Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

UNLEASHING THE GIANT:

Opportunities for State Employee Health Plans to Drive Improvements in Affordability

By Sabrina Corlette,
Maanasa Kona, and
Megan Houston

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Center on Health Insurance Reforms

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Executive Summary

Health care costs are squeezing workers' wages, hindering business competitiveness, and straining government budgets. The agencies that purchase health benefits for state employees are uniquely situated to tackle health care costs. They are often the largest employer purchaser in their state and have the potential to exert considerable pressure on insurers and providers. Through a comprehensive survey of 47 state employee health plan (SEHP) administrators and in-depth interviews with 11 of them, this study scans the landscape of state employee plans around the country, assesses a range of cost containment strategies implemented by SEHPs, and shares lessons for building on those that appear most promising.

Background

Approximately 10 percent of people with employer-sponsored health insurance are employed by state and local governments.[1] In general, public sector employees earn less than their private sector peers, but receive more generous health and pension benefits. In spite of rising health care costs, 28 of the 47 SEHPs that responded to our survey reported that the generosity of their health plans had either shifted higher or stayed the same over the last 10 years. SEHPs also tend to contribute relatively more to employee premiums than their private sector counterparts. While private employers pay on average 70 percent of the cost of premiums, 40 states in our survey reported paying between 80 and 100 percent, and only 6 reported contributing less than 80 percent.

SEHP Cost Containment Initiatives

Cost Containment Targets are not Aligned with Cost Drivers

Most SEHP administrators identified hospital prices as their largest cost driver. However, hospital spending has not been the most common target for SEHPs' cost containment initiatives. States have focused more on prescription drug costs (39 states) and utilization (32 states). In fact, among the top five cost containment initiatives cited by states, only one—Centers of Excellence—has the potential to affect hospital pricing.

The SEHP administrators we interviewed cited three primary drivers for the disconnect between the known top cost driver—hospital prices—and the types of cost containment initiatives they pursue: (1) Lack of competition among hospitals, (2) Political clout of hospitals, and (3) Employee pressure to maintain broad provider networks.

Benefit Design Initiatives: Shifting Costs to Constrain Utilization

SEHP administrators have introduced initiatives to change the incentives enrollees face in their decisions to use health care services. These include:

- Thirty states with a high deductible health plan (HDHP) option, with a slim majority of these (18) also offering and contributing to a Health Savings Account. Only one survey respondent reported any cost savings associated with its HDHP.
- Eighteen states have implemented some form of value-based insurance design and two were able to document associated cost savings.
- Fifteen states have workplace wellness initiatives and two were able to document associated cost savings.
- Ten states have implemented reference pricing or Right to Shop programs to steer enrollees to lower cost providers. Three states were able to attribute cost savings to these programs.

Provider Payment and Network Design Initiatives: Challenges, but Potential for High Rewards

A majority of SEHPs report implementing strategies to target either high prices for hospital or physician services, including:

- Twenty-three states with a Center of Excellence program, with four additional states reporting they are in the process of developing one. Two states were able to document cost savings from these programs, although in interviews several administrators asserted that the program's primary goal is to improve patient outcomes.
- Nineteen states with a primary care-based initiative such as a patient-centered medical home, direct primary care program, or worksite clinic. While only two states were able to document cost savings from these programs, in interviews several administrators argued that their primary goal was to improve care coordination and health outcomes, not to cut costs.
- Nineteen states have implemented risk-sharing payment models in which providers agree to take on some financial risk for their patients' health care costs. Three states reported cost savings from these initiatives.
- Fourteen states have engaged in direct negotiations with providers. Of these, four reported that they had generated cost savings from removing the middleman (often called the third-party administrator) from the process.
- Twelve states offer employees a narrow or tiered network plan, and four of these report measurable cost savings from these plans.
- Seven states have or are pursuing initiatives to set provider rates or peg them to a reference price, such as the Medicare rate. Three additional states report the intent to implement similar programs. Montana reports $47.8 million in savings over three years, and Oregon's program is projected to save the state $81 million.

Other Cost Containment Efforts: Utilization Management, Fraud Prevention, and Global Budgets

States reported engaging in numerous additional cost containment strategies, including the management of chronic and high cost diseases and behavioral health services, prior authorization or referral requirements, an annual spending growth target or cap, non-traditional procurement strategies, and fraud prevention and detection.

Variations in SEHPs' Role and Structure Affect Ability to Achieve Cost Containment Goals

Each SEHP operates within a unique environment, with longstanding and evolving political, market, and operational dynamics that make it challenging to identify strategies that can be replicated across multiple states. For example, while a dozen SEHPs have a sizable proportion of commercial market enrollment (between 11-22 percent), 20 states have less than a 5 percent market share. This is largely because their programs are fragmented, with benefits for teachers, local employees, and others administered separately. Many states also dilute their purchasing power by offering options from more than one insurer or third-party administrator.

Only four states reported collaborating with another state agency, such as Medicaid, to implement a cost containment initiative. Most interviewees indicated that such collaboration is too difficult, given the different missions, structures, and regulatory requirements of the relevant agencies. However, Washington officials report very positive results from that state's efforts to consolidate the state's purchasing power.

Resistance from Stakeholders is a Top Barrier

Several SEHP administrators we interviewed noted that it takes constant, diligent effort to educate their governing boards, legislature, and other policymakers about cost trends and the evidence supporting the effectiveness of proposed initiatives. Employees themselves are also often resistant to any perceived erosion in the generosity of their benefits. Indeed, SEHP administrators face a potentially more challenging set of stakeholders than private employers. While private employers need to educate their boards and employees, SEHP administrators also must confront the perspectives of state legislators and the providers that are often the largest employers in those legislators' districts.

The Role of Labor: Antagonist and Advocate for Cost Containment

Approximately 36 percent of state and local government workers are union members. Unions are well aware of the burden of rising health care costs on total employee compensation, but they generally advocate to maintain or expand health benefits for state employees. The 21 SEHPs reporting a collective bargaining agreement in place are more likely to report offering generous plan benefits than their 26 less unionized peers. However, unions have also proven to be helpful allies in SEHPs' efforts to tackle high provider prices. For example, union representatives in North Carolina, Montana, and Oregon have been key supporters of their SEHPs' efforts to use a Medicare reference price for hospital services.

The Role of SEHP Vendors in Cost Containment Efforts

Almost all our responding states contract with third-party administrators (TPAs) and other vendors to perform a range of functions. Of the 44 states that self-fund their health plans, 26 rely exclusively on the TPA to negotiate provider contracts. Some SEHP administrators we interviewed reported that they contractually incentivize their TPA to implement cost containment initiatives, including financial penalties if it fails to meet a savings target. Several interviewees also indicate that it can be challenging to wrest their claims data from their TPAs, and for those that do they may have limited in-house capacity to analyze and act on it. Fourteen of the 47 survey respondents report that they use procurement strategies to achieve certain cost containment goals, such as "reverse auctions" or an "invitation to negotiate" program.

A Work in Progress: Future Cost Containment Strategies

Eight states report that they intend to implement provider risk-sharing, direct contracting, or reference pricing initiatives that tie provider reimbursement to a benchmark, such as the Medicare rate. Meanwhile, although only one state identified excess utilization as its primary cost driver, ten states plan to expand programs that attempt to lower or optimize utilization, such as HDHPs, value-based insurance design, workplace wellness, Right to Shop, and price transparency.

Lessons Learned from SEHP Cost Containment Initiatives

In the survey and interviews, we heard several recurring themes from SEHP administrators:

- **Education and communication.** SEHPs must build buy-in among both government and external stakeholders for initiatives that target the actual drivers of SEHP cost growth.
- **Leveraging data.** Access to claims data and the capacity to analyze it, without relying on the TPA, are critical to implementing and evaluating cost containment initiatives.
- **The "Lesser of Evils" option.** Sometimes threatening providers with a relatively draconian cost containment initiative can make them more amenable to another one that doesn't cut so deeply, but still generates meaningful savings or meets other key goals.
- **Vendors are not your friend.** SEHP administrators report that TPAs are often too complacent or actually resistant to cost containment initiatives. Several report promising returns, however, from using the vendor procurement process and accountability clauses in TPA contracts to push TPAs to do more.
- **Tailoring to local conditions.** SEHP administrators frequently identified reasons why a cost containment initiative successful in another state would not be replicated in their state. Any effort to constrain health system cost growth needs to be designed for the health care system and culture that the state actually has.

Conclusion

In general, SEHP administrators are fully aware that hospital prices are the primary driver of the steady increase in the cost of employee health benefits. Yet they remain focused on secondary drivers such as excessive or inappropriate utilization. That said, some SEHPs are demonstrating that it is possible to rein in hospital prices through a mixture of political will, creative thinking, and simple hard work. It will be important to document the long-term impact of these efforts and share successful outcomes, including state savings and lower enrollee premiums and cost sharing, so that other SEHPs as well as other government and private purchasers can learn from and implement similar programs.

[1] Bureau of Labor Statistics, Current Employment Statistics survey: In March 2020, there were 5.24 million state government workers (series ID CES9092000001) and 14.65 million local government workers (series ID CES9093000001). Bureau of Labor Statistics. National Compensation Survey: In March 2020, 78 percent of state and local workers participated in health care benefits (series ID NBU39400000000000026172). On file with authors.

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Introduction

By 2028, U.S. health spending is projected to comprise 19.7 percent of the economy, up from 17.7 percent in 2018.[1] In 2020, average annual family premiums for employer-sponsored health insurance reached $21,342, equaling almost one-third of median household income.[2, 3] The average annual deductible now exceeds $1,600 for single coverage, an increase of 25 percent over the last five years.[4] These high and rising costs are squeezing workers' wages, hindering business competitiveness, and straining state and federal budgets.

The agencies that purchase health benefits for state employees are uniquely situated to tackle health care costs. They are often the largest employer purchaser in their state and have the potential to exert considerable pressure on insurers and providers, if they choose to do so. Most pay for health care services at the relatively high commercial rates that private insurers pay, even though they are government-run plans. Given their size, efforts they undertake to shift provider incentives and encourage greater efficiencies can, in some cases, result in system-wide changes. This may be why some lawmakers have used the state employee health plan (SEHP) as a testing ground for health policy innovation. For example, lawmakers in Utah often require the SEHP to pilot state benefit mandates before they will consider extending them to the commercial insurance market. Lawmakers in Wisconsin interested in giving consumers more "skin in the game" with respect to health care costs required the SEHP to offer a high deductible health plan. The Oregon legislature has tapped the state employee plan to be the centerpiece for broader cost containment initiatives by capping how much its SEHP pays hospitals at a Medicare "reference price."[5]

SEHP administrators are often under considerable pressure to generate savings, as the cost of health care strains state budgets. In 2019, state and local governments spent $187.9 billion on premiums for employee health plans, up from $123 billion in 2009.[6] At the same time, they can be under pressure from employees to maintain generous benefits. This can mean difficult choices between the two main drivers of the cost of insurance coverage: utilization and unit prices. To depress health care utilization, plans may need to increase enrollee costs at the point of care, such as through deductibles and other cost sharing. To depress unit prices (the price charged for each service), plans often must be willing to tell a major local hospital or physician group that they will be dropped from the plan network unless they lower their charges. Neither are popular with employees or their families.

Many SEHP administrators are, understandingly, cautious in their approaches to cost containment. State employees tend to place a high value on generous health benefits. Indeed, many have traded the high salaries they might command in the private sector for more generous benefits in the public sector.[7] This makes any effort to trim those benefits, or the choice of providers, a perilous one. Nevertheless, rising prices paid to providers in the commercial insurance market, coupled with a challenging budget environment in most states, have prompted some SEHPs to initiate cost containment strategies that could have a far-reaching impact. Not all of these are replicated in every state, but several initiatives hold considerable promise, and there is much to be learned from the states' experiences designing and implementing these programs.

Through a comprehensive survey of SEHP administrators and in-depth interviews, this study details the landscape of state employee plans across the country. We assess a range of cost containment strategies implemented by SEHPs, and share lessons for building on those that appear most promising.

Methodology

To better understand the structure and governance of each state's SEHP and the cost containment initiatives it has undertaken, we first conducted an environmental scan of relevant scholarly publications and major media coverage about SEHPs and cost containment from the past five years. We also identified the agency in each of the 50 states and the District of Columbia responsible for administering its SEHP. Because many states have more than one entity that administers benefits for state and local government employees, we focused on identifying the agency or entity responsible for administering benefits for state executive branch employees. Further, because there are often different priorities, structures, and financing mechanisms for the administration of retiree health plans, we excluded from our analysis agencies that administer benefits solely for retirees.

Once we identified the SEHP administrator in each state, we fielded a survey between September 15 and December 7, 2020 to collect data on SEHP organizational structure and benefits. We also asked SEHP administrators to identify the primary cost drivers for their plans, any cost containment initiatives implemented in the last three years, barriers to implementation of those initiatives, and any documented cost savings resulting from those initiatives. For the survey questions, see Appendix I.

SEHP administrators were asked to select cost containment initiatives implemented within the last three years from a list of 17 initiatives (Appendix II) that were categorized as follows: (1) benefit design initiatives, (2) provider payment and network design initiatives, (3) utilization management initiatives, and (4) a catch-all category that included annual spending or growth caps, procurement strategies, and fraud prevention.

