of survey results. Forty-six states responded to this question in 2020; 48 states responded in 2022.

And, just as in 2021, SEHPs' cost containment strategies remain primarily focused on prescription drug costs and enrollee utilization, rather than hospital prices. Indeed, states' focus on reducing hospital prices has declined in the last two years (see Table 2).

Table 2. Share of States Targeting Each Cost Driver in 2020 and 2022

Cost Driver	Share of States 2020	Share of States 2022
Prices of prescription drugs	83%	78%
Excessive or inappropriate utilization	67%	58%
Prices of hospital services	57%	48%
Prices of physician or other ambulatory services	46%	32%

Source: Authors' analysis of survey results. Forty-six states responded to this question in 2020; 48 states responded in 2022. States could choose multiple answers.

Further, just as in 2021, of the top 5 cost containment strategies states are pursuing, only one (Centers of Excellence) has the potential to affect hospital pricing (See Table 3). For detailed information on cost containment initiatives implemented in the past two years by each state, see Appendix VII.

Table 3. Top Five Cost Containment Initiatives Implemented Over the Past Five Years

Initiative	Number of States
Disease management	43
Case management	40
Prior authorization	36
Auditing of claims	32
Centers of Excellence	27

Source: Authors' analysis of survey results. Forty-seven states responded to this question in 2022. States could choose multiple answers.

At the same time, SEHPs' survey responses revealed that plans and their third-party administrators (TPAs) are trying many different, concurrent strategies to keep health care cost growth in check. Thirty-five states have implemented six or more cost containment strategies in the last five years; 14 states have implemented 11 or more (see Table 4).

Table 4. Number of New Cost Containment Initiatives Implemented in the Last Five Years

Number of Initiatives	Number of States
1-5	15
6-10	21
11-15	11
16-20	3

Source: Authors' analysis of survey responses. Respondents were permitted to select multiple cost containment initiatives out of a list of 17. Forty-six states responded to this question. For more detailed information about the cost containment initiatives states have implemented, see Appendix VII.

However, most SEHPs are unable to document a return on investment for their cost-containment initiatives. In our survey, only 15 states reported documented cost savings from any initiative. In interviews, SEHPs identified two primary challenges to evaluating and measuring the impact of their programs. First, states complained that they are dependent on their TPAs and other vendors to conduct and report on the evaluations, and that these entities too often withhold critical underlying data. Second, SEHPs' evaluation efforts can be hindered by a lack of in-house capacity to independently assess vendors' reports, or to conduct their own data collection and analysis.

Yet such evaluations are critical to SEHPs' understanding of what is working or not working for their membership—and their bottom lines. For example, one state has rolled back a wellness incentive program provided by a TPA because "virtually nothing was measured." They decided instead to design and implement their own disease management program, focusing on enrollees with multiple chronic conditions. Because everything is done in-house, they have been able to collect and analyze the results. "We've seen a great deal of improvement in biometrics" with the disease management program, reported the administrator.

In the 15 states that could document a return on investment, there does not appear to be a single, "magic bullet" strategy. Reported savings come from a disparate assortment of 22 different approaches, including reference-based pricing, tiered and narrow provider networks, disease management, value-based insurance design, "Right to Shop" programs, and mandating the use of Centers of Excellence (COE). Three states reported savings from tiered and narrow networks; no other approach was cited by more than two states.

ONE STRATEGY, DIVERGENT RESULTS: THE CASE OF CENTERS OF EXCELLENCE

States' widely varying experiences with COEs help illustrate the challenges to finding a cost-savings strategy that is both effective and widely replicable. One of our study states is hoping to expand its COE program because it has generated $1.8 million in savings over three years. In that state, COEs receive a capitated (bundled) payment for each procedure, a payment model that administrators credited for the reduced costs. Conversely, another state has found that its TPA pocketed a significant portion of the discount they claimed to have negotiated with the COEs, which, combined with increased utilization of services due to reduced enrollee cost-sharing, eliminated the cost-savings they had hoped for. A third state found that, although their COE program generated significant savings, "member friction," (complaints from enrollees about the program) led them to roll it back. Yet a fourth state reported that they view their COE program primarily as a way to improve quality of care, not to lower costs: "Part of our intent was to get better outcomes, and we are willing to pay a bit more for that."

Among cost containment initiatives launched prior to our first survey, several states reported that they have or will soon discontinue programs for not generating the hoped-for savings or outcomes. Of these, five states reported they have or will discontinue workplace wellness programs, with a sixth state ending a program designed to prevent diabetes. Other programs zeroed out due to the lack of return are: cost-sharing differentials for high-cost radiology, a primary care provider (PCP) "gatekeeper" plan, requirements to obtain a second surgical opinion, and an on-site employee health clinic. Not all of these programs were eliminated solely due to a lack of savings. For example, the state that implemented the PCP gatekeeper plan reported that while the plan performed "as expected" with respect to savings, it was discontinued because it was unpopular with enrollees and administratively burdensome for the physicians. The state decided to shift instead to a tiered network plan, which it reports is "going as planned," and thankfully, "we've stopped getting angry phone calls on a regular basis."

For the most part, SEHP administrators reported mixed results with their cost-containment programs. For example, one SEHP that coordinated with the state Medicaid agency to implement a provider "episode-based" payment model (in which providers were given incentives to keep costs below a specified level, for each episode of care) reported that although the program is "working fine," it has generated a lot of administrative burden. Similarly, two states that have implemented shared savings payment models for participating providers reported high administrative costs for the program, and challenges finding provider groups willing to participate or maintain participation. "They [providers] were seeing the [financial] trade-off as not being in their interests," administrators in one state reported. Another official noted, "It's just not the same savings opportunity that we saw initially."

Provider and Drug Prices Remain the Top Cost Driver, But Are Hard to Tackle

This year, SEHP administrators reported many of the same obstacles to cost containment efforts as they had in 2021, with the top barrier being "resistance from stakeholders," including plan enrollees and providers. Other top barriers include state legislators, who often enact new benefit mandates or other coverage requirements that increase plan costs, and, as noted above, challenges obtaining (or documenting) a return on investment. (See Table 5.)

Table 5. Share of States Identifying Barriers to Implementing Cost Containment Initiatives, 2020 and 2022

Barrier	2020	2023
Resistance from stakeholders	59%	50%
Legislative mandates or requirements	48%	42%
Limited evidence of return on investment	41%	38%
Governance structure	35%	34%
Procurement policies and requirements	33%	22%
Terms of collective bargaining agreement	22%	26%

Source: Authors' analysis of survey responses. Respondents were permitted to submit more than one response to this question.

In interviews, administrators added provider consolidation to the list of barriers, noting that once hospitals gain sufficient market power, they demand higher reimbursement rates and often decline to participate in payment reform initiatives, such as shared savings or episode-based payment models. Hospital consolidation is "probably our number one challenge," said one administrator, noting that the two dominant hospital systems in his state "have higher reimbursement rates than everybody else, and continue to get higher increases than everybody else." Another SEHP official observed that if their state's largest hospital system left their network, they would lose an estimated 60 percent of their participating physicians.

At the same time, SEHP staff often view providers as partners, not the opposition. In fact, some noted that they see protecting providers as part of their job. As one put it, "We are also beholden to the providers who are in our state . . . Our goal isn't to make providers rich, but we want them to be able to keep their lights on." Keeping providers content can also be critical to positive relations with plan members. One administrator observed that when their participating providers were unhappy with one of their initiatives, they took those concerns to their patients. "The members were writing in [to complain]," he said, "but it was obviously the physicians complaining about it [to their patients]."

SEHPs Report Promising Opportunities For Cost Containment

In spite of the challenges identified above, several states reported promising strategies for constraining costs with limited member or provider "friction," including pegging provider payments to a reference price (such as the Medicare rate), tiered network plans, and multi-payer purchasing strategies.

- ### Reference Pricing

  Nine states in our survey reported pegging provider payments to a reference price (such as a percentage of Medicare), up from five states in 2021. Of those, two states participated in follow-up interviews, and both reported significant savings from their payment approach. "We manage to save about $40 million per year," reported an administrator in a state that sets its prices based on Medicare rates. These states also reported that reference pricing is administratively easy to implement. "When a new hospital opens, we reach out and provide our fee schedules. Because we don't have a negotiation process, there really isn't anything to negotiate." The administrator reported that, thanks to the SEHP's large size, even though their reimbursement levels are not as high as other commercial payers, they have 99.3 percent of hospitals and 80 percent of physicians in the state participating in their network. Another SEHP that has long used a non-negotiable fee schedule for its provider reimbursement noted that, when it was first implemented, it was not presented to stakeholders as a cost-containment tool, limiting pushback from providers. However, over time, the SEHP has been able to use adjustments to the fee schedule to help keep cost growth in check.

- ### Tiered Network Plans

  Fourteen states in our survey reported offering tiered network plans, up from nine states in 2020. In interviews, SEHP administrators reported that tiered network plans offer at least two advantages. First, the plans generally have lower costs than a traditional broad network option—about 8 percent lower, according to one state. Second, they do not prompt the same negative reactions as a narrow network plan that does not include high-priced, but popular, health systems. "A narrow network [plan] is obviously appealing," said one administrator, citing the lower administrative burden relative to tiered network plans, "but [our members] really don't like it."

DEFINITIONS: NARROW, TIERED, AND BROAD NETWORK PLANS

- **Narrow network:** The health plan contracts with a limited set of hospitals, clinicians, and other providers. Generally, non-emergency services obtained outside the network would not be covered.
- **Tiered network:** The health plan contracts with a broader set of providers than in a narrow network plan, but providers are divided into cost-sharing "tiers" based on their performance on metrics of quality and cost-efficiency. Services received from providers in the top tier would have the lowest cost-sharing, with cost-sharing increasing for services received from providers outside the top tier.
- **Broad network:** The health plan contracts with a broad choice of providers, with no differentiation in cost-sharing based on quality or efficiency performance metrics. The plan will typically cover a portion of costs for services received out-of-network, although member cost-sharing is higher.

- ### Multi-Payer Initiatives

  In our survey, only three states (California, New Mexico, and Washington) reported that they had collaborated with another state government purchaser (i.e., Medicaid or the state-based Marketplace) on one or more cost containment initiatives, and only two states—Colorado and Maine—reported collaborating with other private sector purchasers on a cost containment initiative. As they did in 2021, several states reported in interviews that such cross-purchaser initiatives are too challenging for them to manage and implement.

However, the five states that are engaged in such efforts report that such collaborations hold great potential, and all five believe them well worth the coordination and extramural communication required. For example, one SEHP is working in tandem with the state's Marketplace and Medicaid agency to develop standards for plan spending on primary care, a common set of clinical quality metrics, and health equity. "If all three agencies are working together on the same things, we're going to have an enormous impact," predicted an administrator, noting further that their efforts to align across programs ease providers' administrative and reporting burdens. Another SEHP is working across payers to develop a new service delivery model for rural hospitals in the state. The administrator noted that, for hospital executives to engage in the conversation, the pressure has to come from multiple payers. "It wouldn't make sense [for the hospital] to do it for one book of business," he said. Another SEHP is hoping to use its cross-purchaser alignment efforts to become more effective in negotiations with its state's increasingly "giant" hospital systems. "If we can do this and move the market a little bit . . . then that's a move in the right direction," the administrator said. These SEHP administrators noted, however, that to be successful, multi-payer efforts require the support and buy-in from political leadership in the state. "The people who have the authority to make potentially politically hard decisions [have to be] in the room," one administrator observed.