We then used the survey responses to select 11 SEHP administrators for in-depth, structured interviews about the challenges and opportunities they have faced in implementing their cost containment initiatives. These administrators represent SEHPs in California, Connecticut, Kansas, New Jersey, New Mexico, Oregon, South Carolina, Tennessee, Utah, Washington, and Wisconsin. They were selected based on the number and types of cost containment initiatives they have undertaken. We also sought diversity of geographic region, union presence, membership size, and commercial prices for hospital services relative to Medicare rates, as determined in a 2020 RAND study.[8]

Limitations

Forty-seven states responded to our survey. We did not receive responses from Arkansas, the District of Columbia, Maryland, or South Dakota. Additionally, several survey questions included qualitative responses, requiring us to make subjective interpretations to allow comparisons across states.

While cost containment with respect to pharmaceutical benefits is a major concern for SEHP agencies, for this project we focused on initiatives that target enrollee utilization of, and the prices for, hospital and ambulatory services. State efforts to reduce the costs of SEHP pharmacy benefits merit separate study.

Additionally, we queried SEHP administrators about their cost containment initiatives and documented cost savings from those initiatives over the past three years. However, states have varying capabilities and metrics with respect to evaluating their programs. Some states lack the capacity to conduct any assessments. Additionally, it was not always clear from survey responses if the savings reported were net of any costs to design and implement the relevant initiative.

Finally, the COVID-19 pandemic made 2020 an atypical year for health plans across the country, due to a significant decline in the utilization of elective and primary care services. State employees also shifted to telework in large numbers. This led administrators to report challenges evaluating the effectiveness of certain recently implemented initiatives, such as risk-based contracting and worksite-based health clinics.

Background

About half the American population, or 158 million people, receive health insurance through their employer.[9] Of these, approximately 15.5 million, or almost 10 percent, are employed by state and local governments.[10] Generally speaking, public sector employees earn less than their peers in the private sector, but receive more generous health and pension benefits.[11] One metric to measure the richness of a plan is actuarial value, which is “the percentage of total average costs for covered benefits that a plan will cover.”[12] The enrollee is responsible for the remaining costs. Of the 36 states that responded to our survey question about the weighted average actuarial value for their SEHP, 19 had an actuarial value that fell between 80 and 90 percent, while 14 had actuarial values over 90 percent. Only three states reported actuarial values below 80 percent. Over the last five years, 28 survey respondents reported that their plans’ actuarial value had either shifted higher or stayed the same. Only nine reported reducing their plans’ actuarial value over the same period. See Appendix III.

Between 2005 and 2019, private employers paid on average 70 percent of the cost of employee health insurance premiums, whereas state and local government employers picked up closer to 80 percent of the cost.[13] Of the 42 states that responded to our survey question on how much they contributed to individual employee premiums, 37 states said they paid between 80 and 100 percent, while 5 contributed less than 80 percent. Of the 41 states that responded to our survey question on how much they contributed to premiums for the employee’s family, 28 states reported paying between 80 and 100 percent of premiums, while 13 contributed less than that. Although at least one SEHP administrator suggested that the recession of 2008-2009 caused some states to modestly reduce their contributions to employee premiums, the majority of survey respondents said that the state’s share of employee premiums had either stayed the same or increased over the last five years. See Appendix IV.

These relatively generous contributions continue even though health insurance premiums are generally higher in the public sector. In the early 2000s, health insurance premiums in the public and private sector were similar but since then public sector premiums have risen faster than private sector premiums. This is likely because public sector coverage tends to be more generous than in the private sector, with lower deductibles and cost sharing. The public sector workforce also tends to be older, female, have a high level of education, and more likely to be in a union, factors that can contribute to higher health care utilization.[14]

For state employees, a state government agency typically administers its health plan and makes purchasing decisions with respect to plan benefit and network design. SEHP agencies are influenced by the same forces affecting private employers, such as rising health care costs and the need to recruit and retain skilled employees. However, they also are influenced by complex political forces and bureaucratic limitations, such as restrictive government procurement laws or laws that limit how much benefits can be altered. There can also often be tensions among the various government entities responsible for managing state budgets and employees and their union representatives, who generally want to maintain their current level of benefits.

The structure, authorities, and culture of SEHP purchasing vary widely from state to state. For example, our survey found that most SEHPs are available to active state agency employees, retirees, legislators, and state university system employees (faculty and staff), but only half of SEHP plans are available to school district employees (teachers and staff) and local, municipal, or county employees. In these states, local school districts and municipalities either have their own pooled purchasing structure or independently purchase health coverage for employees. See Appendix V.

SEHP Cost Containment Initiatives

Cost Containment Targets are Not Aligned with Cost Drivers

In their survey responses and interviews, SEHP administrators identified hospital prices as their largest cost driver. This is consistent with the commercial insurance market generally, where payments for inpatient and outpatient hospital services is the single largest category of spending.[15] However, hospital spending has not been the most common target for SEHPs' cost containment initiatives. Instead, states have focused more on prescription drug costs and utilization (see Tables 1 and 2).

Table 1. Single Highest Plan Cost-driver, Identified by SEHP Administrators

Cost Driver	Number of States
Prices of hospital services	23
Prices of prescription drugs	21
Excessive or inappropriate utilization	1
Prices of physician or other ambulatory services	1

Source: Authors' analysis of survey responses. Respondents were permitted to select only one of the above cost drivers. This question received 46 responses.

Table 2. Primary Targets for Cost Containment Initiatives

Cost Driver	Number of States
Prices of prescription drugs	40
Excessive or inappropriate utilization	32
Prices of hospital services	27
Prices of physician or other ambulatory services	21

Source: Authors' analysis of survey responses. Respondents were permitted to select multiple potential cost drivers. This question received 47 responses.

In fact, among the top five cost containment initiatives cited by states in their survey responses, 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 three years by each state, see Appendix VI.

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

Initiative	Number of States
Disease management for chronic disease	41
Case management for high-cost enrollees	37
Prior authorization	33
Auditing of claims	30
Centers of Excellence	23

Source: Authors' analysis of survey responses. Respondents were permitted to select multiple cost containment initiatives out of a list of 17 initiatives. This question received 47 responses. For detailed information on cost containment initiatives implemented in the past three years by each state, see Appendix VI.

SEHP administrators cited three primary reasons for the disconnect between a known top cost-driver—hospital prices—and the types of cost containment initiatives they pursue:

- **Lack of competition.** Hospital providers have considerable leverage in price negotiations, as plans must keep hospitals "in network" to maintain adequate access for enrollees. For example, one state respondent noted that only one city in their state had any hospital competition at all. Another noted that in rural areas of his state, "having preferred providers or [network] tiers" would not be viable. In another state, a large integrated health system leverages its "must have" status as an in-network provider to keep prices high, leaving SEHP administrators with utilization management and benefit design changes as their primary tools to contain costs.
- **Political clout.** SEHP administrators are acutely aware of the political power of hospitals within their communities, which often results in significant pressure from local legislators to keep them "well-fed and happy." For example, North Carolina's hospital lobby has used its political muscle to stall the state's plan to cap prices at a percentage of the Medicare rate.[16]
- **Employee pressure.** Several administrators felt that they would experience significant backlash from enrollees if they attempted to cut a high-priced hospital from their network, or significantly increased their cost sharing for obtaining services there.

These challenges have led many SEHP administrators to focus instead on constraining enrollees' use of health care services through deductibles and other benefit design strategies. These strategies also engender opposition from employees and union stakeholders because they involve shifting plan costs to enrollees through higher cost-sharing. However, benefit design strategies can often be calibrated so that enrollees feel the impact only gradually over time (such as an annual increase in the plan deductible). Or they may affect a minority of enrollees (such as those who do not achieve a desired health outcome or who use a particular type of health care service), thus blunting the potential for blowback from employees.

Benefit Design Initiatives: Shifting Costs to Constrain Utilization

SEHPs have initiated a range of cost containment initiatives that target enrollee utilization of health care services by adjusting deductibles and point-of-service cost sharing. The idea is to change the incentives enrollees face in their decisions to use health care services. These include:

- Introducing high deductible plan options;
- Lowering cost sharing for "high value" health care services and increasing it for "low value" health care services (known as "Value-based Insurance Design");
- Adjusting cost sharing for enrollees who participate in wellness programs or meet health targets; and
- Charging enrollees high cost sharing if they receive health care services from high-priced providers (often called reference pricing or "Right to Shop"). See Table 4.

Table 4. SEHPs that Implemented Benefit Design Initiatives to Constrain Costs in the Past Three Years

Initiative	Number of States
High deductible health plan(s)	30
Value-based Insurance Design plan(s)	18
Workplace Wellness program	15
Reference Pricing* or Right to Shop	10

Source: Authors' analysis of survey responses. Respondents were permitted to select more than one initiative. This question received 47 responses. For detailed information on cost containment initiatives implemented in the past three years by each state, see Appendix VI.

* Reference pricing in this context refers to a benefit design program that exposes plan enrollees to higher point-of-service cost sharing if they use a provider who charges more than a reference price.

Public sector employers are often more constrained in their ability to adjust cost sharing than their private sector counterparts. Some SEHPs cannot materially alter the cost-sharing structure of their plans without legislative approval or a burdensome regulatory process. Others may have the requisite authority but must get approval from union representatives or a governing board. In states with collectively bargained plans, increasing enrollee cost sharing is often seen as a "non-starter," with one administrator calling it a "third rail" issue. While states with less union presence appear to have more latitude to modify employee cost sharing, administrators in those states report feeling constrained by employees' expectations that they maintain generous benefits. As a result, most SEHPs we interviewed said that they have made few changes over the years with respect to the overall generosity of their plans.

High Deductible Health Plans: The Most Popular Unpopular Benefit Strategy

Thirty of the 47 responding states offer their active employees a high deductible health plan (HDHP) option, with 23 of them offering it in conjunction with a Health Savings Account (HSA), and 18 of those contributing money to the HSAs. See Appendix VII. However, only one survey respondent reported documented cost savings from increased enrollment in HDHPs.

HIGH DEDUCTIBLE HEALTH PLAN AND HEALTH SAVINGS ACCOUNT

A HDHP is a health plan with a higher deductible than a typical health plan. The monthly premium is usually lower, but the enrollee will pay more out-of-pocket for health services until the plan coverage begins (once the deductible is met). A qualifying HDHP can be combined with a health savings account (HSA), allowing the enrollee to pay for certain medical expenses with money free from federal taxes.

State administrators report that employee take up of HDHPs has been low where the SEHP does not contribute to an HSA. This is also borne out by our survey responses. Twenty of the thirty states that offer HDHP options to their employees had less than 10

percent of their insured population enrolled in them, even though over half (11) contribute to their employees' HSAs. During our interviews, SEHP administrators noted that employees may not fully understand the financial risk they adopt when they sign up for a HDHP, noting low health insurance literacy among employees. "There were many in the agency who felt people would be getting into something they didn't quite understand," observed one. Another state reported that it has launched an online education program to walk employees through the risks and benefits of HDHPs, which they say has "helped a lot" of employees better assess their options. The agency is planning to implement a benefits warehouse system to help enrollees review their personal claims histories to enable a more informed plan choice.

Administrators also identified the potential for HDHPs to lead to adverse selection. Indeed, one administrator told us that they had significant migration of healthy enrollees when they first offered a HDHP, requiring them to risk-adjust premiums across their plans so that the premiums reflect only the richness of the plan and not the expected health care usage of the plan's enrollees.

Three of the states we interviewed do not offer HDHPs at all. One administrator informed us that agency staff are "opposed to cost-shifting as a strategy," while also noting a general "hatred" of HDHPs among enrollees and union stakeholders. Another observed that stakeholder resistance even to "moderate deductibles" made the issue moot for their plans.

Value-based Insurance Design: Savings Hard to Find

Eighteen states reported that they have implemented a value-based insurance design (VBID) initiative in the last three years. Two of these reported that VBID has been a source of documented cost-savings.

VALUE-BASED INSURANCE DESIGN

The plan incentivizes enrollees to use health care services it deems "high value," such as primary care, generic drugs, and chronic disease management, by lowering enrollee cost sharing for those services. It may also try to reduce enrollee utilization of services deemed "low value" by increasing associated cost sharing.

In interviews, SEHP administrators noted that developing VBID programs can require considerable resources. They also can be "spotty," as described by one administrator, who noted that they have rolled out a range of initiatives, such as reducing cost sharing for osteoporosis medication and diabetes management and waiving cost sharing for physical therapy to help combat the overuse of opioids. "We haven't been able to measure the impact of a lot of these," she said. "They're not widespread and many of them are still very new." Another state noted that its board wanted to pursue VBID "because everyone said that saves money." Ultimately, however, she described their VBID initiative as a "hodgepodge" of ideas to incentivize enrollee behavior through cost sharing, suggesting there had been little in the way of an overarching vision or strategy for the program. "In terms of result," this administrator reported, "it's been in effect for two years now, and we haven't seen any clear dollar savings."

Workplace Wellness Programs: Limited Evidence of Effectiveness

Fifteen responding states reported that they have implemented workplace wellness initiatives within the last three years. Only two of these attributed any cost savings to these initiatives.

WORKPLACE WELLNESS INCENTIVES

A program that attempts to encourage enrollees to adopt healthy behaviors or achieve a pre-determined health outcome (such as body mass index or cholesterol level) by tying health plan premiums or cost sharing to participation in a wellness program or achievement of the health outcome.