Mixed Approaches to Accountability for Third-Party Vendors

All but four states (D.C., Idaho, North Dakota, and Wisconsin) in our survey offer one or more self-funded plans. Of these, all contract with one or more third-party administrators (TPAs) or administrative services only (ASO) organizations to help with plan and network design, customer services, and/or claims processing. Many of these vendors also, for a fee, manage certain cost-containment programs, such as Centers of Excellence, workplace wellness, and patient-centered medical homes. SEHPs enter into contracts with their TPAs/ASOs that commonly include performance guarantees, in which the vendor commits to meeting target metrics for activities such as customer and provider services and claims processing. Less common are "trend guarantees," in which the TPA/ASO vendor commits to a limit on cost growth in the plan, with financial or other accountability mechanisms if they fail to achieve the target trend. In our survey, less than half (21) of SEHPs report that they include any cost-containment targets for bidders in their "Request for Proposals" (RFPs) for a new TPA vendor. A slightly higher number of SEHPs—32—report that their contracts with TPAs include accountability mechanisms if the TPA fails to meet specified targets for limiting cost growth.

DEFINITIONS: SELF-FUNDED AND FULLY INSURED

- **Self-funded plan.** In a self-funded employer sponsored health plan, the employer provides the benefits and holds the financial risk of covering incurred claims.
- **Fully insured plan.** A fully insured employer group plan is one the employer purchases from an insurance company. The employer pays a (usually monthly) premium, while the insurance company bears the financial risk of paying incurred claims.

More than half of the states in our survey report that their TPAs are exclusively responsible for negotiating with providers and developing and managing plan networks. The remainder report that network design is either a joint responsibility of the TPA and the SEHP, or the responsibility of the SEHP agency or an appointed advisory or governing body. (See Table 6.)

Table 6. Responsibility for Network Development and Management

Locus of Responsibility	Number of States
Exclusively TPA or insurer	26
Joint (agency and TPA)	11
Exclusively agency (or an advisory/ governing body)	10

Source: Authors' analysis of survey responses. Forty-seven states responded to this question.

However, in interviews, a few SEHP administrators reported that they have or are in the process of taking on more network design and payment reform work in-house, due in no small part to frustration with their TPAs. For a cost containment initiative to succeed, states report that it generally must have the buy-in and cooperation of the plan TPA. But in many cases, SEHPs report that TPAs either drag their feet or, in some cases, actively resist the implementation of cost containment initiatives proposed by plan administrators.

Several states noted that their TPAs discourage any initiatives that aren't "ready-made products," such as a Centers of Excellence or patient-centered medical home that the TPA has designed for and is able to implement across multiple customers. Yet these ready-made products often come with high administrative fees and a limited ability for SEHP administrators to adequately assess the cost savings generated. "We are charged for their services, and it's a fairly steep charge . . . but [when we ask questions], we only get very high-level, nebulous responses," complained one official. Another SEHP that is eager to develop a tiered network plan reported that they have been unable to obtain from their TPAs the necessary data, including providers' performance on quality metrics, that would allow them to move forward. Another state that has implemented a total cost of care program (an alternative payment model that sets a global budget for health care services) found that two of its three TPAs "weren't comfortable with total cost of care…they had to be pushed." That state now makes the ability to conform to their total cost of care model a baseline expectation in their RFP for TPA vendors.

States also observed that it has been particularly challenging to pry race, ethnicity, and gender data that would help them assess or devise solutions to health equity challenges in their networks or benefit designs from their TPAs. Such analyses are particularly important for workplace wellness programs, observed one administrator, because such programs can financially penalize enrollees who don't meet certain health targets. "We know that employees in certain risk groups . . . have greater health inequities, and we want to ensure that we have a program that helps them," the administrator noted. In part because of this lack of data, the SEHP still operates a traditional wellness incentive program through its TPA, though "its days are numbered," he reported.

Data: More Availability, But States Have Limited Capacity To Use it

The ability to access and analyze relevant data is a critical capability for states seeking to develop and assess cost containment strategies. By examining their claims data, SEHPs can identify significant cost drivers or utilization patterns that drive spending, while information on in-network payment rates and allowable amounts for out-of-network providers can point to cost containment opportunities. Information on payment rates across commercial payers can help SEHP administrators benchmark program spending to other employer purchasers. In notable policy developments since our 2021 report, federal rules requiring hospitals and health plans, including SEHPs, to publicly post provider- and payer-specific price data, and the CAA's prohibition on gag clause in provider-payer contracts went into effect.[14,15] These changes in federal policy have improved SEHPs' access to claims and price data, although states face barriers translating that access into more aggressive cost containment strategies.

For example, the transparency in coverage regulations require hospitals and insurance companies to publicly post the prices they charge and the rates they pay, respectively, for health care services. However, most SEHPs report that they are not yet using these price data to inform their cost containment efforts. Thirty-two states have not yet tried to access or analyze the insurer price data; similarly, 29 states have not tried to access or analyze available hospital data. Seventeen SEHPs cite limited staff availability as the primary reason for not taking on this analysis, but eight others did not discern a clear benefit from investing staff time in this work. Seven states reported that they had accessed the data, only to find that it was not in a format they could work with, echoing the challenges that other data researchers have identified.[16]

In interviews, a few SEHP officials reported an interest in using this data to inform pricing decisions. For example, an administrator of a SEHP that sets and manages its own rate schedule intends to use the hospital price data to further refine their hospital rates. Another state noted that they have analyzed claims data drawn from multiple plans by their TPA vendor to inform negotiations over provider prices for the SEHP.

When asked about the CAA's prohibition on gag clauses, 27 states confirmed that their TPAs' and health plans' provider contracts no longer include gag clauses. Eleven states reported that they can now access data that had previously been restricted. In one interview, a SEHP administrator of both self-funded and fully insured plans reported that, prior to the CAA, both entities had been grudging in providing requested information, although they were ultimately able to get what they needed from their TPAs. He also noted that the fully insured plans "[did] enough to keep us from getting angry and remembering that the next time we go out for procurement." These companies have been more "forthcoming" since the federal requirements were implemented. This state hopes to use data from their TPA and fully insured plans to monitor differences in access between urban and rural communities and to determine whether benefit designs could be driving or exacerbating inequities across demographic groups.

In addition, 44 states with self-funded plans report that they have access to their own claims data and information on negotiated provider rates and allowed out-of-network amounts from their TPAs; 35 of these report that they invest staff time and expertise in analyzing the information. Most of the states that do not examine their claims data cite limited staff capacity as the primary constraint on this work, but one state noted that their TPA limits their use of this data. In interviews, a few states reported that simply gaining access to these data took considerable effort. "We've been asking for this information for two years," said one official. "They give it to us in dribs and drabs." When states do delve into these data, several reported using it to inform new cost containment initiatives, such as episode of care payment programs, narrow provider networks, and appropriate pricing for certain services.

Limited Attention to Limits on Surprise Billing

The NSA's protections of consumers covered under group and individual health plans from balance billing by out-of-network providers and facilities, in certain circumstances, was another significant policy development since our 2020 survey. One feature of the law, which went into effect on January 1, 2022, requires billing disputes between payers and out-of-network physicians and facilities to go to an independent dispute resolution process, although states can establish their own processes for determining appropriate payments for these out-of-network providers. The NSA included additional requirements for health plans, such as providing enrollees with price comparison tools and ID cards that include deductible and cost-sharing details, information on providers' network status, and expected cost-sharing responsibilities for scheduled services, known as an Advance Explanation of Benefits (AEOB).

As plan sponsors, SEHPs are responsible for implementing and complying with these new federal requirements. In our survey, however, only 25 SEHPs were aware of their TPAs' plans for providing enrollees with an AEOB, and only 25 reported confirming that their TPAs had price comparison tools that complied with new federal standards. However, almost all SEHPs—43—reported that their TPAs/insurers are providing enrollees with updated ID cards that include the required deductible and cost-sharing information.

With respect to the new protections against surprise medical billing, a majority of SEHPs are in the dark about how the law is working. Thirty-four SEHPs reported not knowing, as of late 2022, whether any out-of-network providers had filed billing disputes against their TPAs or insurance companies, and only three SEHPs had a sense of how many disputes had been resolved. However, one interviewee noted that out-of-network utilization represents just two percent of his plan's total costs, leading him to expect few payment disputes or any changes in their network contracting strategies.

Lessons Learned

Several takeaways from our 2021 report remain relevant today. For example, SEHP administrators still cite the need to work with providers and communicate clearly with enrollees to position cost-containment strategies for success, and they are keenly aware of how the differences across health care markets and political environments limit their ability to import successful approaches from other states. Additional themes from our 2022 survey and 2023 interviews with SEHP administrators reinforce key lessons from our previous work and provide a clearer picture of the opportunities and challenges these programs face today.

A Commitment to Affordability For Members

Survey responses and individual interviews all highlight states' commitment to implementing, managing, and growing cost-control strategies. In the last five years, states have been actively engaged in these efforts, with most states kicking off multiple initiatives. Interviewees shared their experiences managing the moving parts and numerous relationships that are hallmarks of innovation in complex environments. Through these efforts, states believe they have saved money and improved care through a range of approaches, including pricing innovations, network design, utilization controls, and financial incentives. State officials also appear to be motivated by and engaged in this work, with many interviewees sharing future plans for new cost-control initiatives.

Attention to Evaluation and Assessment

For states to build on this foundation of activity, however, they need to systematically understand which initiatives work, which efforts they should expand, and which approaches they should change or even abandon. While every state in our survey cited multiple cost-control initiatives, only 15 indicated they could document savings from any of these projects. In some cases, states may need to design their interventions from the beginning with greater attention to evaluation. In other cases, states may need to secure necessary data and information from their vendors, invest in external or in-house analytic capacity, or take other steps to understand whether and how their cost-control programs are working.

Data's Unfulfilled Promise

As noted above, data is a critical tool for evaluating SEHPs' cost-containment efforts. It can also help SEHP administrators understand their program's cost drivers and identify opportunities for future savings. In 2021, our report revealed that many SEHP agencies did not have access to claims data or information on negotiated rates and out-of-network payment amounts—or, if they could access this data, they did not have the internal analytic capacity needed to fully leverage it for cost containment purposes. This year, thanks in part to federal regulatory and CAA requirements, states report greater access to a range of data, including hospital price and insurer payment rate information. However, analytic capacity remains a challenge. SEHP administrators continue to express interest in understanding this data and using it to inform their cost containment strategies.

Programmatic Tradeoffs include "Friction" and Complexity

To implement a new cost-containment initiative, SEHP administrators need to balance competing demands. For example, a well-researched, evidence-based cost-containment approach may ask enrollees to change their behavior or pay more, require certain providers to accept lower or different payment methods, or ask third-party vendors to customize their services for the SEHP. To mitigate potential backlash, SEHP administrators may choose to adjust their program design, dial back their savings targets, or place more emphasis on communications and stakeholder engagement—ultimately embracing greater complexity and effort to reduce programmatic friction.

Foot-Dragging and Resistance Among TPAs and Other Vendors

In interviews, SEHP administrators highlighted how TPAs and other vendors are frequently a barrier to progress. Most SEHP programs use these vendors to pay claims and build provider networks—but too often SEHPs cannot rely on them to be agile partners in cost control. Examples include a state that endured a "progressive journey" of successive contracts with multiple vendors to get the information they want to make key program decisions, a state that found their TPAs incapable of implementing the state's signature cost-containment strategy, and a state that found their TPA's disease management program to be so opaque, and the evaluation so minimal, that they developed and now manage their own program in-house.

Conclusion

With state budgets in the black and a pandemic-related dip in health care utilization, SEHPs have been under relatively little pressure the last two years to cut costs. Administrators are, however, very aware that health care prices are rising, and the fiscal good times will not last forever. SEHPs are pursuing a wide range of cost containment strategies. However, the most commonly implemented strategies target enrollee utilization and do not attempt to reduce prescription drug or hospital prices, even though most SEHP administrators identify those two trends as their biggest cost drivers.

Identifying and expanding on cost containment strategies that are effective, generate minimal "member friction," and that do not require considerable administrative overhead is challenging for SEHPs. Few SEHPs have the data or analytic capacity to evaluate the effectiveness of their programs, although access to data has improved somewhat since publication of our 2021 report. Another challenge for SEHPs can be third-party vendors, such as TPAs, that resist or are not well equipped to implement effective or customized cost containment strategies. However, a number of SEHP administrators are demonstrating that it is possible to design and implement strategies that reduce provider price inflation while also minimizing pushback from internal and external stakeholders. It will be critical to evaluate and report on these efforts, so that other SEHPs as well as private sector purchasers and policymakers can learn from their experiences.

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About Georgetown University Center on Health Insurance Reforms

The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on commercial health insurance and the complex federal and state laws that shape the market. For more information, visit www.chir.georgetown.edu.

Appendices

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Appendix I - SEHP Administrator 2022 Survey Questions

Note: We fielded this survey between October 17 and December 16, 2022 and received responses from 50 state employee health plan administrators.

SECTION I - Overview

1. Your State _____
2. Your Contact Information (this will be kept confidential)
    a. Name: _____
    b. Email address: _____
    c. Your state agency: _____
3. Does your state employee health plan year align with:
    a. Calendar year
    b. State fiscal year
    c. If b), does the plan year run:
        i. July to June
        ii. April to March
        iii. September to August
        iv. October to September
        v. Other?
4. Which fields of demographic data do you collect on plan enrollees (choose all that apply):
    a. Race
    b. Ethnicity
    c. Preferred language
    d. Gender/gender identity
    e. Disability status
    f. Sexual orientation
    g. Other
5. Is this data required or voluntary?
6. Do you collect it during enrollment? (Yes/No)
7. Are you using this data to identify and address health disparities among your enrollee population? (Yes/No)
    a. If yes, please explain _____
8. Provide the number of lives covered under the state or public employee plan options administered by your agency. Do not include retirees.
    a. Number of individual employees covered: _____
    b. Number of spouses + dependents covered: _____
9. In addition to active state employees, which workforces are eligible to participate in the plan options administered by your agency? (select all that apply)
    a. School district employees – teachers
    b. School district employees – staff
    c. Local, municipal or county employees
    d. State university employees – faculty

e. State university employees – staff
f. Legislators
g. Any others: _____
h. N/A

10. Does your agency also administer health benefits for retirees? (Yes/No)
    a. If No, which state agency is responsible for administering benefits for retirees?

11. How many plan options can your employees choose from? (Do not include any dental or vision plan options. If your answer varies by workforce population, please answer for state agency employees).
    a. 1 plan option
    b. 2-4 plan options
    c. 5 or more plan options

12. Does your agency offer eligible employees a High Deductible Health Plan (HDHP) (deductible is $1,400 or more for a self-only plan; $2,800 or more for a family plan)? (Yes/No)
    a. If Yes, how many active employees are enrolled in the HDHP option with the greatest number of enrollees? Please include dependents.
    b. If Yes, does your agency offer it in conjunction with a Health Savings Account?
    c. If Yes, does your agency contribute to the HSA? (Yes/No)

13. Does your agency contribute to a Health Reimbursement Arrangement or Account? (Yes/No)

14. What plan options does your agency offer eligible employees? (select all that apply)
    a. a closed network plan option (e.g., HMO or EPO) (a plan design that provides no out-of-network coverage)
    b. HMO with out-of-network option
    c. an open network plan option (e.g., PPO) (a plan design that provides lower cost- sharing for in-network coverage and partially covers some out-of-network services)
    d. an indemnity plan option? (a plan design, sometimes also referred to as a fee- for-service plan, that allows enrollees to see any health care provider and pays providers a set amount per service)
    e. If your agency provides multiple plan options, do all active employees have the ability to choose any of the plans? (Yes/No)
        i. If No, explain: _____

15. Is there a collective bargaining agreement in place with one or more state employee unions? (Yes/No) (If you have multiple collective bargaining agreements in place, please answer the following for the agreement that covers the largest number of active employees)
    a. If Yes, does the union (or unions) participate in benefit design decisions (e.g., scope of benefits, level of cost-sharing)? (Yes/No)
    b. If Yes, does the union (or unions) participate in network design decisions? (Yes/No)
    c. If Yes, what is the duration of your collective bargaining agreement?
        i. 1 year
        ii. 2-3 years
        iii. 4+ years

16. If a collective bargaining agreement has a duration of greater than 1 year, are you able to make mid-course changes to the agreement in order to implement cost-containment initiatives?
    a. N/A, because there is no collective bargaining agreement in place
    b. Yes
    c. No

17. Which of the following entities is responsible for network negotiations? (select all that apply)
    a. Your agency
    b. Other state agency
    c. Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
    d. Employee union
    e. Benefit advisory firm, consultant or broker
    f. Other: _____

18. Beyond enrollee premiums, how is the state employee health benefits program— both benefit and administrative costs— funded? (select all that apply)
    a. State appropriation
    b. State general fund
    c. Agency assessment
    d. Other: _____

19. Are the plan options administered by your agency:
    a. All self-funded
    b. All fully insured
    c. Both self-funded and fully insured

20. Do you purchase any stop loss coverage? (Yes/No)

21. If available, what is the weighted average or range of actuarial values across all offered plan options? _____

22. What percentage of the total premium does the state contribute for (NOTE: If you contribute different amount for different types of employees, please respond for full-time, salaried employees):
    a. Employee only?
    b. Employee + spouse, partner, or one dependent?
    c. Employee + children?
    d. Family coverage?

23. Over the last two years, has the weighted average or range of actuarial values shifted:
    a. Higher
    b. Lower
    c. Stayed the same
    d. Not available

24. Over the last 2 years, has the share of the state contribution to premiums increased, decreased, or stayed the same?
    a. Increased
    b. Decreased
    c. Stayed the same
    d. Not Available

25. Do you have more than one TPA/issuer offering plans to your enrollees? (Yes/No)
    a. If yes, how many? ___
    b. If yes, is there a TPA/issuer that has a majority or plurality of SEHP enrollees? (Yes/No)

SECTION II - Cost Containment

1. If you offer more than one plan option, which plan type has the greatest number of active enrollees?
   a. Closed network plan (e.g., HMO or EPO that does not provide out-of-network coverage)
   b. HMO with out-of-network option
   c. Open network plan (e.g., PPO that provides partial coverage for out-of-network services)
   d. Indemnity plan (e.g., a fee-for-service plan that allows enrollees to see any provider and pays providers an established amount per service)
   e. Other: _____
   f. N/A (we offer only one plan option)

2. Is the plan option with the highest number of active employees enrolled a high deductible health plan?
   a. Yes
   b. No

3. If you answered yes, above, is this plan eligible for an HSA?
   a. Yes
   b. No

4. In the last two years has your agency implemented any of the following initiatives to help contain costs (select all that apply)?
   a. Not applicable (state employee plans are all fully insured) (skip questions 1-4)
   b. Benefit design initiatives
      i. Value-Based Insurance Design
      ii. Reference-based pricing (i.e., providing first-dollar coverage (to a defined limit) for nonemergent care)
      iii. Right to Shop, (i.e., reducing enrollee cost-sharing when patients choose more cost-effective providers)
      iv. Wellness incentives that result in an increase or decrease in premiums or cost-sharing based on enrollee's achievement of a target health metric (e.g., BMI, cholesterol level)
      v. Increased cost-sharing for enrollees (i.e., deductibles, copayments, coinsurance)
      vi. Other (please describe) _____
      vii. N/A
   c. Provider payment and network design initiatives:
      i. Narrow provider networks
      ii. Tiered provider networks
      iii. Centers of excellence
      iv. Pegging provider reimbursement to a reference price, such as a percentile of the Medicare rate (sometimes referred to as "reference pricing")
      v. Risk-based contracts with health care providers
      vi. Direct negotiation or contracting with providers
      vii. Primary care-based initiatives (e.g., worksite clinics, near worksite clinics, DPCs, patient-centered medical home)
      viii. Other (please describe) _____
      ix. N/A
   d. Utilization management initiatives
      i. Case management for high-cost enrollees
      ii. Disease management for enrollees with one or more chronic conditions (e.g., diabetes, heart disease)
      iii. Prior authorization and other methods of utilization management (e.g., primary care physician referral for specialty care)

iv. Other (please describe) _____
v. N/A

e. Other initiatives
i. Annual spending growth target or cap
ii. Price transparency initiatives (e.g., Member shopping tools - plans/providers)
iii. Requiring removal of anti-competitive clauses from provider/payer contracts
iv. Behavioral health management strategies or benefit carve out
v. Auditing of claims (e.g., utilization auditing, payment accuracy, fraud identification)
vi. Procurement strategies (e.g., reverse auction)
vii. Other (please describe) _____
viii. N/A

f. Our agency has not implemented any cost-containment initiatives in the last two years.

5. For the cost-containment initiatives selected in the previous questions, were any of them implemented as part of a:
a. cross-agency purchasing strategy, i.e., with your state Medicaid agency, state- based marketplace, or other state purchasing agencies? (Yes/No)
i. If Y, which initiative(s)?
b. purchasing collaboration with other states? (Yes/No)
c. If Y, which initiative(s)?
d. employer purchasing coalition with private employers? (Yes/No)
i. If Y, which initiative(s)?
e. The Center for Medicare and Medicaid Innovation's (CMMI) Learning and Action Network (LAN) or State Innovation Model (SIM) initiative? (Yes/No)
i. If Y, which initiative(s)?