Among the states we interviewed, most indicated that their wellness programs were limited to offering employees a modest amount of money or reducing their plan cost sharing if they took an annual health risk assessment* or agreed to undertake certain healthy actions during the year. However, these administrators had little to report in terms of these programs' ability to produce better health outcomes or savings for the plan.

* A health risk assessment or HRA is a questionnaire that evaluates lifestyle factors and risks that can affect an individual's health. Questions in an HRA often cover nutrition, fitness, stress, sleep, and mental health status. Many also collect biometric information such as blood pressure and cholesterol.

One SEHP administrator noted that they had found their program, which offered employees a gift card to complete a health risk assessment and biometric screening,* "remarkably unsuccessful." They are now shifting their focus to programs that are not incentive-based. For example, she touted a recently implemented program that offers enrollees tools and informational videos on how to lose weight. "Within eight weeks our members had lost over 20,000 pounds. People are really eager to do the right thing if you give them the right tools."

However, another state was able to report strong results from what they described as their "quite elaborate" wellness program, which offers employees the ability to earn "wellness credits" towards their premiums or deductibles. Within the last three years, they have reported declines in spending on nine of their top ten chronic conditions, representing approximately one percent of their total spend.

* A biometric screening is a brief health exam that includes bloodwork and measurements like height, weight, and waist circumference.

Reference Pricing or "Right to Shop": Potential for System-wide Savings?

Ten states in our survey reported implementing a reference pricing or "Right to Shop" initiative to steer enrollees to lower cost providers in the last three years. Of these, three states attributed plan cost savings to these programs.

REFERENCE PRICING

A program in which the health plan surveys provider prices for a specific service within a defined geographic area and determines a cap or "reference price" as the maximum it will pay for that service. If the enrollee chooses to receive services from a provider that charges a higher price than the reference price, the enrollee must pay the difference. This type of reference pricing should not be confused with initiatives that peg provider reimbursement to a percentile of the Medicare rate. This is also often called reference pricing.

RIGHT TO SHOP

Similar to the reference pricing strategy, when an enrollee chooses a lower price provider, the health plan will share the savings with the enrollee in the form of reduced cost sharing.

In interviews, SEHP administrators touted these programs' potential for cost savings, not just for their plan, but for other purchasers as well. For example, when one SEHP implemented a reference pricing program for joint replacement procedures, it prompted the hospitals where those services were being performed to implement cost savings measures for all joint replacements, not just those provided to SEHP enrollees. Although it is not possible to know whether these hospitals passed the savings onto other commercial purchasers, "We've seen dramatic savings [for the SEHP]," which the administrator estimated at approximately $10 million annually.

Administrators did flag factors that can serve as barriers to implementing Right to Shop programs. First, two states noted that it can take a lot of clinical work and a big data team to identify the list of "shoppable" services and the high value providers for those services. Another state observed that the lack of these resources within their agency made it hard to measure provider performance.

Second, states reported challenges educating enrollees about these programs at the point in time when enrollees are making decisions about needed services. To address this, administrators are developing web tools for price comparisons, sending letters to enrollees when they schedule a shoppable service, and informing participating surgeons about the relative costs of facilities within the reference pricing program. However, states note that these programs are largely non-viable in areas facing provider shortages or a single dominant health system.

Provider Payment and Network Design Initiatives: Challenges, but Potential for High Rewards

A majority (57 percent) of SEHPs report that, in the last three years, they have pursued strategies that target rising prices for hospital services, and 46 percent say they have implemented initiatives to reduce their spending for physician or ambulatory services. They are largely doing so through network design strategies, including:

- Establishing Centers of Excellence for selected medical procedures;
- Creating incentives for improved primary care access and care coordination;

- Entering into financial risk-sharing arrangements with physician groups and health systems;
- Directly contracting with selected providers;
- Offering narrow or tiered provider network plans;
- Establishing a maximum or standard reimbursement rate for provider services, in some cases by reference to the price Medicare pays. See Table 5.

Table 5. SEHPs that Implemented Network Design Initiatives to Constrain Costs in the Past Three Years

Initiative	Number of States
Centers of Excellence	23
Primary Care-based strategies	19
Risk-sharing arrangements	19
Direct contracting	14
Narrow or tiered provider networks	Narrow: 7 Tiered: 4 Both: 5
Rate-setting or reference pricing	7

Source: Authors' analysis of survey responses. Respondents were permitted to select more than one initiative. This question received 47 responses. For detailed information on cost containment initiatives implemented in the past three years by each state, see Appendix VI.

Centers of Excellence: A Lower Price is not the Primary Goal

Although the Center of Excellence is the most popular network-based cost containment initiative cited in our survey, it has been implemented in only 23 of the responding states in the last three years.

Centers of Excellence

When health plans incentivize the use of integrated medical systems that have demonstrated their ability to deliver better patient outcomes at a lower cost for certain (or specific) groups of conditions such as heart, cancer, spine and transplants.

While four additional states reported that they are considering Centers of Excellence as a future cost containment tactic, only two of the 23 states with Centers of Excellence reported any documented cost savings from these programs. Of the eleven states we interviewed, seven have pursued Centers of Excellence to varying degrees. They are all limited in scope, and none offer Centers of Excellence for the full range of potential procedures. Several states have established a Center of Excellence for only one procedure to date, and there were mixed responses to whether they would expand the program to include more.

Other states with multiple insurers or third-party administrators (TPAs)* may have established a Center of Excellence with just one insurer or TPA, limiting the amount of enrollee traffic they can drive to the Center of Excellence, and thus limiting the potential discounts they can extract.

Other states consider the primary goal of their Center of Excellence programs to be improving clinical quality and patient outcomes, not extracting price concessions from providers. As one administrator put it, "the overarching idea is that if they have better quality you will get the cost savings [through] good outcomes and [fewer] readmissions."

Others discussed why they have chosen not to develop a Center of Excellence program, which include objections from key stakeholders. For example, one SEHP administrator recalled encountering "a lot of resistance" to offering financial incentives for enrollees to travel to a large urban center for certain procedures, instead of using their local provider. "Most communities—and the state representatives from those communities—are fiercely loyal to their local hospital," he said.

* States use different terms to refer to the entities that help administer their health plans. States with self-funded plans use third-party administrators (TPAs), managed care organizations (MCOs), and administrative services only (ASO) entities to conduct a range of administrative functions while the plan itself bears the financial risk of paying claims. States with fully insured plans purchase insurance from health insurance issuers that both bear financial risk of paying claims and perform critical plan functions such as benefit and network design, utilization management, and claims processing.

Primary Care-based Initiatives: Better Health Outcomes, Less Evidence of Cost Savings

The second-most popular network-based initiative cited in our survey relates to primary care, with 19 states indicating that they had implemented one or more of the following strategies in the last three years: Patient-centered Medical Home, Direct Primary Care, and worksite or worksite-adjacent clinics.

SEHP administrators widely recognize that access to primary care is critical to improved health outcomes, and only two percent of states indicated that the cost of ambulatory services is a driver of rising costs for their plan. As a result, a key focus of their primary care-based initiatives is quality improvement, better care coordination, and reduced absenteeism, leading to investments that may not always translate into observable or short-term cost savings.

PRIMARY CARE-BASED INITIATIVES

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 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 and to follow high quality and safety practices.

Direct Primary Care: A model of delivering primary care services that charges patients a monthly, quarterly, or annual fee in exchange for on demand primary care services that often also includes laboratory services, care coordination, and disease management services. DPC is often used in addition to a regular health insurance plan that covers hospitalization and emergency services.

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 improve worker productivity and lower overall health costs by steering patients to lower cost specialty or other services.

Two states in our survey have been able to document cost savings from their Patient-centered Medical Home programs. In interviews, administrators were generally positive about the impact of Patient-centered Medical Homes. One reported “very promising” results from its “direct primary medical home” program, noting a reduction in emergency room admissions as well as high patient satisfaction. Another state views its primary care initiatives as part of a longer-term effort to shift physician groups from fee-for-service based payment to a risk-sharing arrangement that includes accepting some downside financial risk. This SEHP worked with its TPA to create Patient-centered Medical Homes over a decade ago and over time has converted those medical homes into accountable care organizations accepting risk-based payments. Today, 85 percent of their primary care practices are in accountable care organizations.

Worksite, or worksite-adjacent, primary care clinics have grown in popularity. One state cited it as a source of cost savings. However, although sometimes pitched as a cost containment strategy, several SEHP administrators disagreed with that characterization. One noted that cost savings have been “difficult to demonstrate.” Another argued that the clinics’ primary benefit is convenience for employees and reduced absenteeism. Yet another state that recently opened its worksite clinics observed that COVID-19 and the sudden switch to a virtual workplace had negated whatever potential benefits the clinics could provide.

Risk-sharing Arrangements: Easier Said than Done

Nineteen states reported implementing, in the last three years, payment models in which providers take on financial risk through either rewards or penalties (or both) based on their ability to deliver services at lower cost, better patient outcomes, or better performance on selected quality metrics. These risk-based arrangements can take various forms, such as capitation, accountable care organizations, or episode-based payments.

Three states in our survey reported that they could document cost savings associated with one or more risk-sharing arrangements. In interviews, several SEHP administrators had high hopes that risk-sharing payment models would result in better patient care and

demonstrable efficiencies. "Rather than constantly trying to . . . increase utilization within their facilities and increase their reimbursement rates," one said, "we're trying to have [providers] compete . . . to improve their quality and efficiency." For many SEHPs, their contracts with TPAs require the TPAs to engage in, and grow, their risk-sharing arrangements with providers.

RISK-SHARING ARRANGEMENTS

Capitation: A provider or group of providers agrees to accept a certain amount of compensation per patient over a defined period of time, such as per month. If the cost of delivering services to those patients exceeds the amount received from the payer, the provider bears the financial loss.

Accountable Care Organizations (ACOs): A model of delivering services where a group of providers work together to coordinate care for patients. If the ACO meets quality and cost-savings targets, they share in those savings with the payer. Some ACOs also take on "downside" financial risk, meaning that they must bear the financial loss if the cost of delivering care exceeds a target amount.

Episode-based Payments: A provider or group of providers will receive a pre-established total amount of compensation for a patient's sequence of care related to a single episode or medical event, instead of a fee for each service delivered by each individual provider. If the patient's care for that episode exceeds the pre-determined amount, the provider must bear the financial loss.

Value-based Payments: Also sometimes called "Pay for Performance," these programs link providers' performance on quality metrics, and sometimes cost savings targets, to enhanced reimbursement.

However, administrators cited several obstacles to these programs. Two states are in the process of implementing episode-based payment models with their network providers. Both noted that the effort is resource intensive for their agency. It's "a ton of work," one said.

Other administrators pointed to challenges getting providers to agree to risk-sharing arrangements, particularly those that have the potential for downside financial risk. However, there is evidence that payment programs that expose providers solely to upside risk do not generate savings (and indeed, can even increase costs).[17] "We have an open invitation" to providers to engage in a risk-sharing initiative with both upside and downside financial risk," said one administrator. "Not tons of success yet, but we have it out there." Another began its risk-sharing initiative by requiring providers to take on both upside and downside risk, but had to reverse course. "We got a lot of pushback—and a lot of legislative pushback . . . we ended up with just upside [risk] after the pushback from providers." Additionally, hospitals and hospital systems are less likely to participate in accountable care organizations because they are disinclined to take on downside risk, and often have the market power to reject such requests during contract negotiations.[18] As a result, accountable care organizations in the commercial insurance market often only involve physician group practices.

One SEHP leveraged a credible threat of shifting to Medicare-based reference pricing (with support from the Governor's office) to bring providers to the negotiating table for a risk-sharing initiative that requires them to take on downside financial risk. The administrator noted that, while the risk-sharing arrangement is a "longer-term strategy" than reference pricing, he hoped it would better align incentives between providers and the state as a purchaser, leading not only to lower costs but also to quality improvement.

Another frustration with accountable care organizations is that the payment incentives are on top of a reimbursement structure that is entirely based on a fee-for-service model, so that providers retain strong incentives to deliver excess services. One state, for example, abandoned its accountable care organization program in favor of an episode-based care initiative for that reason. "About three years ago, we'd had enough with the [accountable care organization] negotiations between the [TPAs] and the providers, because they always ended up back at fee-for-service," he said.

Direct Contracting: Cutting Out the Middleman

Fourteen states reported engaging in direct negotiations or contracting with providers in the last three years, essentially cutting their TPA out of the process. Of these, four states reported documented cost savings from their direct contracting initiative.

DIRECT PROVIDER CONTRACTING

Direct-to-provider contracting is a strategy in which a self-insured entity negotiates a contract directly with a provider of health care services rather than through a TPA. The goals of such efforts include obtaining lower provider prices than achieved by the TPA, engaging in a risk-sharing program, or encouraging value-based care.

In interviews, states engaged in direct contracting initiatives pointed to several advantages, but also some challenges with instituting such programs. For example, one state that uses direct contracting across all providers and services touted it as their primary source of cost savings, and reported minimal friction with providers. Another state used its direct contracting to obtain a “preferential government rate” compared to the rest of the commercial market. It was later able to leverage that preferential rate when it merged the state employee plan with the state teacher plan, which had previously been paying an undiscounted commercial rate.

However, another state reported difficulties finding a TPA willing to work with them when they sought to direct contract for an episode-based care payment initiative. Most of the TPAs they approached declined to participate. A very large TPA that had a significant portion of their business decided to “walk away,” the administrator said. “They didn’t want to agree to let us directly negotiate with hospitals and other provider groups.”

Other states reported interest in pursuing direct contracting but faced other constraints. In one, administrators found that the SEHP’s small market share (with enrollment representing only five percent or less of the employer market) and conservative culture meant “you don’t see a whole lot of innovation.” Another administrator found that, in several regions of the state, there were no “deals to be had,” because providers were sufficiently consolidated that they could make no believable threat to drop them from the network. And another noted that his state had a severe provider shortage, similarly reducing their ability to ask those providers to agree to greater discounts.

Narrow and Tiered Provider Networks: Where Feasible, Positive Returns

Twelve states in our survey indicated that they had offered SEHP enrollees a narrow network plan in the last three years. Five out of the 12 SEHPs also offer tiered network plans. Another four states have offered just tiered network plans in the last three years. Both types of networks have the potential to generate savings by encouraging providers to agree to discounted prices in exchange for higher patient volume.

NETWORK DESIGN STRATEGIES

Narrow Network Plan: A plan that limits coverage to a select set of hospitals, physicians, and other providers. Similar to an HMO, these plans may not cover the cost of services received out-of-network.

Tiered Network Plan: A plan that groups or “tiers” providers based on their performance on cost and/or quality metrics. Enrollees are encouraged to seek services from the top performing providers through lower cost-sharing.

Four states indicated that offering a narrow or tiered network plan has produced documented cost savings. However, for many states, their ability to generate price concessions from providers is blunted by the compulsion to offer enrollees a broad network plan option in addition to the narrow or tiered network option. As a result, they are unable to guarantee providers sufficient growth in patient volume to justify large discounts. Further, some state administrators report that, even when the narrow network plan option is less expensive than a broad network option, their enrollees are unwilling to give up unfettered choice of providers. “We presented it probably the wrong way,” said one. “It was presented as a ‘gatekeeper plan,’ and our members don’t like those.” The state is working to improve its communications with enrollees about the benefits of a narrow network plan, as well as increasing the differential in premiums between the narrow and broad network options.

Where other states have a large differential in premium for narrow versus broad network plans, they report greater enrollment in the narrow network option. For at least one state, however, they were unhappy with the result. "[The narrow network plan] is very cheap because nobody on it uses any health care . . . . It is actually driving up the costs of the other plans." This happens because as healthy people gravitated to the narrow network option, the insurers offering broad network plans were left with enrollees with higher claims costs, forcing them to increase their premiums. "You need to . . . narrow the choices so you don't get so much adverse selection," the official said.

For tiered networks, SEHP administrators pointed to two challenges. First, they noted that a lack of data and data analytics capacity can make it difficult to identify and classify providers who are high performers on quality metrics. Second, another SEHP found that even significant cost-sharing incentives were not sufficient to move enrollees from lower-performing providers to higher-performing providers. "People don't know what 'tiered' means, and inertia is one of the most powerful forces in health care," the administrator said. "People didn't take it because they weren't educated about it."

Rate Setting, Reference Pricing: Exercising Market Power to Improve Affordability

Seven states indicated that in the last three years they have or are currently pursuing initiatives to set provider rates or peg those rates to a reference price, such as the amount Medicare pays for the service. An additional three states have plans to implement such a program in the future.

RATE-SETTING AND REFERENCE PRICING

Rate-setting: The plan or payer establishes a non-negotiable price for each health care service.

Reference pricing: Not to be confused with reference pricing or "Right to Shop" initiatives that adjust enrollee cost sharing based on provider costs (discussed above), under this initiative the plan or payer pays providers a non-negotiable, established rate that is equal to or a percentile of a reference rate, such as the price Medicare pays for the same service.

One SEHP that engages in rate setting established a fee schedule for hospital and ambulatory services that it updates annually. According to this SEHP's administrator, its TPA does not negotiate provider rates and serves primarily as a claims administrator. The agency sets rates based on the commercial prices in the state's all-payer claims database (thus does not use a Medicare reference price). "It's the leading thing we have to address costs," the administrator reported, noting further that by tweaking its fee schedule as needed to meet budget targets, the plan had been able to protect enrollees from increased cost-sharing or reduced benefits. He further noted that providers have largely accepted the SEHP fee schedule for two primary reasons. First, he believes providers appreciate that the SEHP is a "fast payer," meaning that their TPA is able to process claims more quickly than other payers. Second, their ability to keep deductibles low means providers "have less patient liability to collect . . . that's something providers generally hate to do in my experience," he said. "They'd rather get the money from the plan."

Negotiating with hospitals based on a Medicare reference price (averaging 234 percent of Medicare in the first year) has paid off for Montana's SEHP, saving the state $47.8 million over three years.[19] Similarly, when Oregon enacted legislation in 2017 to limit its SEHP to paying no more than 200 percent of the Medicare rate for in-network hospital services and 185 percent of Medicare for out-of-network hospital services, it was projected to save the state $81 million.[20] However, an administrator in one state with reference pricing identified a downside to the effort: providers who had previously been paid at prices lower than the benchmark began demanding to have their compensation increased to equal the benchmark.

Other Cost Containment Efforts: Utilization Management, Fraud Prevention, Global Budgets and More

States reported engaging in a range of cost containment strategies, in addition to the benefit and network design strategies discussed above. These include utilization management initiatives such as:

- Management of chronic conditions such as diabetes, heart disease;
- Case management for high-cost enrollees;
- Prior authorization or requiring referrals prior to receipt of specialty care services; and
- Behavioral health management.

Such programs are common among SEHPs. Forty-one of the 47 responding states have implemented a chronic disease management program; twenty-nine have implemented three or more of the above initiatives (see Table 6). Seven states report that they have documented cost savings from one or more of these utilization management activities. For more detail on states' activities in these areas see Appendix VI.

Table 6. Common Additional Cost Containment Initiatives Reported by Responding States

Initiative	Number of States
Chronic disease management	41
Case management for high-cost enrollees	37
Prior authorization or referrals	33
Behavioral health management	10

Source: Authors' analysis of survey responses. Respondents were permitted to select more than one initiative. This question received 47 responses. For detailed information on cost containment initiatives implemented in the past three years by each state, see Appendix VI.

SEHPs have been active with other strategies designed to constrain cost growth. Six states reported having an annual spending growth target or cap in place. In interviews, two states reported that either their legislature or another agency within the executive branch had imposed a cap on the percentage of spending growth, and one state mentioned they were able to use that externally set growth cap as leverage during their discussions with stakeholders and negotiations with vendors.

Thirty states report that they audit claims to identify inappropriate utilization or fraud. Eighteen states report providing enrollees with greater transparency about the prices of shoppable health care services to encourage enrollees to consider cost in choosing a provider. However, few states report that either of these initiatives have generated any cost savings. For more detail on SEHP activity on these initiatives, see Appendix VI.

Variations in SEHPs' Role and Structure Affect Ability to Achieve Cost Containment Goals

The adage "When you've seen one state, you've seen one state" holds true for SEHPs. Each operates within the context of their state's unique environment, with longstanding and constantly evolving political, market, and operational dynamics that make it challenging to identify strategies or programs that can be replicated easily across all or even many states. For example, although many SEHPs have a sizable proportion of commercial market enrollment compared to other employer plans, that is not universally true (see Table 7).

Table 7. SEHP Enrollment as a Percentage of Total Enrollment in Employer-sponsored Insurance

Percent of People with ESI Enrolled in a SEHP	Number of States
0-5	20
6-10	14
11-15	8
16-22	5

Source: Survey responses and KFF. 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 2019 to find the total number of people in each state enrolled in employer-sponsored insurance, available at https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. For more detailed information on enrollment data, see Appendix V.

The smaller market share for many SEHPs results from their fragmented nature. While Washington and Oregon, for example, have worked to consolidate health benefit plan purchasing for public employees within a single state agency, many other states administer benefits for teachers, local government employees, or retirees separately. This can limit their negotiating clout with TPAs, providers, and other vendors. Conversely, consolidating state and local government employees under one purchasing agency can improve the SEHP's power to garner concessions from providers. For example, one state that recently added municipal employees to its plan reported that the added enrollment has helped make providers more willing to accept a new risk-based payment model.

Many states also dilute their health benefit purchasing power by offering options from more than one insurer or TPA. At least 19 states offer both self-funded and fully insured plan options, while Wisconsin's fully insured SEHP has nine different health insurers participating. One-third of states offer employees five or more different plans. At the same time, administrators in states with only one dominant carrier told us that it can lead to complacency and inertia. "We don't see a whole lot of innovation [from our TPA]" said one.

State government employees also tend to be scattered geographically, with many located in lightly populated, rural parts of the state. The SEHP must ensure these employees have access to in-network providers. This means that they have no choice but to enter into contracts with hospitals and physician group practices in rural communities where there is limited competition. This blunts the SEHP's potential negotiating power, resulting in payments to these providers that significantly exceed the amount Medicare or Medicaid would pay for the same services.

Cross-Agency Collaboration is the Exception, not the Norm

In our survey, only four states reported collaborating with another state agency to implement a cost containment initiative. For example, Tennessee's SEHP has partnered with TennCare, the Medicaid agency, to implement a program to pay providers an incentive payment if their spending is below a specified level for an episode of care and if quality metrics are achieved.[21] Of all states, Washington has engaged in the most comprehensive effort to combine the market clout of its public purchasers by bringing their K-12 teachers, public higher education employees, and state agency employee plans together with Medicaid into one integrated purchasing agency.[22]

For the most part, SEHP administrators told us that cross-agency collaboration is too difficult, given the different missions, regulatory structure, and populations covered under different state programs, particularly between the SEHP and the Medicaid programs. "The way we each get

data makes it hard to collaborate," said one administrator. "And our populations are so different." Although thus far successful, the cross-agency effort in Tennessee to implement episode-based payments was made possible because of a grant from the federal CMS Innovation Center.

One SEHP administrator eager to engage in a joint initiative with her state Medicaid agency could not find a willing partner. "We express interest all the time [in a collaborative purchasing approach] . . . . But the sense I get . . . is that the idea of embarking on a cost savings initiative in Medicaid is unheard of . . . . It's a total missed opportunity."

Washington officials reported several benefits of joint SEHP-Medicaid purchasing efforts, including an ability to discuss "bigger picture purchasing goals" for the state, engage in "sensitive rate conversations" that can remain proprietary, and jointly respond to provider and other stakeholder pushback, including litigation. "When one side gets sued, we know the other side is likely to get sued, and we try to settle all aspects of potential litigation for both parts of the purchasing portfolio if possible." The official went on to say: "These things may sound small, but they are huge advantages."

Resistance from Internal and External Stakeholders is a Top Barrier to Cost Containment

Even for those SEHPs with a proportionately large membership, which might offer the power to demand lower provider prices, a number of barriers remain to implementing cost containment initiatives. In their survey responses, SEHPs identified "resistance from stakeholders" as the top barrier. That resistance can take several forms, depending on the type of stakeholder. For example, several SEHP administrators noted that it took constant, diligent effort—and significant in-house data analysis capacity—to educate their governing boards, legislators, and other influential policymakers about cost trends and the evidence supporting the effectiveness of different initiatives. As one administrator put it: "[The board] wants lower rates, but . . . they don't want narrower networks, increased cost sharing, or lower actuarial value. So how are we going to do that when the costs of health care are the costs of the services that are being provided?" Indeed, SEHP administrators face a potentially more challenging set of stakeholders than private employers. While private employers need to educate their boards and employees, SEHP administrators also must confront the perspectives of state legislators and the providers that are often the largest employers in those legislators' districts.

SEHP administrators reported varying degrees of engagement from their legislatures and other executive branch agencies. They also noted that as the makeup of the legislature changes over time, so too can its interests. "The legislators could be very provider-friendly, or friendly towards the insurance industry . . . it really varies . . . [but] it can really impact us." In many cases, SEHPs are under legislative pressure to control costs. "The path we're on is unsustainable," noted one administrator. "As we're having conversations with the legislature about what we're doing to control costs, our answer can't be nothing." Others reported very little direct interference in their work from legislators, while others noted that legislative involvement can lead to increased costs, such as when the SEHP is used to pilot a state benefit mandate. In others, the legislature has sought to use the SEHP as a proving ground for cost containment initiatives, such as high deductible health plans or, as in Oregon's case, a requirement to cap hospital prices at 200 percent of the Medicare rate. As one administrator put it, the only reason their SEHP has a high deductible health plan is that it was "one of the few instances where it was directly decided by the legislature."

Other executive branch agencies can also influence SEHPs. For example, one state administrator reported that the SEHP was often an enticing source of savings for their budgeting agency. "When they need . . . an extra $4 or $5 million to close their budget . . . we've been able to deliver for the most part."

Perhaps the biggest constraint on state cost containment initiatives is less structural than cultural. The expectation among public employees that they have a generous benefit package and unfettered choice of providers—and the strong resistance to any erosion of that—has led most SEHP administrators to be extremely conservative in their approach to plan changes. A common perception among employees is that "a dollar saved is a dollar saved for the state" and therefore a dollar taken away from enrollees, reported one administrator. Others noted that any effort to cut costs by, for example, dropping a marquee hospital system from a plan network, would garner immediate and severe blowback from enrollees and the politically powerful unions that represent them.