6. Of the cost containment initiatives you have implemented in the last 5 years:
a. Which, if any, have resulted in demonstrated cost savings?
i. (a) None
ii. (b) (open answer/fill in)
b. Which, if any, have you expanded because of cost savings and/or improved health outcomes?
i. (a) None
ii. (b) (open answer/fill in)
c. Have you discontinued or scaled any back due to lack of return on investment?
i. (a) None
ii. (b) (open answer/fill in)

7. Who initiates and/or develops new cost-containment approaches (select all that apply)?
a. Agency leadership
b. Governor's office
c. Legislators
d. Insurance plans/TPAs
e. A different state agency
f. External consultants
g. Other (please explain)

8. Does the state employee plan contribute claims data to an All-Payer Claims Database (All-Payer Claims Database or APCD: Statewide databases that include all medical, pharmacy and dental claims collected from all private and public payers)? (Yes/No)

9. Does your agency use data from the APCD to assess cost trends or cost drivers affecting the state employee plan program? (Yes/No)

10. Does your agency have access to claims data and/or data on provider negotiated rates and/or allowed amounts from its Third-Party Administrator (TPA) or issuer? (Yes/No)
    a. If Yes, have you analyzed the data? (Yes/No)
    b. If No, why?
        i. Lack of data analysis capacity
        ii. TPA or issuer imposes limits on use of the data
        iii. Other _____
    c. If Yes, does your agency use those data to assess cost trends/drivers? (Yes/No)
    d. If Yes, is data analysis performed (select all that apply):
        i. In-house at the agency
        ii. By the issuer/TPA
        iii. By a consultant
        iv. Other: _____

11. Have you included new cost-containment targets for your TPA vendors to commit to or attain in your RFP process? (Yes/No)

12. If yes, do your TPA contracts include accountability mechanisms for failure to meet specified cost containment goals? (Yes/No)

13. Is your agency using any tools to assess the finances of hospitals in your state? (For example, NASHP's hospital cost tool or Sage Transparency's pricing tool) (Yes/No)
    a. If yes, what data source are you using?

14. Beginning January 2021, hospitals are required to publicly post data on their negotiated rates for in-network providers and allowed amounts for out-of-network providers. Have you attempted to access or analyze this data? (Yes/No)
    a. If Yes, have you used this data to inform cost containment initiatives or contract negotiations? (Yes/No)
        i. If Yes, please explain _____
    b. If No, is it because (check all that apply):
        i. Lack of compliance among hospitals in your state
        ii. Data is not in a usable format
        iii. Lack of staffing/capacity to conduct data analysis
        iv. Unclear benefit
        v. Other _____

15. Beginning July 1, 2022, health plans are required to post data on their negotiated rates for in-network providers and allowed amounts for out-of-network providers. Have you attempted to access or analyze this data? (Yes/No)
    a. If yes, and you were successful, do you anticipate using this data to inform cost containment initiatives or contract negotiations with TPAs? (Yes/No)
        i. If Yes, please explain
    b. If No, is it because (check all that apply)
        i. Our TPA/issuer has not posted this data yet
        ii. Our TPA/issuer has posted the data but the file is too large to access
        iii. We were able to access the data file but the data is not in a format conducive to analysis
        iv. Lack of staffing/capacity to conduct data analysis
        v. Unclear benefit
        vi. Other _____

16. Have you had any conversations with your TPA/issuers about making their price data more accessible to you? (Yes/No/Don't Know)

17. Federal law prohibits gag clauses in payer-provider contracts. Have you been able to confirm that your TPA(s) no longer includes these clauses in their contracts with providers? (Yes/No)
    a. If Yes, have you been able to obtain access to claims or other data that was previously denied to you? (Yes/No)
        i. If yes, has your issuer/TPA attempted to place restrictions or limits on your use of claims or other data?

18. Federal law requires employer health plans to provide enrollees with an "Advanced Explanation of Benefits (EOB)" prior to a scheduled service. Does your TPA(s) have an existing process, or a plan for implementing a new process, for receiving good faith cost estimates from providers and incorporating them into Advanced EOBs? (Yes/No/Don't Know)

19. Federal law requires employer health plans to provide enrollees with a price comparison tool enabling them to compare cost-sharing across providers for 500 specified services by January 1, 2023. Do your plans have existing price comparison tools that comply with the federal requirements? (Yes/No/Don't know)
    a. If no, have you been working with your TPA(s) to implement the new price comparison tools by January 1, 2023? (Yes/No)

20. Will you be communicating with your enrollees about the new price comparison tools during your open enrollment period, or during plan year 2023? (Yes/No)

21. Federal law requires that employer plans provide enrollees with Plan ID cards that include their annual deductible and maximum out-of-pocket limit, effective January 1, 2022. Have your TPA/insurer(s) created new ID cards that comply with this requirement? (Yes/No/Don't Know)

22. The federal No Surprises Act (NSA) and some state laws protect plan enrollees from balance billing in certain situations. The NSA also creates an independent dispute resolution process (federal IDR) for resolving payment disputes between plans and out- of-network providers. For those situations covered by NSA, is your plan subject to the dispute resolution process or other standard prescribed by:
    a. Your state law?
    b. Federal law (federal IDR)?
    c. Varies, depending on the situation, such as the setting or provider?
    d. Don't know

23. Are you or your TPA/health plan(s) educating enrollees about their rights under either your state balance billing law or the federal No Surprises Act? If so, are you or they (choose all that apply?)
    a. Mailing information to enrollees about their rights under NSA/state law?
    b. Providing information on an enrollee-facing website?
    c. Sharing information with employees through Department/Agency leaders?
    d. Other? (Please explain).

24. Have there been any (and if so, how many) disputes between your TPA/health plans and out-of-network providers filed through the state or federal independent dispute resolution process since January 1, 2022?
    a. No disputes filed
    b. 1-10
    c. 10-20
    d. 20-30
    e. Greater than 30
    f. Don't know
    g. Of the disputes filed do you know how many have been resolved?
        i. How many ____
        ii. I don't know

h. Of disputes that have been resolved, have the majority been decided in favor of:
   i. The provider
   ii. The plan
   iii. I don't know

25. Federal law requires employer health plans to improve the accuracy of provider directories, beginning January 1, 2022. How are you monitoring your TPA(s) compliance with new requirements for updating their provider directories?
    a. Relying on TPA attestation of compliance
    b. Reviewing TPA's policies and procedures for updating provider directories and processing member requests for out-of-network services
    c. Including penalties for non-compliance in TPA contracts
    d. Conducting secret shopper, member surveys, or other checks to assess accuracy of provider directories
    e. Other (please specify) _____

26. Is the state plan considering the implementation of any new cost-containment initiatives in the next 1-2 years? (Yes/No)
    a. If Yes, please describe: _____

27. What are the primary barriers to your agency implementing cost-containment initiatives (select all that apply)?
    a. Governance structure
    b. Terms of the collective bargaining agreement
    c. Procurement policies and requirements
    d. Resistance from stakeholders (e.g., providers or enrollees)
    e. Resistance from TPAs/issuers
    f. Market consolidation among providers
    g. Limited or no evidence of return on investment
    h. Legislative mandates or requirements
    i. Lack of access to data or capacity to analyze data on cost drivers
    j. Other: _____

28. Please identify the single highest cost driver for your plans:
    a. Prices of hospital services
    b. Prices of physician and other ambulatory services
    c. Prices of prescription drugs
    d. Excessive or inappropriate utilization
    e. Other: _____

29. Which of the following benefit categories does your agency primarily target when considering cost-containment initiatives (select all that apply)?
    a. Prices of hospital services
    b. Prices of physician and other ambulatory services
    c. Prices of prescription drugs
    d. Excessive or inappropriate utilization
    e. Other: _____

Appendix II - Glossary of Cost Containment Initiatives

Benefit Design Initiatives	
Value-Based Insurance Design	Benefit design that provides incentives for policyholders to seek high-value, cost-effective services (i.e., primary care, generic drugs) through lower cost-sharing. Some programs also increase enrollee cost-sharing for services that are considered lower value.
Reference Pricing	A type of benefit design in which insurers or employers survey what providers are charging for a specific treatment and subsequently set a cap or a "reference price" as the most they will pay for a service. If enrollees choose a higher-priced provider, they must pay the difference between the reference price and the price charged by the provider. Enrollees are thus encouraged to choose lower-priced providers and services.
Right to Shop	A type of benefit design that allows enrollees to share in the cost-savings associated with choosing lower-priced providers or services to incentivize high-value choices in providers and services.
Provider Payment and Network Design Initiatives	
Narrow Provider Networks	When health plans work with a smaller pool of providers in exchange for lower prices for services.
Tiered Provider Networks	When health plans place providers with higher quality and/or lower costs in the most-preferred tier rankings and use financial incentives like lower cost-sharing to steer enrollees to preferred providers.
Centers of Excellence	When health plans incentivize the use of integrated medical systems that have demonstrated their ability to deliver superior patient outcomes at a lower cost for different groups of conditions such as heart, cancer, spine and transplants.
Risk-Based Contracts	Financial arrangements between insurers and providers in which providers take on financial risk through either rewards or penalties associated with lower costs, patient health outcomes, or performance on quality measures.
Worksite Clinics or Near Worksite Clinics	A setting in which an employer provides access to medical services exclusively for its employees. Clinics are often located in close proximity or in the same facility as the workplace and are offered as an employee benefit for easy access to health services for employees. Such clinics have the potential to help employers lower overall health costs by steering patients to lower cost specialty or other services.
Direct Provider Contracting (DPC)	A model of developing a plan provider network in which a self-insured health plan negotiates a contract directly with a provider of health care services rather than through a TPA.
Patient-Centered Medical Homes	A primary care delivery model that emphasizes comprehensive and coordinated health care. Medical homes are accountable for meeting the physical and mental health needs of patients with an emphasis on prevention and wellness. Services are often delivered by a care team that includes a wide variety of providers including physicians, advance practice nurses, pharmacists, dietitians, social workers and care coordinators. Care is expected to be accessible after hours on an urgent basis, following high quality and safety practices.

Glossary of Cost Containment Initiatives, cont'd

Utilization Management Initiatives	
Case Management	A program for enrollees of a health plan who have complex health needs or are high-cost members to help them manage their care and utilize services in a cost-efficient way.
Disease Management	Programs that provide structured treatment plans that intend to help patients better manage their chronic diseases. They typically include an element of health education to engage patients in their care and sometimes provide care coordination between different providers helping patients manage multiple chronic diseases.
Prior Authorization	A method of medical management in which approval from a health plan that may be required before the patient can receive a service or fill a prescription in order for the service or prescription to be covered by the plan.
Utilization Management	Tools that health insurers and employers use to limit the overuse of health care services by imposing restrictions or gatekeeping to certain health care services like claims review or step therapy in order to contain costs and prohibit inappropriate utilization of health care services.
Other Initiatives	
Annual Spending Growth Target or Cap	A pre-established target for the overall growth of health care spending for a particular population, as set by an insurer, employer, or state government. This approach can be enhanced by imposing financial penalties or other incentives to ensure plans and/or providers adhere to the spending growth target.
Reverse Auction	Multiple pre-qualified suppliers openly bid against one another electronically in an allotted time frame, prices decrease as the auction progresses, and suppliers are allowed to see each other's bids.
Behavioral Health Management Strategies	Strategies that health plans use to reduce costs with respect to mental health and substance use disorder services. For example, by subcontracting with a separate entity responsible for administering mental health or substance use disorder benefits, also called a behavioral health "carve out."
Invitation to Negotiate (ITN)	A solicitation for competitive sealed replies to select one or more vendors with which to commence negotiations.