The Role of Labor: Antagonist and Advocate for Cost Containment

Approximately 36 percent of state and local government workers are union members, a number that has declined over the last two decades.[23] The union membership rate of public-sector workers is consistently higher than the rate of private-sector workers, with more than five times the level of union membership in 2020.[24] In our survey, 21 of 47 states reported that they have a collective bargaining agreement in place with one or more state employee unions. See Appendix VIII. Of these, 15 report that unions participate in the SEHP's benefit design decisions and seven report that they engage in decision-making over the plan's network designs.

While unions are not indifferent to the burden of rising health care costs on total employee compensation, they generally advocate to maintain or expand health benefits for their members.[25] The 21 SEHPs reporting a collective bargaining agreement or agreements in place are more likely to report offering generous plan benefits compared to those reported by their 26 less unionized peers. The average actuarial value (or the amount the plan covers for the average plan enrollee) is 90 percent in these states, compared to 84 percent in those states without collective bargaining agreements in place. Even in states that reported that their unions were not involved in benefit or network design decisions, administrators noted that labor groups engaged heavily in efforts to maintain or increase the state's contributions to employee plan costs.

Administrators generally reported that unions are effective advocates for maintaining robust plan benefits and pushing back against efforts to increase cost-sharing or limit provider access. Administrators in less unionized states appeared to have had less pushback in cost-shifting exercises such as increasing deductibles. Only 38 percent of states with collective bargaining agreements had a high deductible health plan (HDHP) option, compared to 81 percent of states without a collective bargaining agreement.

State administrators also reported that union representatives pushed to maintain a robust network of providers. For example, one administrator observed its membership would only support the SEHP offering plans with narrow provider networks if enrollees could continue to have a broad network plan option. However, when faced with a choice between increased enrollee cost-sharing and more constrained provider choice, administrators reported that unions are more likely to favor the latter.

As a result, unions can be helpful allies in SEHPs' efforts to tackle high and rising provider prices. For example, union representatives in North Carolina and Oregon have supported their state SEHP efforts to target hospital prices to a Medicare reference price.[26] "There was a lot of interest from labor [in the reference pricing initiative]," observed one administrator. "The increases in [health care] costs were seen as a threat to the sustainability of robust benefits."

The Role of SEHP Vendors in Cost Containment Efforts

According to the survey, almost all states contract with TPAs, benefit consultants, or pharmacy benefit managers (PBMs) to perform a range of functions, including providing actuarial services, designing benefits and cost-sharing, developing plan networks, conducting utilization management, delivering customer service, and processing claims. Of the 44 state SEHPs that self-fund at least one of their plans, 26 of them rely exclusively on their TPA to negotiate provider contracts and manage networks, while only nine states reported that they collaborate with their TPA on network development. See Appendix IX. In interviews, SEHP administrators who oversee self-funded plans reported that they largely delegate network design responsibilities to their TPAs. As one put it, network design "is almost exclusively handled through the health plans . . . . If a provider proposes a [price] increase that would materially impact our costs, we're advised . . . [but] we generally support the health plans in their negotiating positions."

Setting Performance Targets

TPAs, by design, do not hold any direct financial risk for high and rising claims costs. SEHP respondents reported that they must contractually incentivize TPAs to implement cost containment initiatives, and in many cases the TPAs have resisted new and innovative cost containment strategies. In our survey, six SEHPs report that they contractually require their TPAs to meet an annual spending growth target. A number of these contracts include financial penalties if the TPA fails to meet the target. In interviews, administrators in a few of these states reported that they do not dictate to their TPAs how to meet these targets, so long as they do meet them. However, the level of enforcement of these targets varies across states. For example, one state reported that its TPA faces only a modest $20 per enrollee-per month fee if it fails to meet its discount guarantees, an amount the administrator did not feel was a sufficient incentive. Another SEHP administrator touted their contracts' strong penalties, asserting that they "force [the TPAs] to either negotiate better, or steer people to lower-cost facilities." Yet another state does not set explicit performance targets, but has negotiated a financial arrangement with its TPAs in which the state holds the fee-for-service claims dollars in an account from which it reimburses the plans. Any costs that exceed the dollars reserved in the account must be borne by the health plans. Administrators in this state report that this self-funding/fully insured hybrid model gives the SEHP the benefits of self-funding while passing along the financial risk of excessive claims costs to its contracted TPAs.

Leveraging the Procurement Process

Fourteen survey respondents report that they use the vendor procurement process to advance their cost containment goals. In interviews, three SEHP administrators emphasized the importance of this process in extracting performance guarantees and holding TPAs accountable to cost containment goals. As one administrator put it, "The best way to get [your TPA] to take it seriously is to make sure it's part of the formal procurement process."

Some states have begun rethinking their procurement process in order to generate greater savings from potential vendors. For example, one state reported "incredible success" with the use of a tailored reverse auction system. Another state was able to report savings from its "invitation to negotiate" program, which uses responses from potential vendors to initiate a negotiation process.

REVERSE AUCTION

A process by which the state shares bid information among competing vendors in order to incentivize lower offers in subsequent rounds of bidding.

INVITATION TO NEGOTIATE

A solicitation for competitive sealed replies to select one or more vendors with which to commence negotiations.

Reverse auctions have generated interest among several of the SEHP administrators interviewed. The process begins with each vendor submitting an initial bid and technical and programmatic responses as requested by the SEHP agency. The state then shares information about the bids received with each competing bidder. For example, the SEHP might tell a PBM bidder that they are the third lowest-priced within the specialty drug category. Each bidder then re-submits offers in subsequent rounds of bidding, with the goal of improving its placement for each category. This state reported that the reverse auction not only works well to attract the lowest possible price from vendors, but also to achieve certain programmatic goals, such as cost transparency. “We’d tell [the bidder] that three out of the four finalists have agreed to [greater transparency] but you haven’t . . . . By the end [of the reverse auction] we ended up with a bidder that agreed to everything we wanted.” This process encourages bidders whose initial bids were not in line with what the state wants to refine these bids to better suit the state’s needs.

Although one SEHP administrator characterized the reverse auction process as a “win win” for the state, there are barriers that may make it challenging to implement or less effective. First, in many states, SEHPs need legislative changes to procurement rules to enable a reverse auction. For example, New Jersey’s law permits reverse auctions for PBMs but not for TPAs.[27] Second, many states have just one dominant insurance carrier, and would face significant employee pushback if that carrier were to be replaced as the plan’s TPA.

Access to and Use of Claims Data

Having access to claims data and the capacity to analyze it can be critical to the development and assessment of cost containment strategies. For self-funded SEHPs, TPAs are responsible for claims administration and thus house their SEHP client’s claims data. Out of 47 survey respondents, 43 reported that they have access to their claims data, but during interviews administrators raised some challenges with respect to both access and analysis. See Appendix X.

One state reported having access to their claims data, but noted that the claims were not in a format to facilitate analysis. The legislature has enacted a requirement for the SEHP to contract with a data warehouse, which the administrator predicted would improve their ability to use the data to identify cost drivers and evaluate the effectiveness of programs and initiatives. However, she also observed that their current TPA has generally resisted these legislatively mandated efforts to improve the SEHP’s data analytic capabilities. Another state reported that it had to terminate its relationship with a longstanding TPA because the carrier refused to share its data on provider prices. In North Carolina, the SEHP has had to turn to the legislature to grant it the authority to view its own claims data.[28]

Other states expressed frustration with their ability to use their claims data in meaningful ways. For example, one SEHP administrator in a state with significant regional provider shortages noted that data on provider costs and clinical quality was not useful when there were too few providers to institute tiered networks or other initiatives that would steer enrollees to high performing providers. Another state acknowledged that while they have access to the data they need, they did not have the in-house capacity or expertise to use the data to inform their cost containment efforts.

Maintaining a Level Playing Field: Risk Mitigation Strategies

For SEHPs with multiple carriers or a mix of fully insured and self-funded plans, a key component of several cost containment strategies is to prevent adverse selection that could disadvantage certain carriers while favoring others. For example, when enrollees have a choice between a plan with a broad provider network and one with a narrow provider network, those with higher risk profiles are more likely to select the plan with the broad network. This can lead to higher costs for the broad network plan and higher premiums for its enrollees. Similarly, when given a choice between a high deductible plan and a low deductible plan, sicker employees are more likely to choose the low deductible plan. In interviews, one state reported that adverse selection among its plans has led to price distortions. As a result, it is planning to implement a front-end risk adjustment program that adjusts enrollee premiums so they do not reflect the expected health costs of each plan’s enrollees.

A Work in Progress: Future Cost Containment Strategies

States identified a number of cost containment strategies that they hope to implement in the next one or two years. Eight states plan to implement provider risk-sharing, direct contracting, or reference pricing initiatives that tie provider reimbursement to a benchmark, such as the Medicare rate. Meanwhile, although only one state identified excess utilization as its primary cost driver, ten states plan to expand programs that attempt to lower or optimize utilization, such as HDHPs, value-based insurance design, wellness incentives, Right to Shop, "rare condition management," and price transparency.

Among the network design strategies, several states emphasized various forms of risk-based contracting as most appealing, in part because these payment arrangements tend to focus not just on cost but on improving clinical quality and outcomes. As a cost containment measure, however, many of these initiatives are unproven. A few states that have implemented risk-sharing more recently also noted that the dramatically depressed utilization caused by the COVID-19 pandemic in 2020 had limited their ability to evaluate whether these programs have generated any savings.

Increasing enrollee cost-sharing via benefit design remains a key cost containment strategy for SEHP administrators. One state discussed its intent to introduce new plan options with higher enrollee cost-sharing. Employees would be automatically enrolled in these plans unless they proactively choose something else. Workplace wellness programs also remain popular, in spite of the fact that few states have been able to document any measurable savings. In interviews, administrators suggested that their workplace wellness programs were worthwhile endeavors, with or without any cost savings. Others believe that if they could target their wellness program just to those employees most in need, such as diabetics, they could obtain a better return on the investment.

States identified several other strategies that are showing promise. For example, after reports of New Jersey's success with a reverse auction for its PBM, several states expressed interest in a similar process. Others noted it could work not just for PBM procurement but for other vendors as well, including TPAs.

Other states pointed to the value of greater access to claims data, including previously proprietary, negotiated payment rates between commercial payers and providers. One administrator reported looking forward to using this newly available data (as required by recent federal regulations) to force providers to offer the SEHP a "most favored nation" discount, meaning the SEHP would always pay no more for health care services than other commercial payers. "I'm just asking the hospital to give me their lowest negotiated rate that they're giving any other commercial payer," she said. "If they want me to go in the direction Montana or North Carolina did, we can, but I just want them to give me their best deal. I think that's hard to argue with."

Lessons Learned from SEHP Cost Containment Initiatives

SEHPs—or any large health care purchaser—looking to implement a cost containment initiative can draw lessons from the experiences of their peers in other states. Through the survey and in interviews, we heard several recurring themes.

Education and Communication

Successful implementation of significant cost containment initiatives requires buy-in from multiple stakeholders, including the SEHP's governing board, the executive branch and legislators, TPA vendors, unions if applicable, participating providers, and of course, state employees themselves. Administrators cited the need for constant and consistent education of these stakeholders about the drivers of health care costs, the trade-offs associated with different benefit and network design options, and consequences of inaction. SEHPs' communication with and messaging to their enrollees is particularly important, with multiple administrators discovering that an initiative they had thought promising, such as a narrow network plan option or reference pricing program, generated anemic results because enrollees were either unaware of or had a mistaken or poor perception of the program. By the same token, engaging stakeholders and helping them to understand the SEHP's cost drivers and the tradeoffs of strategies to bring costs under control can bear considerable fruit. For example, the Montana SEHP's efforts to institute Medicare reference pricing for hospitals was aided by partnering with the employee union, which then launched a successful letter writing campaign to pressure hospitals to participate in the program.[29]

Leveraging Data to Achieve Cost Containment Goals

Many SEHP agencies either do not have access to claims and other data that could inform and improve their cost containment initiatives or do not have the analytic capacity to use the data effectively. However, several administrators commented on the importance of being able to review and analyze the health claims generated by SEHP enrollees, and two states we interviewed are in the process of improving their data analytic capacity. As one administrator put it, "it really pays" to have data expertise in-house instead of relying on the TPA or other external consultants. This can help the SEHP identify outliers or cost drivers and ask vendors the right questions. In at least one case, it enabled a state to determine that it could do a better job containing costs by bypassing its TPA and directly contracting with providers.

The "Lesser of Evils" Option: Getting Provider Stakeholders on Board

SEHP administrators almost universally recognize hospitals as the primary driver of rising costs. They also are well aware of the political risks of threatening to exclude or shift business away from certain high cost hospitals, with many bearing the scars of blowback from legislators and employees when they tried to do just that. Yet some states have been able to generate provider buy-in to one cost containment initiative by threatening to implement another that the providers deem more draconian. For example, one administrator reported using his Governor's budget proposal to institute Medicare reference pricing to convince providers to agree to a risk-sharing payment model in which they had been previously reluctant to engage.

Vendors are Not Your Friend: Breaking Down Complacency and Inertia to Reach Cost Savings Goals

The majority of SEHPs in our survey delegate all network design responsibility, including the negotiation and establishment of provider reimbursement rates, to their TPA. Yet there is strong evidence that TPAs lack sufficient incentive to extract the largest possible cost savings from network providers. In interviews, SEHP administrators reported significant resistance from their TPAs to payment reform initiatives, such as the expansion of risk-sharing arrangements. For example, one state administrator reported that their TPA was "so unwilling to annoy the hospital system" that they backed away from implementing a tiered network strategy. A number of SEHPs report promising returns, however, from efforts to use the vendor procurement process, such as reverse auctions and annual growth caps, to ratchet up pressure on TPAs to deliver more cost savings through network design strategies.