Appendix III - Actuarial Value of SEHPs

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Weighted average or range of actuarial values across all plan options	Difference in weighted average or range of actuarial values over last 2 years
AK	85%	Higher
AL	85%	Higher
AR	61% rising to 80%	N/A
AZ	88.6%	Lower
CA	88%-99%	Stayed the same
CO	85%	Stayed the same
CT	98%	Stayed the same
DC	N/A	N/A
DE	81.1-92.4%	Stayed the same
FL	N/A	Not available
GA	82%	Higher
HI	90.5%	Higher
IA	N/A	N/A
ID	N/A	N/A
IL	Approximately 94%	Higher
IN	80.3% to 90.3%	Stayed the same
KS	82%	Higher
KY	72% to 88%	Stayed the same
LA	N/A	N/A
MA	70% to 80%	Stayed the same
MD	N/A	N/A
ME	93%	Lower
MI	Weighted average unavailable. Self-funded plan 89.7%; HMOs 94.8%	Higher
MN	Approximately 92%	Stayed the same
MO	83%	Lower
MS	73.8% to 79.3%	Higher
MT	80%	Lower
NC	80%	Higher
NE	N/A	N/A
ND	N/A	Higher
NH	95%	Higher
NM	82 to 87%	Stayed the same
NV	87.3% or 92.0%	N/A
NY	93%	Higher
OH	80%	Stayed the same
OK	86%	Lower
OR	N/A	N/A
PA	89%	Stayed the same
RI	N/A	N/A
SC	86%	Higher
SD	N/A	N/A
TN	80.0% to 90.5%	Higher
TX	83%	Higher
UT	88% Traditional; 91% HDHP w/ HSA	Stayed the same
VA	92%	Higher
VT	98%	Stayed the same
WA	81% to 92%	Stayed the same
WI	N/A	N/A
WV	N/A	Lower
WY	N/A	N/A

Appendix IV - SEHP Employer Premium Contribution

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Percentage of Total Premium that the State Contributes for				Difference in share that state contributes over the last 2 years
	Employee only	Employee + spouse/partner/ one dependent	Employee + children	Family coverage	
AK	91%	76%	76%	76%	Increased
AL	93%	83%	83%	83%	Increased
AR	N/A	N/A	N/A	N/A	N/A
AZ	92%	90%	88%	86%	Increased
CA	80%	80%	80%	80%	Increased
CO	86%	94%	84%	85%	Stayed the same
CT	85%	85%	85%	85%	Decreased
DC	N/A	N/A	N/A	N/A	N/A
DE	86.75-95%	86.75-95%	86.75-95%	86.75-95%	Stayed the same
FL	93.65%	N/A	N/A	90.24%	Increased
GA	83%	78%	81%	78%	Increased
HI	Ranges from 47.1% to 84.3% for the medical/ drug premium. 60% for dental and vision	Ranges from 47.1% to 84.3% for the medical/drug premium. 60% for dental and vision	Ranges from 47.1% to 84.3% for the medical/ drug premium. 60% for dental and vision	Ranges from 47.1% to 84.3% for the medical/ drug premium. 60% for dental and vision	Increased
IA	93% HMO, -85% PPO	N/A	N/A	90% HMO, 82% PPO	Stayed the same
ID	94%	91%	87%	81%	Increased
IL	87%	85.5%	N/A	87.1%	Increased
IN	85%	N/A	N/A	85%	Stayed the same
KS	90%	77%	86%	66%	Increased
KY	93%	N/A	87%	75%	Increased
LA	75%	62% for Employee + Spouse; 71% for Employee + Child	71%	61%	Increased
MA	75%	N/A	N/A	75%	Stayed the same
MD	N/A	N/A	N/A	N/A	N/A
ME	90-100% contingent on annual wages	Employee only % -plus- 60% of dependent premium	Employee Only & -plus- 60% dependent premium	Employee Only % -plus- 60% dependent premium	Stayed the same
MI	80% self-funded; 85% fully insured (HMOs)	80% self-funded PPO; 85% fully insured HMOs	80% self-funded PPO; 85% fully insured HMOs	80% self-funded PPO; 85% fully insured HMOs	Stayed the same
MN	95%	88%	88%	88%	Stayed the same
MO	94%	86%	93%	88%	Increased
MS	100% for HDHP, 90% - 95% for non-HDHP Option	State does not contribute to dependent coverage	State does not contribute to dependent coverage	State does not contribute to dependent coverage	Stayed the same

SEHP Employer Premium Contribution, cont'd

State	Percentage of Total Premium that the State Contributes for				Difference in share that state contributes over the last 2 years
	Employee only	Employee + spouse/partner/ one dependent	Employee + children	Family coverage	
MT	97.2%	80.3%	91.3%	76.3%	Stayed the same
NC	93%	45.0%	66%	44%	Stayed the same
NE	79%	79%	79%	79%	Stayed the same
ND	100%	N/A	N/A	100%	Stayed the same
NH	92.0%	92.0%	N/A	92.0%	Increased
NM	72%	72%	72%	72%	Stayed the same
NV	91.9%	82.6%	86.6%	80.9%	Decreased
NY	Salary grade 9 and below=88%, Salary grade 10 and above=84%	N/A	N/A	Salary grade 9 and below=73%, Salary grade 10 and above=69%	Stayed the same
OH	85%	85%	85%	85%	Stayed the same
OK	$686.56/mo	$1,365.80/mo (EE + Spouse); $928.28/mo (EE + Child)	$1,096.78/mo	$1,605.00/mo (EE + Spouse + Child); $1,745.76/ mo (EE + Spouse + Children 2 or more)	Increased
OR	95% or 99%, depending on plan selection	95% or 99%, depending on plan selection	95% or 99%, depending on plan selection	95% or 99%, depending on plan selection	Increased
PA	89%	89%	89%	89%	Stayed the same
RI	80%	80%	80%	80%	Stayed the same
SC	82.6%	79.2%	84.0%	80.0%	Increased
SD	N/A	N/A	N/A	N/A	N/A
TN	80%	80%	80%	80%	Stayed the same
TX	100%	73%	78%	67%	Stayed the same
UT	92% for Traditional; 98% for HSA	92% Traditional; 98% HSA	N/A	Traditional 92%; HSA 98%	Stayed the same
VA	90%	87%	N/A	88%	Stayed the same
VT	80%	80%	N/A	80%	Stayed the same
WA	85%	85%	85%	85%	Stayed the same
WI	88%	N/A	N/A	88%	Stayed the same
WV	80%	80%	80%	80%	Increased
WY	82%	82%	82%	82%	Increased

Appendix V - Enrollment and Eligibility

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Number of individual employees covered	Number of dependents covered	Percentage of population with employer-sponsored insurance enrolled in the SEHP*	Workforces eligible to participate in addition to active executive branch employees
AK	29,652	28,569	19.24%	• Legislators
AL	30,638	30,071	2.66%	• Legislators • Retirees
AR	130,000	45,000	14.51%	• Legislators • School district employees - teachers/staff
AZ	53,264	67,418	3.77%	• State university employees faculty/staff • Legislators • Retirees
CA	433,555	580,279	5.63%	• School district employees - teachers/staff • Local, municipal or county employees • Retirees
CO	30,953	26,000	1.96%	• State university employee staff • Legislators
CT	77,040	106,161	10.08%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators
DC	27,865	27,247	15.43%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators
DE	33,324	44,512	16.39%	• cccc
FL	143,343	178,485	3.81%	• State university employees faculty/staff • Legislators • Retirees
GA	231,000	256,000	9.67%	• School district employees - teachers/staff • Legislators • Retirees
HI	65,000	51,200	16.68%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
IA	20,798	32,841	3.25%	• Legislators • Retirees
ID	24,600	58,000	9.24%	• School district employees - teachers/staff • State university employees - faculty/staff
IL	87,984	120,287	3.16%	• State university employees faculty/staff • Legislators
IN	26,217	31,689	1.67%	• School district employees - teachers/staff • Legislators • Retirees

Enrollment and Eligibility, cont'd

State	Number of individual employees covered	Number of dependents covered	Percentage of population with employer-sponsored insurance enrolled in the SEHP*	Workforces eligible to participate in addition to active executive branch employees
KS	36,230	33,120	4.60%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
KY	143,577	120,442	13.81%	• School district employees - teachers/staff • Local, municipal, or county employees • Legislators
LA	73,747	71,790	8.02%	• School district employees - teachers/staff • State university employees - faculty/staff • Legislators • Retirees
MA	170,000	100,000	7.27%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
ME	12,846	16,066	4.77%	• Legislators • Retirees
MD	68,605	74,500	4.51%	• Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Satellite orgs as defined in COMAR
MI	42,434	68,556	2.25%	• Judges • Legislative staff • Retirees
MN	49,886	72,601	3.93%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
MO	31,536	30,248	1.98%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
MS	108,000	51,549	13.29%	• School district employees - teachers/staff • State university employees - faculty/staff • Legislators • Retirees
MT	13,053	15,590	6.11%	• Legislators • Retirees
NC	309,190	183,362	10.50%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
NE	12,769	14,080	2.54%	• Legislators • Retirees

Enrollment and Eligibility, cont'd

State	Number of individual employees covered	Number of dependents covered	Percentage of population with employer-sponsored insurance enrolled in the SEHP*	Workforces eligible to participate in addition to active executive branch employees
ND	25,424	58,903	19.78%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
NH	9,465	13,844	3.00%	• Legislators • Retirees
NM	27,350	30,176	7.69%	• Local, municipal, or county employees • State university employees - faculty/staff • Legislators
NV	26,757	24,231	3.40%	• State university employees - faculty/staff • Legislators • Retirees
NY	331,880 (includes enrollees of New York State and local public employees)	239,619 (includes dependents of enrollees of New York State and local public employees)	6.06%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
OH	41,448	61,706	1.78%	• Legislators
OK	91,502	57,738	9.01%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
OR	55,250	86,700	6.97%	• Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
PA	74,416	89,505	2.56%	• Retirees
RI	12,500	20,000	5.92%	• State university employees - faculty/staff • Legislators • Retirees
SC	196,295	188,379	17.37%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
SD	N/A	N/A	N/A	• N/A
TN	129,920	135,792	8.22%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Pre-65 retirees • Legislators • Retirees
TX	200,353	150,071	2.63%	• State university employees - faculty/staff • Legislators • Retirees
UT	24,786	50,658	3.95%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators

Enrollment and Eligibility, cont'd

State	Number of individual employees covered	Number of dependents covered	Percentage of population with employer-sponsored insurance enrolled in the SEHP*	Workforces eligible to participate in addition to active executive branch employees
VA	85,756	99,264	4.13%	• State university employees - faculty/staff • Legislators • Retirees
VT	17,583	25,373	14.44%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff
WA	263,862	272,848	13.73%	• All K-12 employees – teachers, classified staff, administrators, etc. • State university employees - faculty/staff • Legislators • Retirees (both state agency and K-12) • Judges • Charter school employees The following can opt into the system: • Local, municipal, county, and other political subdivision employees • Tribal governments • Locally elected school boards • Employee organizations representing state civil service employees
WI	79,783	113,048	6.16%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
WV	70,000	90,000	20.93%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Legislators • Retirees
WY	17,136	18,995	12.95%	• School district employees - teachers/staff • Local, municipal, or county employees • State university employees - faculty/staff • Retirees

* Author's analysis of survey responses. In order to calculate the percentage of population with employer sponsored insurance enrolled in the state employee health plan, we used the enrollment numbers (both individuals and dependents) provided by respondent states in our survey and used Kaiser Family Foundation's State Health Facts for 2021 to find the total number of people in each state enrolled in employer-sponsored insurance.

Appendix VI - Enrollment Data: Collection and Use

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Are enrollees required to submit demographic data?	Which fields of demographic data do you collect on plan enrollees?	Are you using demographic data to address health disparities?	Do you collect demographic data during open enrollment?
AK	Yes	Gender/gender identity	No	Yes
AL	Yes	Gender/gender identity	No	Yes
AR	No	N/A	N/A	No
AZ	No	Disability status	N/A	No
CA	No	Sexual orientation, disability status, gender/gender identity, preferred language, ethnicity, race	N/A	No
CO	Yes	Gender/gender identity, disability status	No	Yes
CT	No	Race, ethnicity, gender/gender identity, All of the above data is limited. It is collected in part by state employees (not for dependents or municipal employees) or can be voluntarily provided by members.	Yes	No
DC	No	Race, ethnicity, gender/gender identity	No	No
DE	No	N/A	No	No
FL	No	Gender/gender identity	N/A	Yes
GA	No	Race, ethnicity, preferred language, gender/gender identity, disability status	N/A	Yes
HI	Yes	Gender/gender identity	No	Yes
IA	No	Race, ethnicity, gender/gender identity, disability status	No	Yes
ID	No	Disability status, gender/gender identity	No	Yes
IL	No	N/A	N/A	N/A
IN	No	Gender/gender identity, race, ethnicity	Yes	Yes
KS	Yes	Race, gender/gender identity	N/A	Yes
KY	No	N/A	N/A	No
LA	No	Gender/gender identity	N/A	No
MA	No	Gender/gender identity	Yes	Yes
ME	Yes	Gender/gender identity, disability status, domestic partnership	No	Yes
MD	Yes	Gender/gender identity, disability status	No	Yes
MI	No	Gender/gender identity	No	Yes
MN	No	Race, ethnicity, gender/gender identity, disability status	Yes	No

Enrollment Data: Collection and Use, cont'd

State	Are enrollees required to submit demographic data?	Which fields of demographic data do you collect on plan enrollees?	Are you using demographic data to address health disparities?	Do you collect demographic data during open enrollment?
MO	No	N/A	N/A	No
MS	Yes	Gender/gender identity	No	Yes
MT	No	N/A	N/A	No
NC	Yes	N/A	No	Yes
NE	Yes	N/A	No	Yes
ND	Yes	Gender/gender identity	No	Yes
NH	No	Gender/gender identity	N/A	Yes
NM	Yes	Race, ethnicity, preferred language, gender/gender identity	No	Yes
NV	No	Gender/gender identity	No	Yes
NY	Yes	Gender/gender identity	No	Yes
OH	Yes	Gender/gender identity, Age	No	No
OK	Yes	Race, ethnicity, Marital Status; Sex; Date of Birth; We will begin collecting race/ethnicity for Medicare members beginning 2023.	N/A	Yes
OR	No	Race, ethnicity, gender/gender identity	No	Yes
PA	No	N/A	N/A	No
RI	Yes	Gender/gender identity	No	Yes
SC	Yes	Gender/gender identity, DOB, home location, marital status	No	Yes
SD	No	Gender/gender identity	No	No
TN	No	N/A	N/A	No
TX	Yes	Preferred language, gender/ gender identity	Yes	Yes
UT	No	Gender/gender identity	No	Yes
VA	Yes	Race, gender/gender identity	No	Yes
VT	Yes	Gender/gender identity, disability status	Yes	Yes
WA	Yes	Gender/gender identity, disability status	No	Yes
WI	Yes	Disability status, gender/ gender identity	No	Yes
WV	No	Gender/gender identity, disability status	N/A	No
WY	No	N/A	N/A	No

Appendix VII - Cost Containment Initiatives

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Cost Containment Initiatives Implemented by the State in the Last Two Years			
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives
AK	N/A	• Centers of excellence	• Case management • Disease management • Utilization management	• Behavioral health management strategies • Auditing of claims
AL	N/A	N/A	N/A	N/A
AR*	• Reference-based pricing • Wellness incentives	N/A	• Utilization management	N/A
AZ	• Reference-based pricing • Wellness incentives	• Tiered provider networks	• Case management • Disease management • Utilization management	N/A
CA	• Value-Based Insurance Design • Reference-based pricing	• Narrow provider networks • Centers of excellence • Primary care-based initiatives	• Utilization management • Case management • Disease management	• Behavioral health management • Auditing of claims • Procurement strategies • Health equity • Performance measures
CO	• Value-Based • Insurance Design • Right to shop	• Direct contracting • Primary care-based initiatives	• Case management • Disease management	• Behavioral health management • Price transparency • Procurement strategies
CT	• Value-Based Insurance Design • Right to Shop • Wellness incentives • Manufacturer assistance program	• Tiered provider networks • Centers of excellence • Risk-based contracts • Direct contracting • Primary care-based initiatives	• Disease management • Case management	• Price transparency • Auditing of claims • Procurement strategies
DC*	N/A	N/A	• Disease management • Case management	N/A
DE	• Right to shop	• Centers of excellence	• Disease management • Case management • Utilization management	• Auditing of claims
FL	• Right to shop	• Direct contracting	• Utilization management	• Auditing of claims • Procurement strategies
GA	• Wellness incentives	• Centers of excellence	• Disease management • Case management	• Behavioral health management • Auditing of claims
HI	N/A	N/A	• Disease management • Utilization management	N/A
IA	N/A	• Centers of excellence • Narrow provider networks • Tiered provider networks • Direct contracting • Primary care-based initiatives	• Case management • Disease management • Utilization management	• Price transparency • Behavioral health management
ID	• Value-Based Insurance Design • Right to shop	N/A	• Utilization management	• Price transparency • Procurement strategies

Cost Containment Initiatives, cont'd

State	Cost Containment Initiatives Implemented by the State in the Last Two Years			
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives
IN	N/A	• Primary care-based initiatives • Tiered provider networks • Risk-based contracts	• Case management • Disease management • Utilization management	• Price transparency • Direct contract with providers
KS	• Value-Based Insurance Design • Wellness incentives • Right to Shop	• Centers of excellence • Primary care-based initiatives	• Disease management	• Price transparency • Auditing of claims • Behavioral health management
KY	• Value-Based Insurance Design • Right to shop • Wellness incentives • Increased cost-sharing	• Centers of excellence • Primary care-based initiatives	• Case management • Disease management • Utilization management	• Price transparency • Behavioral health management • Auditing of claims • Annual spending growth target or cap
LA	N/A	• Primary care-based initiatives	N/A	N/A
MA	• Value-Based Insurance Design • Right to shop	• Narrow provider networks • Tiered provider networks • Centers of excellence • Risk-based contracts	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims • Procurement strategies • Behavioral health management • Annual spending growth target or cap
MD*	• Wellness incentive	N/A	• Disease management	• Behavioral health management
ME	• Value-Based Insurance Design • Wellness incentives	• Tiered provider networks • Centers of excellence	• Case management • Disease management • Utilization management	• Behavioral health management • Auditing of claims
MI	N/A	N/A	N/A	N/A
MN	N/A	N/A	N/A	• Price transparency • Auditing of claims • Procurement strategies
MO	• Right to shop	N/A	N/A	N/A
MS	• Increased cost-sharing	• Direct contracting	• Case management • Disease management • Utilization management	• Auditing of claims
MT	• Reference Pricing • Wellness incentives	• Centers of excellence • Provider reference pricing • Primary care-based initiatives	• Case management • Disease management • Utilization management	• Price transparency
NC	N/A	N/A	N/A	N/A
NE	N/A	N/A	N/A	N/A
ND	• Value-Based Insurance Design	• Narrow provider networks • Primary care-based initiatives	• Case management • Disease management	• Auditing of claims
NH	• Value-Based Insurance Design • Right to shop	• Centers of excellence • Primary care-based initiatives • Risk based contracts	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims • Procurement strategies
NM	• Value-Based Insurance Design • Wellness incentives	• Tiered provider networks • Risk-based contracts • Primary care-based initiatives	• Disease management • Utilization management	• Procurement strategies • Auditing of claims

Cost Containment Initiatives, cont'd

State	Cost Containment Initiatives Implemented by the State in the Last Two Years			
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives
NV	• Increased cost-sharing	• Narrow provider networks	• Utilization management	• Procurement strategies • Auditing of claims
NY	• Increased cost-sharing	• Provider reference pricing	N/A	N/A
OH	• Wellness incentives • Increased cost-sharing	• Narrow provider networks • Centers of excellence	• Case management • Disease management	N/A
OK	N/A	N/A	• Disease management	• Auditing of claims
OR	• Wellness incentives • Increased cost-sharing	• Centers of excellence	• Disease management	• Annual spending growth target or cap • Behavioral health management
PA	N/A	N/A	N/A	• Procurement strategies
RI	• Wellness incentives • Increased cost-sharing • Value-Based Insurance Design	• Centers of excellence • Primary care-based initiatives • Tiered provider networks • Provider reference pricing	• Disease management • Utilization management	• Price transparency initiatives
SC	• Value-Based Insurance Design • Increased cost-sharing • "Part B Solution"	• Centers of excellence • Provider reference pricing • Risk-based contracts • Direct negotiation or contracting • Primary care-based initiatives • Narrow provider networks • Continuation and expansion of site-neutral pricing	• Case management • Disease management • Utilization management	• Price transparency initiatives • Procurement strategies • Behavioral health management • Academic detailing for pharmacy
SD*	• Wellness incentives • Increased cost-sharing	• Centers of Excellence	• Case management • Disease management • Utilization management	N/A
TN	• Value-Based Insurance Design • Increased cost-sharing for enrollees	• Substance use disorder waived treatment costs when using select providers • Waived costs for some hip, knee, and back surgeries when using select providers	• Case management	• Behavioral health management • Auditing of claims
TX	• Right to Shop	Primary care-based initiatives	N/A	• Price transparency • Auditing of claims
UT	• Reference Pricing • Right to Shop	• Risk-based contracts • Direct contracting • Narrow provider networks • Primary care-based initiatives	• Case management • Disease management • Utilization management	• Price transparency • Behavioral health management • Auditing of claims
VA	• Value-based insurance design	N/A	• Disease management	• Auditing of claims
VT	N/A	N/A	• Disease management	• Auditing of claims • Price transparency initiatives

* Arkansas, D.C., Maryland, and South Dakota did not respond to the 2020 survey. We therefore asked for their responses to include cost containment initiatives implemented in the past five years.