No Cookie Cutters: Programs Must be Tailored to Unique State Conditions

An age-old question in health care policy is why a strategy that is proven successful in one state is not broadly adopted, or if adopted, fails to perform as hoped. Time and again, SEHP administrators identified reasons why certain cost containment initiatives implemented by their peers would not work in their state. Reasons include unique political dynamics, such as the 2017 push by the Oregon legislature to institute Medicare reference pricing. Given the level of hospital opposition to such efforts, a similar legislative effort is unlikely to be replicated in many other states. Other states are dominated by just one large insurer, making it almost impossible to leverage TPAs against one another during a procurement process. Similarly, many states are dominated by a very small number of "must have" hospital systems, such that efforts to engage in direct contracting or offer a narrow network plan wouldn't generate much in savings. In these states, cost containment strategies need to be designed for the health care system they actually have.

Conclusion

SEHP administrators are fully aware of the factors—notably hospital prices—that are driving the steady increase in the cost of employee health benefits. Yet to date they have focused their cost containment energy primarily on initiatives that target secondary cost drivers such as enrollee utilization. All cost containment is difficult—if there is a strategy that harms no one it has already been implemented—but so far strategies that shift costs to employees, such as high deductible plans and wellness incentive programs, have proven easier to implement. That said, some states are demonstrating that it is possible to rein in hospital prices through a mixture of political will, creative thinking, and simple hard work. It will be important to document the impact of these efforts and share successful outcomes, including state savings and lower enrollee premiums and cost sharing, so that other state SEHPs as well as other government and private purchasers can learn from and implement similar programs.

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About Georgetown University Center on Health Insurance Reforms

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Endnotes

[1] Centers for Medicare and Medicaid Services, *National Health Expenditure Fact Sheet 2019-2028*, December 16, 2020, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (accessed February 25, 2021).

[2] Claxton G, Rae M, Young G, McDermott D, *2020 Employer Health Benefits Survey*, Menlo Park, CA: Kaiser Family Foundation, October 8, 2020, https://www.kff.org/report-section/ehbs-2020-section-1-cost-of-health-insurance/ (accessed February 25, 2021).

[3] Segema J, Kollar M, Shrider EA, Creamer J, *Income and Poverty in the United States: 2019*, U.S. Census Bureau, September 15, 2020, https://www.census.gov/library/publications/2020/demo/p60-270.html (accessed February 25, 2021).

[4] Claxton G et al., *2020 Employer Health Benefits Survey*.

[5] Oregon HB 2266 (2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2266.

[6] Centers for Medicare and Medicaid Services, *National Health Expenditures: 2019,* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical (accessed April 6, 2021).

[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] Whaley CM et al., *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans*, Santa Monica, CA: RAND Corporation, 2020, https://www.rand.org/pubs/research_reports/RR4394.html.

[8] Kaiser Family Foundation, *State Health Facts: Health Insurance Coverage of the Total Population*, Menlo Park, CA: 2019, https://www.kff.org/other/state-indicator/total-population/?dataView=0¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed March 22, 2021).

[10] Bureau of Labor Statistics, Current Employment Statistics survey.

[11] Keefe J, "Are Public Employees Overpaid?" *Labor Studies Journal* 37(1): 104-126, 2012.

[12] HealthCare.Gov, Glossary – Actuarial Value, https://www.healthcare.gov/glossary/actuarial-value/ (accessed April 2021).

[13] Centers of Medicare and Medicaid Services, *National Health Expenditure Data, Table 24: Employer-Sponsored Private Health Insurance, 2020*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical (accessed March 2021).

[14] Zawacki AM, Vistnes JP, and Buchmueller TC, "Why are employer-sponsored health insurance premiums higher in the public sector than in the private sector?" *Monthly Labor Review*, Bureau of Labor Statistics. September 2018, https://www.bls.gov/opub/mlr/2018/article/pdf/employer-sponsored-health-insurance-premiums.pdf.

[15] Kurani N, Cox C, *What drives health spending in the U.S. compared to other countries*, Menlo Park, CA: Peterson-Kaiser Family Foundation Health System Tracker, November 2020, https://www.healthsystemtracker.org/brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/.

[16] Rau J, "North Carolina Treasurer Took on the Hospitals. Now He's Paying Political Price," *Kaiser Health News*, October 26, 2020, https://khn.org/news/north-carolina-treasurer-took-on-the-hospitals-now-hes-paying-political-price/ (accessed March 1, 2021).

[17] Verma S, "Pathways To Success: A New Start For Medicare's Accountable Care Organizations," Washington, DC: Health Affairs Blog, August 2018, https://www.healthaffairs.org/do/10.1377/hblog20180809.12285/full/.

[18] Corlette S, Hoadley J, Keith K, Hoppe O, Assessing Responses to Increased Provider Consolidation in Six Markets: Final Report, Washington, DC: National Institute for Health Care Reform, October 2019, https://georgetown.app.box.com/s/65qfhbzz7fabx9oypsteg6d1aghz4fsj.

[19] Schramm S, Aters Z, *Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan*, Optumas, April 2021, https://www.nashp.org/wp-content/uploads/2021/04/MT-Eval-Analysis-Final-4-2-2021.pdf.

[20] Oregon Office of the Secretary of State, *Notice of Proposed Rulemaking: Amendments to Hospital Payment Rules*, October 30, 2020, https://www.oregon.gov/oha/OEBB/DivisionRules/Proposed-OEBB-80-Hospital-Payment-20201030.pdf#page=2.

[21] Division of TennCare, *Episodes of Care*, Nashville, TN, https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html (accessed April 23, 2021).

[22] Riley T, Schneiter E, Hensley-Quinn M, et al., Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power, op. cit.

[23] Wolfe J, Schmitt J, *A profile of union workers in state and local government*, Washington, DC: Economic Policy Institute, Jun. 2018, https://www.epi.org/publication/a-profile-of-union-workers-in-state-and-local-government-key-facts-about-the-sector-for-followers-of-janus-v-afscme-council-31/.

[24] Union Members – 2020. Bureau of Labor Statistics. U.S. Department of Labor. January 22, 2021, https://www.bls.gov/news.release/pdf/union2.pdf.

[25] Budd, JW. "The Effect of Unions on Employee Benefits: Updated Employer Expenditure Results." *Journal of Labor Research* XXVI(4): 670-674 (2005).

[26] State Employees Association of North Carolina, *Clear Pricing Project*, https://www.seanc.org/clear-pricing-project (accessed April 14, 2021); Testimony of Joe Baessler, Oregon AFSCME, Testimony is [sic[support of HB 2266, https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/202821 (accessed April 14, 2021).

[27] P.L. 2016, c.67. New Jersey S.B. 2749 (2016) (enacted).

[28] North Carolina HB 169 (2021). See also King D, "Bill to make medical bill data accessible moves forward," *Carolina Journal*, April 14, 2021, https://www.carolinajournal.com/news-article/bill-to-make-medical-bill-data-accessible-moves-forward/.

[29] Allen M, *In Montana, a Tough Negotiator Proved Employers Don't Have to Pay So Much for Health Care*, ProPublica, October 2, 2018, https://www.propublica.org/article/in-montana-a-tough-negotiator-proved-employers-do-not-have-to-pay-so-much-for-health-care.

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Appendix I: SEHP Administrator Survey Questions

We fielded this survey between September 15 and December 7, 2020 and received responses from 47 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. 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: _________

4. In addition to active state agency employees, which workforces are eligible to participate in the plan options administered by your agency (select all that apply)?

   _____School district employees – teachers

   _____School district employees – staff

   _____Local, municipal or county employees

   _____State university employees – faculty

   _____State university employees – staff

   _____Legislators

   _____Any others: ___________

   _____N/A

5. Does your agency have the authority to execute contracts with plans and/or third-party vendors, such as Third-party Administrators (Third-Party Administrator (TPA): Also sometimes known as an Administrative Services Only (ASO) entity, these entities deliver services like claims processing and employee benefit management for employers who self-fund health benefits instead of purchasing them from an insurer), Administrative Services Only entities (ASOs), benefit advisory firms, or Pharmacy Benefit Managers (Pharmacy Benefit Manager (PBM): A third party administrator of prescription drug benefits. These entities are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims)? ____Yes ____No ____Other

6. Does your agency also administer health benefits for retirees? ____Yes____No. If No, which state agency is responsible for administering benefits for retirees? ____

7. Do the employees eligible for the health benefits administered by your agency have a choice of: (Do not include any dental or vision plan options. If your answer varies by workforce population, please answer for state agency employees).

   _____1 plan option

   _____2-4 plan options

   _____5 or more plan options

8. 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 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? (Health Savings Account (HSA): A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses if you have a High Deductible Health Plan (HDHP)) ____Yes____No. If Yes, does your agency contribute to the HSA? ____Yes____No.

9. Does your agency contribute to a Health Reimbursement Arrangement or Account (Health Reimbursement Arrangement or Account (HRA): Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year)? ____Yes____No

10. Does your agency offer eligible employees (NOTE: If you offer more than one of any of the following plan options, please respond for the plan option with the largest enrollment) (select all that apply):

    _____A closed network plan option (e.g., HMO or EPO) (a plan design that provides no out-of-network coverage)

    _____HMO with out-of-network option

    _____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)

    _____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)

11. If your agency provides multiple plan options, do all active employees have the ability to choose any of the plans? ____Yes____No. If No, explain: ____

12. 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. If Yes, what is the duration of your collective bargaining agreement? ____ 1 year ____ 2-3 years____ 4+ years?

13. Which of the following entities is responsible for network negotiations (select all that apply)?

    _____Your agency

    _____Other state agency

    _____Third-party Administrator (TPA) or Administrative Services Only (ASO) organization

    _____Employee union

    _____Benefit advisory firm, consultant or broker

    _____Other: ____

14. Beyond enrollee premiums, how is the state employee health benefits program—both benefit and administrative costs—funded (select all that apply)?

    _____State appropriation

    _____State general fund

    _____Agency assessment

    _____Other: ____

15. Are the plan options administered by your agency:

    _____All self-funded (a type of plan where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered)

    _____All fully insured (a health plan purchased by an employer from an insurance company or managed care organization)

    _____Both self-funded and fully insured

16. Do you purchase any stop loss coverage? ____Yes____No

17. If available, what is the weighted average or range of actuarial values across all offered plan options? (Actuarial Value: the percentage of the total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, the average enrollee would be responsible for 30% of the costs of all covered benefits). ________________

18. Over the last five years, has the weighted average or range of actuarial values shifted:

    _____Higher

    _____Lower

    _____Stayed the same

    ____Not available

19. 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? ________________________________

20. Over the last 5 years, has the share of the state contribution to premiums increased, decreased, or stayed the same over the last 5 years?

    _____Increased

    _____Decreased

    _____Stayed the same

    _____Not Available

21. Are more than 50% of employees eligible for the health benefits administered by your agency enrolled in a single plan option?

    ____Yes____No ____I don't know

If Yes, please continue to Section II. If No, proceed to Section III.

Appendix I: SEHP Administrator Survey Questions

SECTION II – Plan Details

If your state offers multiple plan options, please respond to the rest of these questions for the plan option with the greatest number of active state agency employees.

1. In addition to active state agency employees, which workforce populations are eligible to participate in this plan option (select all that apply)?

   _____School district employees – teachers
   _____School district employees – staff
   _____Local, city, or county employees
   _____State university system – faculty
   _____State university system – staff
   _____Legislators
   _____Others: ____

2. What type of plan is this?

   _____Closed network plan option (e.g., HMO or EPO)
   _____HMO with out-of-network option
   _____Open network plan option (e.g., PPO)
   _____Other: ____

3. Is this a HDHP? ____Yes____No. If Yes, is it eligible for an HSA? ____Yes____No

4. What is the actuarial value for this plan option for active state employees? __________________________________

5. Is this plan option:

   _____Self-funded?
   _____Fully insured?

Appendix I: SEHP Administrator Survey Questions

SECTION III – Cost-Containment Initiatives

1. In the last 3 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:

   _____Value-Based Insurance Design
   _____Reference pricing
   _____Right to Shop
   _____Wellness incentives that result in an increase or decrease in premiums or cost-sharing based on enrollee's achievement of a target health metric (i.e., BMI, cholesterol level).
   _____N/A

   c. Provider payment and network design initiatives:

   _____Narrow provider networks
   _____Tiered provider networks
   _____Centers of Excellence
   _____Pegging provider reimbursement to a reference price, such as a percentile of the Medicare rate (sometimes referred to as "reference pricing")
   _____Risk-based contracts with health care providers
   _____Direct negotiation or contracting with providers
   _____Primary care-based initiatives (e.g., worksite clinics, near worksite clinics, DPCs, patient-centered medical home)

   d. Utilization management initiatives:

   _____Case management for high-cost enrollees
   _____Disease management for enrollees with one or more chronic conditions (e.g., diabetes, heart disease)
   _____Prior authorization and other methods of utilization management (e.g., primary care physician referral for specialty care)
   _____N/A

   e. Other initiatives:

   _____Annual spending growth target or cap
   _____Price transparency initiatives (e.g., Member shopping tools - plans/providers)
   _____Behavioral health management strategies or benefit carve out
   _____Auditing of claims (i.e., utilization auditing, payment accuracy, fraud identification)
   _____Procurement strategies (e.g., reverse auction, invitation to negotiate)
   _____Other: ____

   f. Our agency has not implemented any cost-containment initiatives in the last 3 years.___________

2. For the cost-containment initiatives selected in the questions above were any of them implemented as part of a:

   _____Cross-agency purchasing strategy, i.e., with your state Medicaid agency, state-based marketplace, or other state purchasing agencies? ____Yes____No. If Yes, which initiative(s)?____
   _____Purchasing collaboration with other states? ____Yes____No. If Yes, which initiative(s)?____________________________
   _____Employer purchasing coalition with private employers? ____Yes____No. If Yes, which initiative(s)?__________________

3. Have you identified any documented cost savings from the cost-containment initiatives selected in questions above? ____Yes____No. If Yes, which initiative(s)?____

   If you can quantify cost savings, what were they and how did you measure them? If possible, break it down by initiative.