Cost Containment Initiatives, cont'd

State	Cost Containment Initiatives Implemented by the State in the Last Two Years			
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives
WA	N/A	N/A	• Case management	• Auditing of claims • Behavioral health management • Procurement strategies
WI	N/A	N/A	N/A	• Clear bagging for specialty pharmacy
WV	• Wellness incentives	N/A	• Case management • Disease management • Utilization management	• Auditing of claims
WY	• Increased cost-sharing	N/A	• Case management • Disease management • Utilization management	N/A

Appendix VIII - Cost Containment: Results and Accountability

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Which initiatives resulted in cost savings, if any?	Which initiatives have you expanded because of cost savings and/or improved health outcomes?	Which initiatives have you discontinued or scaled back due to lack of return on investment?	Who initiates and/or develops new cost containment approaches?	Have you included new cost-containment targets for your TPA vendors to commit to or attain in your RFP process?	Do your TPA contracts include accountability mechanisms for failure to meet specified cost containment goals?
AK	N/A	N/A	• Some wellness initiatives	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants	No	Yes
AL	N/A	N/A	N/A	• Agency leadership • Insurance plans/ TPAs • External consultants	No	No
AR	N/A	N/A	• Wellness program	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants	No	Yes
AZ	• New RFP contracts with Medicaid and PBM vendors	N/A	None	• Agency leadership	Yes	Yes
CA	N/A	N/A	None	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants • A different state agency	No	N/A
CO	N/A	• Wellness plan coaching	• Insurer wellness program	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants	No	No
CT	• Manufacturer Assistance for Prescription Drugs	N/A	• Site of service cost share differentials for high-cost radiology	• Agency leadership • Governor's office • External consultants	No	No

Cost Containment: Results and Accountability, cont'd

State	Which initiatives resulted in cost savings, if any?	Which initiatives have you expanded because of cost savings and/or improved health outcomes?	Which initiatives have you discontinued or scaled back due to lack of return on investment?	Who initiates and/ or develops new cost containment approaches?	Have you included new cost-containment targets for your TPA vendors to commit to or attain in your RFP process?	Do your TPA contracts include accountability mechanisms for failure to meet specified cost containment goals?
DE	N/A	N/A	None	• Agency leadership • Governor's office • External consultants	Yes	No
DC	N/A	N/A	N/A	• Insurance plans/ TPAs	No	No
FL	N/A	N/A	N/A	• Legislature • External consultants	Yes	Yes
GA	• Disease Management Initiatives	• Chronic Disease Programs that target Diabetes/ Hypertension	N/A	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants	No	Yes
HI	N/A	N/A	• Digital Diabetes Prevention Program	• Insurance plans/ TPAs	No	No
IA	N/A	N/A	• Wellness incentives	• Insurance plans/ TPAs	Yes	Yes
ID	• Value Based Care Program • MSK Preauthorization • Imaging Preauthorization	N/A	N/A	• Agency leadership • Insurance plans/ TPAs • External consultants	No	No
IL	N/A	N/A	N/A	• Agency leadership • Insurance plans/ TPAs • External consultants	Yes	Yes
IN	• Tiered network	N/A	N/A	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs	No	Yes
KS	• Right to Shop • On-site Clinic	• On-site clinic	N/A	• Agency leadership • Insurance plans/ TPAs • External consultants	No	Yes
KY	• Well-being program • Transparency (shopping) • PBM initiatives • Site of Care program (UM) • Payment Integrity review (claims mining)	• Transparency (shopping) • PBM initiatives	• Portions of wellness program	• Agency leadership • Insurance plans/ TPAs • External consultants	Yes	Yes

Cost Containment: Results and Accountability, cont'd

State	Which initiatives resulted in cost savings, if any?	Which initiatives have you expanded because of cost savings and/or improved health outcomes?	Which initiatives have you discontinued or scaled back due to lack of return on investment?	Who initiates and/ or develops new cost containment approaches?	Have you included new cost-containment targets for your TPA vendors to commit to or attain in your RFP process?	Do your TPA contracts include accountability mechanisms for failure to meet specified cost containment goals?
LA	N/A	N/A	• Capitated Primary Care Provider Network	• Agency leadership • External consultants	Yes	Yes
MA	• Tiered providers • Chronic case management	N/A	None	• Agency leadership • Insurance plans/ TPAs • External consultants	No	Yes
MD	N/A	N/A	N/A	• Agency leadership • Legislature • External consultants	No	No
ME	Mandated COE use	N/A	• 2nd Surgical opinion	• Agency leadership • Legislature • Insurance plans/ TPAs • External consultants	Yes	Yes
MI	N/A	N/A	N/A	• Agency leadership • Insurance plans/ TPAs • External consultants	No	No
MN	N/A	N/A	N/A	• Agency leadership • Legislature • Insurance plans/ TPAs • External consultants	No	Yes
MO	N/A	N/A	N/A	• Agency leadership	Yes	Yes
MS	N/A	N/A	N/A	• Agency leadership	No	Yes
MT	N/A	N/A	N/A	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants	Yes	Yes
NC	N/A	N/A	N/A	• Agency leadership • Insurance plans/ TPAs • Legislature	No	Yes
NE	N/A	N/A	N/A	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants	Yes	Yes
ND	N/A	N/A	None	• Agency leadership • Insurance plans/ TPAs	No	Yes

Cost Containment: Results and Accountability, cont'd

State	Which initiatives resulted in cost savings, if any?	Which initiatives have you expanded because of cost savings and/or improved health outcomes?	Which initiatives have you discontinued or scaled back due to lack of return on investment?	Who initiates and/or develops new cost containment approaches?	Have you included new cost-containment targets for your TPA vendors to commit to or attain in your RFP process?	Do your TPA contracts include accountability mechanisms for failure to meet specified cost containment goals?
NH	N/A	N/A	N/A	• Agency leadership • Insurance plans/ TPAs	No	No
NM	N/A	N/A	N/A	• Agency leadership • Governor's office • Legislature	Yes	Yes
NV	• Network changes (narrowing)	N/A	N/A	• Agency leadership • Insurance plans/ TPAs	No	Yes
NY	N/A	N/A	N/A	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs	No	No
OH	N/A	N/A	N/A	• Agency leadership • Insurance plans/ TPAs • External consultants	No	No
OK	• Health Choice Select	• Health Choice Select	• Health Choice Select	• Agency leadership • Insurance plans/ TPAs • Legislature	Yes	Yes
OR	• Premium cap	N/A	N/A	• Insurance plans/ TPAs • External consultants	Yes	Yes
PA	N/A	N/A	N/A	• PEBTF	No	N/A
RI	N/A	N/A	N/A	• Agency leadership • Governor's office • Insurance plans/ TPAs • External consultants	No	Yes
SC	• Site-neutral provider pricing • Patient Centered Medical Homes in primary care • Lab management program • Targeted provider pricing strategy • Academic detailing • Pharmacy (Physician-administered specialty drug management ("Part B Solution"	• Site-neutral pricing (cost savings) • Targeted pricing (cost savings) PCMH • Improved health outcomes/cost savings	None	• Agency leadership • Insurance plans/ TPAs • External consultants	No	No

Cost Containment: Results and Accountability, cont'd

State	Which initiatives resulted in cost savings, if any?	Which initiatives have you expanded because of cost savings and/or improved health outcomes?	Which initiatives have you discontinued or scaled back due to lack of return on investment?	Who initiates and/or develops new cost containment approaches?	Have you included new cost-containment targets for your TPA vendors to commit to or attain in your RFP process?	Do your TPA contracts include accountability mechanisms for failure to meet specified cost containment goals?
SD	N/A	N/A	N/A	• Agency leadership	No	Yes
TN	N/A	N/A	We are closing the employee clinic next year and, therefore, are not reprocuring those services this year	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs • External consultants	Yes	Yes
TX	N/A	N/A	N/A	• Agency leadership • Legislature • Insurance plans/ TPAs • External consultants	Yes	N/A
UT	N/A	N/A	N/A	• Us—PEHP	No	No
VA	N/A	N/A	N/A	• Agency leadership • Governor's office • Legislature • Insurance plans/ TPAs	No	Yes
VT	N/A	N/A	N/A	• Agency leadership • Insurance plans/ TPAs • External consultants	Yes	Yes
WA	N/A	N/A	N/A	• Agency leadership • Governor's Office • Legislature • Insurance plans/ TPAs • External consultants	Yes	Yes
WI	N/A	N/A	N/A	• Agency leadership • Governor's Office • Legislature • Insurance plans/ TPAs • Agency staff with agency oversight board	Yes	No
WV	N/A	N/A	N/A	• Leadership	Yes	Yes
WY	N/A	N/A	N/A	• Agency leadership • External consultants	Yes	Yes

Appendix VIX - SEHP Offerings

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Number of plan options offered: 1 plan option, 2-4 plan options, 5+ plan options	Types of plan options	High-Deductible Health Plans (HDHP)			
			Offered?	Percentage of total enrollees in HDHPs*	Offered with a Health Savings Account?	Does state contribute to the Health Savings Account?
AK	1	PPO	N			
AL	1	PPO	N			
AR	2-4	PPO	Y	13.14%	Y	Y
AZ	1	PPO	Y	16.88%	Y	Y
CA	5+	HMO or EPO, PPO	N			
CO	5+	HMO or EPO, PPO	Y	20.77%	Y	Y
CT	2-4	PPO, HMO or EPO, HMO with out-of-network option	N			
DC	2-4	PPO, HMO with out-of-network option	Y	1.64%	Y	N
DE	2-4	HMO or EPO, PPO	Y	6.81%	N	
FL	2-4	HMO or EPO, PPO	Y	2.53%	Y	Y
GA	5+	HMO or EPO	Y	1.89%	Y	N
HI	5+	HMO or EPO, PPO	N			
IA	2-4	HMO or EPO	N			
ID	2-4	PPO	Y	0.65%	Y	
IL	5+	HMO or EPO, HMO with out-of-network option, PPO	N			
IN	2-4	PPO	Y	93.40%	Y	Y
KS	5+	PPO	Y	59.27%	Y	Y
KY	2-4	PPO	Y	60.38%	N	
LA	5+	HMO or EPO, PPO	Y	13.34%	Y	Y
MA	5+	HMO or EPO, PPO, an indemnity plan option	N			
ME	1	PPO	N			
MI	5+	PPO, HMO or EPO, HMO with out-of-network option	Y	0.96%	Y	Y
MD	N/A	N/A	N/A	N/A	N/A	N/A
MN	2-4	HMO or EPO	Y	0.23%	Y	Y
MO	2-4	PPO	Y	8.79%	Y	Y
MS	2-4	PPO	Y	16.17%	N	
MT	1	PPO	N			
NC	2-4	PPO	N			
NE	5+	PPO	Y	5.04%	Y	Y
ND	2-4	PPO	Y	2.27%	Y	Y
NH	2-4	HMO or EPO, PPO	N			
NM	2-4	HMO or EPO, PPO	N			

SEHP Offerings, cont'd

State	Number of plan options offered: 1 plan option, 2-4 plan options, 5+ plan options	Types of plan options	High-Deductible Health Plans (HDHP)			
			Offered?	Percentage of total enrollees in HDHPs*	Offered with a Health Savings Account?	Does state contribute to the Health Savings Account?
NV	2-4	HMO or EPO, PPO	Y	72.77%	Y	Y
NY	2-4	HMO or EPO, PPO	N			
OH	2-4	PPO	Y	1.68%	Y	Y
OK	5+	HMO or EPO, PPO	Y	12.70%	Y	N
OR	2-4	HMO or EPO, HMO with out-of-network option, PPO	N			
PA	2-4	HMO or EPO, PPO	N			
RI	2-4	PPO	Y	4.62%	Y	Y
SC	2-4	PPO	Y	4.79%	Y	N
SD	N/A	N/A	N/A	N/A	N/A	N/A
TN	2-4	PPO	Y	4.45%	Y	Y
TX	2-4	PPO	Y	1.52%	Y	Y
UT	2-4	PPO	Y	44.00%	Y	Y
VA	5+	HMO or EPO, PPO	Y	0.87%	N	
VT	2-4	PPO	Y	6.59%		
WA	5+	HMO or EPO, HMO with out-of-network option, PPO	Y	7.08%	Y	Y
WI	5+	HMO or EPO, PPO	Y	14.69%	Y	Y
WV	5+	HMO or EPO, HMO with out-of-network option, PPO	Y	2.50%	N	N
WY	2-4	PPO	Y	3.92%	N	N

* Author's analysis of survey responses. The survey asked respondents to provide the total enrollment in high-deductible health plans as well the number of individuals and dependents enrolled in all plans. This percentage was calculated using the numbers provided by survey respondents.