   ____

4. Of the cost containment initiatives implemented in the last 3 years . . .

   a. have any of them been expanded? ____Yes____No. If Yes, which initiative(s)?____________________________________
   b. have any of them not resulted in savings or been eliminated? ____Yes____No. If Yes, which initiative(s)?_____________

5. Does the state employee plan contribute claims data to an All-Payer Claims Database (APCD) - Statewide databases that include all medical, pharmacy and dental claims collected from all private and public payers)? ____Yes____No

6. Does your agency use data from the APCD to assess cost trends/drivers in the state employee plan program? ____Yes____No

7. Does your agency have access to claims data from its Third-Party Administrator (TPA)? ____Yes____No ____N/A

   a. If Yes, does your agency use those claims data to assess cost trends/drivers? ____Yes____No. If Yes, is claims data analysis performed (select all that apply):
      _____In-house at the agency?
      _____by the carrier/TPA?
      _____by a consultant?
      _____Other?____

8. 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? ____Yes____No____N/A,because there is no collective bargaining agreement in place.

Your responses to questions 9 through 13 will be aggregated with other state responses and will not be attributed to your agency or your state.

9. Is the state considering the implementation of any new cost-containment initiatives in the next 1-2 years? ____Yes____No

   If Yes, please describe: ____

10. What are the primary barriers to your agency implementing cost-containment initiatives (select all that apply)?

    _____Governance structure
    _____Terms of the collective bargaining agreement
    _____Procurement policies and requirements
    _____Resistance from stakeholders (e.g., providers or enrollees)
    _____Limited or no evidence of return on investment
    _____Legislative mandates or requirements
    _____Other: ____

11. Please identify the single highest cost driver for your plans:

    _____Prices of hospital services
    _____Prices of physician and other ambulatory services
    _____Prices of prescription drugs
    _____Excessive or inappropriate utilization
    _____Other: ____________________________________

12. Which of the following benefit categories does your agency primarily target when considering cost-containment initiatives (select all that apply)?

    _____Prices of hospital services

    _____Prices of physician and other ambulatory services

    _____Prices of prescription drugs

    _____Excessive or inappropriate utilization

    _____Other: ________

13. If available, please share any relevant public reports or agency documents evaluating the cost-containment initiatives above and about any cost savings produced. If you would rather send us publicly accessible links, please email them to Maanasa. Kona@georgetown.edu.

Appendix II: List of 17 Cost Containment Initiatives

Benefit Design Initiatives	
Value-Based Insurance Design (VBID)	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 program in which the health plan surveys provider prices for a specific service within a defined geographic area and determines a cap or "reference price" as the maximum they will pay for that service. If the enrollee chooses to receive services from a provider that charges a higher price than the reference price, the enrollee must pay the difference. This type of reference pricing should not be confused with initiatives that peg provider reimbursement to a percentile of the Medicare rate. This is also often called reference pricing.
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.
Wellness Incentives	A program that attempts to encourage enrollees to adopt healthy behaviors or achieve a pre-determined health outcome (such as body mass index or cholesterol level) by tying health plan premiums or cost sharing to participation in a wellness program or achievement of the health outcome.
Provider Payment and Network Design Initiatives	
Narrow Provider Networks	A plan that limits coverage to a select set of hospitals, physicians, and other providers. Similar to an HMO, these plans may not cover the cost of services received out-of-network.
Tiered Provider Networks	A plan that groups or "tiers" providers based on their performance on cost and/or quality metrics. Enrollees are encouraged to seek services from the top performing providers through lower cost-sharing.
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.
Reference Pricing Provider Reimbursement	The plan or payer pays providers a non-negotiable, established rate that is equal to or a percentile of a reference rate, such as the price Medicare pays for the same service. This should not be confused with reference pricing or "Right to Shop" initiatives that adjust enrollee cost sharing based on provider costs.
Risk-Based Contracts with Providers	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.
Direct Contracting with Providers	Direct-to-provider contracting is a strategy in which a self-insured entity negotiates a contract directly with a provider of health care services rather than through a TPA. The goals of such efforts include obtaining lower provider prices than achieved by the TPA, engaging in a risk-sharing program, or encouraging value-based care.

List of Cost Containment Initiatives, cont'd

Primary Care-Based Initiatives	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. Direct Primary Care: A model of delivering primary care services that charges patients a monthly, quarterly, or annual fee in exchange for on demand primary care services that often also includes laboratory services, care coordination, and disease management services. Patient-Centered Medical Home: 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.
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 and Other Methods of Utilization Management	Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your 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 prior authorization 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.
Price Transparency Initiatives	Member shopping tools and cost or price transparency requirements for payers or providers.
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."
Auditing of Claims	Utilization auditing, payment accuracy, fraud identification
Procurement Strategies (e.g., Reverse Auction or Invitation to Negotiate	Reverse Auction: A process by which the state shares bid information among competing vendors in order to incentivize lower offers in subsequent rounds of bidding.

Appendix III: Actuarial Value of SEHPs

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. We did not receive a response from Arkansas, District of Columbia, Maryland, and South Dakota.

State	Weighted average or range of actuarial values across all plan options	Difference in weighted average or range of actuarial values over last 5 years
AK	70%	Not available
AL	85%	Higher
AZ	82%	Lower
CA	95.6%	Higher
CO	85%	Stayed the same
CT	93%	Stayed the same
DE	81.1-92.4%	Stayed the same
FL	N/A	Not available
GA	82%	Higher
HI	85.4%	Lower
IA	N/A	Lower
ID	N/A	Not available
IL	Approximately 94%	Higher
IN	78.7% to 90%	Stayed the same
KS	82%	Higher
KY	72% to 88%	Stayed the same
LA	N/A	Not available
MA	70% to 80%	Stayed the same
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% (2016)	Higher
MT	80%	Lower
NC	95%	Lower
NE	N/A	Not available
ND	N/A	Higher
NH	95%	Higher
NJ	97%	Stayed the same
NM	82 to 87%	Stayed the same
NV	87.3% or 92.0%	Not available
NY	93%	Higher
OH	80%	Stayed the same
OK	86%	Lower
OR	N/A	Not available
PA	89%	Stayed the same
RI	N/A	Not available
SC	81%	Higher
TN	74.1% to 87.8%	Higher
TX	83%	Higher
UT	88% Traditional; 91% HDHP w/ HSA	Stayed the same
VA	92%	Higher
VT	98%	Stayed the same
WA	80% to 91%	Stayed the same
WI	N/A	Not available
WV	N/A	Lower
WY	N/A	Not available

Appendix IV: SEHP Employer Premium Contribution

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. We did not receive a response from Arkansas, District of Columbia, Maryland, and South Dakota.

State	Percentage of Total Premium that the State Contributes for:				Difference in share that state contributes over the last 5 years
	Employee only	Employee + spouse/partner/one dependent	Employee + children	Family coverage	
AK	N/A	N/A	N/A	N/A	Stayed the same
AL	91%	76%	76%	76%	Increased
AZ	89%	89%	89%	89%	Decreased
CA	80%	80%	80%	80%	Increased
CO	95%	86%	94%	85%	Stayed the same
CT*	63%	63%	63%	63%	Decreased
DE	86.75 - 95%	86.75 - 95%	86.75 - 95%	86.75 - 95%	Stayed the same
FL**	6.35%	N/A	N/A	9.76%	Increased
GA	83%	78%	81%	78%	Increased
HI	Ranges from 45.6% to 84.3% for the medical/ drug premium; 60% for dental and vision	Ranges from 45.6% to 84.3% for the medical/ drug premium; 60% for dental and vision	Ranges from 45.6% to 84.3% for the medical/ drug premium; 60% for dental and vision	Ranges from 45.6% to 84.3% for the medical/ drug premium; 60% for dental and vision	Increased
IA**	7%	N/A	N/A	10%	Increased
ID	94%	91%	87%	81%	Increased
IL	87%	85.5%	N/A	87.1%	Increased
IN	80%	N/A	N/A	80%	Stayed the same
KS	90%	76%	86%	64%	Increased
KY	93%	N/A	87%	75%	Increased
LA	75%	62% for Employee + Spouse; 71% for Employee + Child	71%	61%	Stayed the same
MA**	25%	N/A	N/A	25%	Stayed the same
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	93%	84%	92%	85%	Stayed the same
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
MT	97.2%	80.3%	91.3%	76.3%	Stayed the same
NC	95%	47.5%	44%	32%	Increased
NE	79%	79%	79%	79%	Stayed the same
ND	100%	N/A	N/A	100%	Stayed the same
NH	94.5%	94.5%	N/A	94.5%	Increased
NJ	95%	95%	95%	95%	Decreased
NM	72%	72%	72%	72%	Stayed the same
NV	91.9%	82.6%	86.6%	80.9%	Decreased

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 5 years
	Employee only	Employee + spouse/partner/one dependent	Employee + children	Family coverage	
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	$659.89/mo	$1,312.75/mo (EE + Spouse); $892.24/mo (EE + Child)	$1,054.18/mo	$1,542.66/mo (EE + Spouse + Child); $1,677.96/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	80.5%	75.9%	81.1%	76.5%	Increased
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	On average 85%	On average 85%	On average 85%	On average 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%	Decreased

* State confirmed that federal grants and other funds help subsidize employee premiums beyond the 63% contribution.

** Authors believe these entries to be an error and these states have been excluded for the purposes of calculating the totals in page 8 of the report.

Note: States may partially fund their SEHP program and premium contributions through federal grants and other revenue sources.

Appendix V: Enrollment and Eligibility

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. We did not receive a response from Arkansas, District of Columbia, Maryland, and South Dakota.

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	5,900	8,900	4.36%	• School district employees – teachers, staff • Local, municipal or county employees • Retirees
AL	29,652	28,569	2.59%	• Legislators • Retirees
AZ	138,000	70,000	6.50%	• State university employees - faculty, staff • Legislators • Retirees
CA	427,371	595,555	5.52%	• School district employees - teachers, staff • Local, municipal or county employees • Retirees
CO	32,274	30,000	2.08%	• State university employees, staff • Legislators
CT	74,707 as of September 2020	106,534 as of September 2020	9.92%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
DE	33,302	69,983	22.08%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
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 employed before June 30, 2009
HI	66,500	52,700	16.33%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
IA	23,525	33,053	3.40%	• Legislators • Retirees
ID	19,000	28,000	5.48%	• State university employees - faculty, staff • Legislators • Judicial brance employees • Retirees
IL	97,984 as of 6/30/20	120,287 as of 6/30/20	3.24%	• 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	37,031	35,759	4.77%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
KY	180,969	114,000	14.54%	• School district employees - teachers, staff • Local, municipal, or county employees • Legislators
LA	76,163	74,749	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	128,46	16,066	4.77%	• Legislators • Retirees
MI	43,692	71,758	2.32%	• Judges • Legislative staff • Retirees
MN	52,087	75,820	4.01%	• Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
MO	34,584	34,234	2.23%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
MS	111,600	52,716	13.58%	• School district employees - teachers, staff • State university employees - faculty, staff • Legislators • Retirees
MT	12,204	13,090	5.66%	• 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	13,010	14,427	2.58%	• Legislators • Retirees
ND	19,200	31,900	12.56%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
NH	9,791	14,578	3.30%	• 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
NJ	340,000	356,000	14.37%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • 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	622,593	616,250	13.15%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
OH	44,162	65,990	1.84%	• Legislators
OK	109,093 as of 10/31/2020	66,400 as of 10/31/2020	10.07%	• 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	195,594	187,140	16.90%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • Retirees
TN	138,957	142,719	8.87%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislative, judicial branch employees • Pre-65 Retirees
TX	214,252	163,390	2.81%	• State university employees - faculty, staff • Legislators • Retirees
UT	24,786 state and other eligible individual employees	50,658	3.95%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators
VA	83,098	103,717	4.22%	• State university employees - faculty, staff • Legislators • Retirees
VT	7,574	9,834	6.01%	• 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
WA	260,515	277,625	13.7%	• 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	79,569	114,279	6.04%	• 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	17,853	25,373	15.02%	• School district employees - teachers, staff • Local, municipal, or county employees • State university employees - faculty, staff • Legislators • 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 2019 to find the total number of people in each state enrolled in employer-sponsored insurance.