Appendix X - Collective Bargaining Agreements

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Collective bargaining agreement in place?	Does the union participate in benefit design decisions (i.e. scope of benefits, level of cost-sharing)?	Does the union participate in provider network design decisions?	What is the duration of your collective bargaining agreement?
AK	Y	Y	Y	2-3 years
AL	N			
AZ	N			
CA	Y	N	N	Depends on the union
CO	N			
CT	Y	Y	Y	4+ years
DE	N			
FL	Y	N	N	4+ years
GA	N			
HI	Y	N	N	2-3 years
IA	Y	N		
ID	N			
IL	Y	Y	N	4+ years
IN	N			
KS	N			
KY	N			
LA	N			
MA	N			
ME	Y	Y	Y	2-3 years
MI	Y	Y	N	2-3 years
MN	Y	Y	Y	2-3 years
MO	N			
MS	N			
MT	Y	N	N	2-3 years
NC	N			
NE	Y			2-3 years
ND	N			
NH	Y	Y	N	2-3 years
NM	N			
NV	N			
NY	Y	Y	Y	4+ years
OH	Y	Y	N	2-3 years
OK	N			
OR	Y	Y	Y	2-3 years
PA	Y	Y	Y	4+ years
RI	Y	Y	N	2-3 years
SC	N			
TN	N			

Collective Bargaining Agreements, cont'd

State	Collective bargaining agreement in place?	Does the union participate in benefit design decisions (i.e. scope of benefits, level of cost-sharing)?	Does the union participate in provider network design decisions?	What is the duration of your collective bargaining agreement?
TX	N			
UT	N			
VA	N			
VT	Y	Y	N	2-3 years
WA	Y	N	N	2-3 years
WI	N			
WV	N			
WY	N			

Appendix XI – Self-funded or Fully Insured: Who Negotiates the Networks?

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	All self-funded, all fully insured, or both	Entities that participate in network negotiations
AK	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization, SEHP Agency
AL	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
AR	All self-funded	SEHP Agency, Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
AZ	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
CA	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
CO	Both self-funded and fully insured	SEHP Agency, Benefit advisory firm, consultant, or broker
CT	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization, SEHP Agency
DC	All fully-insured	SEHP Agency
DE	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
FL	Both self-funded and fully insured	SEHP Agency
GA	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
HI	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization, Insurance carrier
IA	Both self-funded and fully insured	SEHP Agency
ID	All fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
IL	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
IN	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
KS	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
KY	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
LA	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
MA	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
MD	N/A	N/A
ME	All self-funded	SEHP Agency
MI	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
MN	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization, SEHP Agency, Benefit advisory firm, consultant, or broker
MO	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization

Self-Funded or Fully Insured - Who Negotiates the Networks, cont'd

State	All self-funded, all fully insured, or both	Entities that participate in network negotiations
MS	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
MT	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization, SEHP Agency
NC	Both self-funded and fully insured	SEHP Agency, Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
NE	All self-funded	SEHP Agency
ND	All fully insured	SEHP Agency, Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
NH	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
NM	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
NV	Both self-funded and fully insured	SEHP Agency, Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
NY	Both self-funded and fully insured	SEHP Agency, Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
OH	All self-funded	Other state agency
OK	Both self-funded and fully insured	SEHP Agency
OR	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
PA	All self-funded	PEBTF
RI	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
SC	All self-funded	SEHP Agency, Third-party Administrator (TPA) or Administrative Services Only (ASO) organization, Benefit advisory firm, consultant, or broker
SD	N/A	N/A
TN	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
TX	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
UT	All self-funded	SEHP Agency
VA	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
VT	All self-funded	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
WA	Both self-funded and fully insured	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
WI	All fully insured	Fully-funded health plans
WV	Both self-funded and fully insured	SEHP Agency, Third-party Administrator (TPA) or Administrative Services Only (ASO) organization
WY	All self-funded	Other

Appendix XII - Claims Data

NOTE: We display all responses as they were provided by survey respondents with minimal edits. We did not receive a response from New Jersey.

State	Does the SEHP agency have access to claims data from its TPA?	Does the SEHP agency use its claims data to assess cost trends/drivers?	Does the SEHP agency contribute claims data to an All-Payer Claims Database (APCD)?	Does the SEHP agency use data from the APCD to assess cost trends/drivers?
AK	Y	Y	N	N
AL	Y	Y	N	N
AR	N/A	N/A	N/A	N/A
AZ	Y	Y	N	N
CA	Y	Y	N	N/A
CO	Y	Y	Y	Y
CT	Y	Y	Y	N
DC	N/A	N/A	N/A	N/A
DE	Y	Y	Y	N
FL	Y	Y	Y	N
GA	Y	Y	N	N
HI	Y	Y	Y	N
IA	Y	Y	N	N/A
ID	Y	Y	N	N
IL	Y	Y	N	N
IN	Y	Y	N	N
KS	Y	Y	Y	Y
KY	Y	Y	N	N
LA	Y	Y	N	N
MA	Y	Y	Y	Y
MD	N/A	N/A	N/A	N/A
ME	Y	Y	Y	Y
MI	Y	Y	N	N
MN	Y	Y	Y	Y
MO	Y	Y	N	N
MS	Y	Y	N	N
MT	Y	Y	N	N
NC	Y	Y	N	N
NE	Y	Y	N	N
ND	Y	Y	N	N
NH	Y	Y	Y	N
NM	Y	Y	N	N
NV	Y	Y	N	N
NY	Y	Y	N	N
OH	Y	Y	N	N
OK	Y	Y	N	N
OR	Y	Y	Y	N
PA	Y	Y	N	N

State	Does the SEHP agency have access to claims data from its TPA?	Does the SEHP agency use its claims data to assess cost trends/drivers?	Does the SEHP agency contribute claims data to an All-Payer Claims Database (APCD)?	Does the SEHP agency use data from the APCD to assess cost trends/drivers?
RI	Y	Y	Y	N
SC	Y	Y	Y	N
SD	N/A	N/A	N/A	N/A
TN	Y	Y	N	N
TX	Y	Y	N	N
UT	N/A	N/A	Y	Y
VA	Y	Y	Y	Y
VT	Y	Y	N	N
WA	Y	Y	Y	Y
WI	N/A	N/A	N	N
WV	Y	Y	Y	N
WY	Y	Y	N	N

Endnotes

[1] Centers for Medicare and Medicaid Services, *National Health Expenditure Fact Sheet, 2021-2030*, Feb. 17, 2023, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet#:~:text=Historical%20NHE%2C%202021%3A,17%20percent%20of%20total%20NHE (accessed Apr. 13, 2023).

[2] Kaiser Family Foundation, "Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage," Oct. 27, 2022, https://www.kff.org/interactive/premiums-and-worker-contributions-among-workers-covered-by-employer-sponsored-coverage/ (accessed Apr. 13, 2023).

[3] Kaiser Family Foundation, "2022 Employer Health Benefits Chart Pack," Oct. 27, 2022, https://www.kff.org/slideshow/2022-employer-health-benefits-chart-pack/ (accessed Apr. 13, 2023).

[4] Anderson GF, Hussey P, Petrosyan V, "It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt," *Health Affairs* Vol. 38, No. 1, Jan. 2019, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.

[5] Kona M, Corlette S, "Can Employer-Sponsored Insurance Be Saved? A Review of Policy Options: Limiting Provider Consolidation and Anti-Competitive Behavior," *CHIRblog*, Mar. 8, 2023, https://chirblog.org/can-employer-sponsored-insurance-saved-review-policy-options-limiting-provider-consolidation-anti-competitive-behavior/.

[6] Corlette S, Kona M, Houston M, "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability" (Georgetown University Center on Health Insurance Reforms, June 2021), https://sehpcostcontainment.chir.georgetown.edu/documents/SEHP-report-final.pdf.

[7] Riley T, Schneiter E, Hensley-Quinn M et al., Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power (Portland, ME: National Academy for State Health Policy, April 2019), https://www.nashp.org/wp-content/uploads/2019/04/States-Leverage-Purchasing-Power.pdf.

[8] Irwin N, Brown C, "Economic Tailwind from Flush States," Axios, February 21, 2023, https://www.axios.com/2023/02/21/economic-tailwind-from-flush-states (accessed May 5, 2023).

[9] White K, *Rainy Day Funds Reach Historic Levels, Leaving States More Prepared than Ever for a Future Downturn*, National Association of State Budget Officers, January 25, 2023, https://community.nasbo.org/budgetblogs/blogs/kathryn-white/2023/01/25/rainy-day-funds-reach-historic-levels (accessed May 5, 2023).

[10] McGough M, Amin K, Cox C, "How Has Health Care Utilization Changed Since the Pandemic?" Peterson-KFF Health System Tracker, January 24, 2023, https://www.healthsystemtracker.org/chart-collection/how-has-healthcare-utilization-changed-since-the-pandemic (accessed May 5, 2023).

[11] Centers for Medicare & Medicaid Services, *NHE Fact Sheet*, February 27, 2023, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet (accessed May 5, 2023).

[12] Hoadley J, Keith K, Lucia K, *Unpacking The No Surprises Act: An Opportunity To Protect Millions*, Health Affairs Forefront, December 18, 2020, https://www.healthaffairs.org/do/10.1377/forefront.20201217.247010 (accessed April 28, 2023).

[13] Transparency in Coverage, 85 Fed. Reg. 72158 (2020), https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage#h-11.

[14] 45 C.F.R. §180.40 et seq., 45 C.F.R. § 147.212.

[15] Pub. L. 116-260 (Dec. 27, 2020).

[16] "Transparency in Coverage: Recommendations for Improving Access to and Usability of Health Plan Price Data," Georgetown University Center on Health Insurance Reforms, Jan. 2023, https://georgetown.app.box.com/file/1116022270307?s=1ezsggz1c7smsaexkr8rght15sokgusl. -