Appendix VI: Cost Containment Initiatives & Documented Cost Savings

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. For complete list of the 17 initiatives that states could choose from, see Appendix II.

State	Cost Containment Initiatives Implemented by the State in the Past Three Years				Which initiatives resulted in cost Savings, if any?
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives	
AK	• Value-Based Insurance Design	• Narrow provider networks	• Case management • Disease management • Utilization management	N/A	Stayed the same
AL	• Wellness incentives	N/A	• Case management • Disease management	• Price transparency	N/A
AZ	• Wellness incentives	• Centers of Excellence • Primary care-based initiatives	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims • Procurement strategies	N/A
CA	• Value-Based Insurance Design • Wellness incentives	• Narrow provider networks • Primary care-based initiatives • Risk-based contracts	• Utilization management	• Behavioral health management	N/A
CO	• Value-Based Insurance Design • Reference pricing	• Centers of Excellence • Primary care-based initiatives • Risk-based contracts • Direct contracting	• Case management • Disease management • Utilization management	• Behavioral health management • Price transparency • Auditing of claims • Procurement strategies	N/A
CT	• Value-Based Insurance Design • Right to shop	• Narrow provider networks • Tiered provider networks • Centers of Excellence • Primary care-based initiatives • Risk-based contracts • Direct contracting	• Disease management • Utilization management	• Annual spending growth target or cap • Price transparency • Auditing of claims • Procurement strategies	VBID, Right to Shop, Disease management
DE	• Value-Based Insurance Design	• Centers of Excellence • Risk-based contracts • Direct contracting	• Case management • Disease management • Utilization management	• Auditing of claims	Direct contracting for Centers of Excellence
FL	• Right to shop	• Centers of Excellence • Direct contracting	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims • Procurement strategies	

Cost Containment Initiatives & Documented Cost Savings, cont'd

State	Cost Containment Initiatives Implemented by the State in the Past Three Years				Which initiatives resulted in cost Savings, if any?
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives	
GA	• Wellness incentives	N/A	• Case management • Disease management • Utilization management	• Behavioral health management • Price transparency • Auditing of claims	Wellness program
HI	N/A	N/A	• Case management • Disease management • Utilization management	• Auditing of claims	N/A
IA	N/A	• Centers of Excellence	• Case management • Disease management	N/A	N/A
ID	• Value-Based Insurance Design	• Risk-based contracts	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims	Value based payment arrangements, claim payment auditing (both pre-payment and post-payment), disease management programs
IL	• Wellness incentives	N/A	N/A	N/A	N/A
IN	N/A	• Primary care-based initiatives	• Case management • Disease management	• Prior authorization	N/A
KS	• Value-Based Insurance Design • Wellness incentives • Right to shop	• Tiered provider networks • Centers of Excellence • Risk-based contracts • Direct contracting	• Case management • Disease management • Utilization management	• Annual spending growth target or cap • Behavioral health management • Price transparency • Auditing of claims • Procurement strategies	Smart Shopper program, RFP process, Wellness program, and annual vendor audits
KY	• Value-Based Insurance Design	• Centers of Excellence • Primary care-based initiatives	• Case management • Disease management • Utilization management	• Behavioral health management • Price transparency • Auditing of claims	Value-based design
LA	• Wellness incentives	• Narrow provider networks • Tiered provider networks • Primary care-based initiatives	• Case management • Disease management • Utilization management	• Auditing of claims	N/A
MA	• Value-Based Insurance Design	• Narrow provider networks • Tiered provider networks • Centers of Excellence • Risk-based contracts	• Case management • Disease management	• Behavioral health management • Price transparency • Auditing of claims • Procurement strategies	Utilization management initiatives and contracted pass-through of PBM rebates

Cost Containment Initiatives & Documented Cost Savings, cont'd

State	Cost Containment Initiatives Implemented by the State in the Past Three Years				Which initiatives resulted in cost Savings, if any?
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives	
ME	• Value-Based Insurance Design • Wellness incentives	• Narrow provider networks • Tiered provider networks • Centers of Excellence • Risk-based contracts	• Case management • Disease management • Utilization management	• Annual spending growth target or cap • Auditing of claims • Procurement strategies	N/A
MI	N/A	N/A	• Case management • Disease management	• Auditing of claims • Procurement strategies	PBM prior authorization
MN	• Value-Based Insurance Design • Wellness incentives	• Tiered provider networks • Centers of Excellence • Risk-based contracts	• Case management • Disease management • Utilization management	• Auditing of claims	N/A
MO	• Right to shop	• Primary care-based initiatives	• Case management • Utilization management	• Auditing of claims	N/A
MS	N/A	• Centers of Excellence • Provider reference pricing • Risk-based contracts • Direct contracting	• Case management • Disease management • Utilization management	• Auditing of claims	Prior authorizations, case management, direct contracting, etc.
MT	• Wellness incentives • Reference pricing	• Centers of Excellence • Provider reference pricing • Primary care-based initiatives • Direct contracting	• Case management • Disease management	• Price transparency	N/A
NC	• Reference pricing	• Provider reference pricing • Primary care-based initiatives • Direct contracting	• Case management • Disease management • Utilization management	• Auditing of claims	N/A
NE	N/A	• Narrow provider networks • Tiered provider networks • Primary care-based initiatives	N/A	• Auditing of claims	N/A
ND	• Value-Based Insurance Design	• Risk-based contracts	• Case management • Disease management	• Auditing of claims	N/A
NH	• Value-Based Insurance Design	N/A	• Case management • Disease management • Utilization management	• Auditing of claims	N/A

Cost Containment Initiatives & Documented Cost Savings, cont'd

State	Cost Containment Initiatives Implemented by the State in the Past Three Years				Which initiatives resulted in cost Savings, if any?
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives	
NJ	• Wellness incentives	• Tiered provider networks • Primary care-based initiatives • Direct contracting	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims • Procurement strategies	N/A
NM	• Value-Based Insurance Design	• Centers of Excellence • Primary care-based initiatives • Risk-based contracts	• Case management • Disease management • Utilization management	• Procurement strategies	N/A
NV	N/A	• Narrow provider networks • Centers of Excellence • Direct contracting	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims	N/A
NY	N/A	• Direct contracting	N/A	• Auditing of claims	N/A
OH	• Wellness incentives	• Primary care-based initiatives	• Case management • Disease management	• Procurement strategies	N/A
OK	N/A	N/A	• Disease management	N/A	N/A
OR	• Wellness incentives	• Narrow provider networks • Centers of Excellence • Provider reference pricing	• Disease management • Utilization management	• Annual spending growth target or cap	N/A
PA	N/A	• Narrow provider networks • Centers of Excellence	• Case management • Disease management	• Behavioral health management • Auditing of claims	Narrow networks
RI	• Wellness incentives	• Centers of Excellence • Primary care-based initiatives	• Case management • Disease management • Utilization management	N/A	N/A
SC	• Value-Based Insurance Design	• Centers of Excellence • Provider reference pricing • Primary care-based initiatives • Risk-based contracts • Direct negotiations or contracting Note: State sets a site-neutral fee schedule	• Case management • Disease management • Utilization management	N/A	All provider contracting initiatives, PCMH, utilization management, case management
TN	• Value-Based Insurance Design	• Narrow provider networks • Centers of Excellence • Primary care-based initiatives • Risk-based contracts	• Case management • Disease management • Utilization management	• Annual spending growth target or cap • Behavioral health management • Price transparency • Auditing of claims	Narrow networks, utilization management, prior authorization, disease management, onsite clinic

Cost Containment Initiatives & Documented Cost Savings, cont'd

State	Cost Containment Initiatives Implemented by the State in the Past Three Years				Which initiatives resulted in cost Savings, if any?
	Benefit Design Initiatives	Provider Payment and Network Design Initiatives	Utilization Management Initiatives	Other Initiatives	
TX	• Right to shop	• Centers of Excellence • Primary care-based initiatives • Risk-based contracts	• Case management • Disease management • Utilization management	• Behavioral health management • Price transparency • Auditing of claims	Patient-centered medical home initiative
UT	• Reference pricing • Right to shop	• Narrow provider networks • Risk-based contracts • Direct contracting	• Case management • Disease management • Utilization management	• Behavioral health management • Price transparency • Auditing of claims	Pharmacy program, medical management, narrow network option, exclusive contracting for DME, claims review, price transparency with "Right to Shop Cash Back," contract negotiations with providers including risk-bearing, use of data analytics, increased use of HSAs
VA	N/A	N/A	• Case management • Disease management • Utilization management	• Procurement strategies	N/A
VT	N/A	N/A	• Disease management	• Auditing of claims	N/A
WA	• Value-Based Insurance Design	• Centers of Excellence • Risk-based contracts	• Disease management	• Annual spending growth target or cap • Procurement strategies	Accountable care program (implemented in 2016); Centers of Excellence (prospective bundled payment for hips/knees, and spine care)
WI	N/A	N/A	N/A	• Annual spending growth target or cap • Procurement strategies	Annual spending growth cap; invitation to negotiate
WV	• Value-Based Insurance Design • Wellness incentives • Reference pricing	• Narrow provider networks • Centers of Excellence • Provider reference pricing • Primary care-based initiatives • Risk-based contracts • Direct contracting	• Case management • Disease management • Utilization management	• Price transparency • Auditing of claims	Opiate program
WY	N/A	N/A	• Case management • Disease management • Utilization management	• Price transparency	Member shopping

Appendix VII: SEHP Offerings

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. We did not receive a response from Arkansas, District of Columbia, Maryland, and South Dakota.

State	Number of plan options offered	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	2-4	PPO	Y	3.11%	Y	N
AL	1	PPO	N			
AZ	2-4	HMO or EPO, PPO	Y	7.21%	Y	Y
CA	Depends on the region	HMO or EPO, PPO	N			
CO	5 or more	HMO or EPO, PPO	Y	22.48%	Y	Y
CT	2-4	PPO, HMO or EPO, HMO with out-of-network option	N			
DE	2-4	HMO or EPO, PPO	Y	6.43%	N	
FL	2-4	HMO or EPO, PPO	Y	2.53%	Y	Y
GA	5 or more	HMO or EPO	Y	1.89%	Y	N
HI	5 or more	HMO or EPO, PPO	N			
IA	2-4	HMO or EPO	N			
ID	2-4	PPO	Y	0.69%	N	
IL	5 or more	HMO or EPO, HMO with out-of-network option, PPO	N			
IN	2-4	PPO	Y	93.40%	Y	Y
KS	5 or more	PPO	Y	46.37%	Y	Y
KY	2-4	PPO	Y	39.27%	N	
LA	5 or more	HMO or EPO, PPO	Y	13.54%	Y	Y
MA	5 or more	HMO or EPO, PPO, an indemnity plan option	N			
ME	1	PPO	N			
MI	5 or more	PPO, HMO or EPO	N			
MN	2-4	HMO or EPO	Y	0.18%	Y	Y
MO	2-4	PPO	Y	7.65%	Y	Y
MS	2-4	PPO	Y	13.41%	N	
MT	1	PPO	N			
NC	2-4	PPO	N			
NE	5 or more	PPO	Y	8.81%	Y	Y
ND	2-4	PPO	Y	2.30%	Y	Y
NH	2-4	HMO or EPO, PPO	N			
NJ	5 or more	HMO with out-of-network option, PPO	Y	0.22%	Y	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.

SEHP Offerings, cont'd

State	Number of plan options offered	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?
NM	2-4	HMO or EPO, PPO	N			
NV	2-4	HMO or EPO	Y	72.77%	Y	Y
NY	2-4	HMO or EPO, PPO	N			
OH	2-4	PPO	Y	0.92%	Y	Y
OK	5 or more	HMO with out-of-network option, PPO, an indemnity plan option	Y	11.28%	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	5.19%	Y	N
TN	2-4	PPO	Y	4.26%	Y	Y
TX	2-4	HMO or EPO, PPO	Y	1.00%	Y	Y
UT	2-4	PPO	Y	40.00%	Y	Y
VA	5 or more	HMO or EPO, PPO	Y	0.87%	N	
VT	2-4	PPO	N			
WA	5 or more	HMO or EPO, HMO with out-of-network option, PPO	Y	6.60%	Y	Y
WI	5 or more	HMO or EPO, HMO with out-of-network option, PPO	Y	11.31%	Y	Y
WV	5 or more	HMO or EPO, HMO with out-of-network option, PPO	Y	0.38%	N	
WY	2-4	PPO	Y	6.59%	N/A	N/A

* 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 VIII: Collective Bargaining Agreements

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. We did not receive a response from Arkansas, District of Columbia, Maryland, and South Dakota.

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
NJ	Y	Y	N	4+ 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			
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 VIX: – Self-funded or Fully Insured - Who Negotiates the Networks?

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. We did not receive a response from Arkansas, District of Columbia, Maryland, and South Dakota.

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
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
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
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
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

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
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
NJ	Both self-funded and fully insured	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
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	Third-party Administrator (TPA) or Administrative Services Only (ASO) organization

Appendix X: Claims Data

NOTE: All responses seen are as they were provided by survey respondents with minimal edits. We did not receive a response from Arkansas, District of Columbia, Maryland, and South Dakota

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
AZ	Y	Y	N	N
CA	Y	Y	N	N/A
CO	Y	Y	Y	Y
CT	Y	Y	Y	N
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
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
NJ	Y	N	N	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
RI	Y	Y	Y	N
SC	Y	Y	Y	N
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