

***A Model for Saving Public School Health Care Dollars Through  
Large Claim Pooling, Increased Competition and Improving  
Health Care Quality***

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Health care spending, by several measures, continues to rise at the fastest rate in US history. Total national health expenditures increased by 7.7 percent in 2003 (the latest year that data is available) over 2002 - four times the rate of inflation in 2003.<sup>1</sup> In 2004, employer health insurance premiums increased by 11.2 percent - nearly four times the rate of inflation.<sup>2</sup> Double digit, or near double digit increases are projected to continue.

While the United States spends more on health care than other industrialized countries, the US does not rank among the highest in terms of health outcomes or coverage. For example, "healthy" life expectancy in the US is nearly the lowest of the 23 OECD (Organization for Economic Co-operation and Development) countries<sup>3</sup>. Only the Czech Republic has a lower rate than the US. With 45 million uninsured Americans, the US is the only industrialized nation that does not provide health insurance to all their citizens.<sup>4</sup>

The US health care system suffers from a significant quality chasm that is well documented by the Institute of Medicine and leading researchers. This chasm is evidenced by the nearly 98,000 deaths per year that result from avoidable medical errors.<sup>5</sup> The Centers for Disease Control estimates that each year 2 million patients acquire an infection in the hospital and that nearly 90,000 of those patients will die as a result of the infection.<sup>6</sup> Outpatient care is also not without its problems. A recent study by RAND found that only 54.9% of the time patients received the recommended, evidence-based health care for their preventive, acute or chronic condition.<sup>7</sup>

The response to the cost and quality problems in the US should be one that is formulated on a sound healthcare policy and truly addresses the issues that plague the system. Healthcare should be a right, not a luxury. Employees who already have significant co-pays and premium shares should not have more and more of their hard earned dollars going to insurance, health care providers and pharmaceutical company profits. Employers should not have to pay to cover the cost of healthcare for employees of companies that fail to do so. The percent of private sector with health care benefits dropped by 1/3 over the past 13 years and the erosion of jobs with health care coverage appears to be accelerating.<sup>8</sup>

Without a national healthcare system, employers increasingly are shifting costs to their employees by increasing health care premium sharing, deductibles, and copays. Cost shifting strategies ignore other beneficial approaches to control health care costs and improve quality, such as collective group purchasing, efficient plan administration, and improving member health. The emphasis of the HayGroup's report, the company commissioned by supporters of a statewide healthcare plan for school employees (SB 55/56), is to cut benefits and reduce administration cost.

The HayGroup report that explored the feasibility and cost-effectiveness of a consolidated health care plan for K-14 public education employees, including charter schools, offers many findings on potential areas of cost savings. The strategies suggested in the report will greatly restrict collective bargaining for health care benefits at the school district level. Further, the HayGroup approach also eliminates the benefits of health care plan competition on cost and quality. It is our belief, however, that the savings identified in the report can be achieved without jeopardizing the integrity of the collective bargaining process or the efficiencies found in a competitive market environment.

Is requiring school employees to be in a health plan totally controlled by the state the right answer? No. Monopolies, by definition, eliminate competition. While some may argue that health care does not lend itself to competition, Medicare, the largest health care purchaser, is aggressively moving in directions that promote competition, not limit competition. Local markets with significant health plan competition have seen aggressive pricing and high levels of innovation.

Rather than just criticizing the Hay Group's results and proposed approach, we suggest using the findings to develop an alternative model for school employee health care insurance.

The proposed model maintains employees' current bargaining rights for health care coverage, the freedom to choose their health plan, proactive approaches to improve their health and the health of their family members. The estimated first year savings for the proposed model are \$156 million, more than reported in two of the HayGroup options. Additional savings can be realized through the use of chronic care management programs, and PPOs.

The following elements form the foundation of the proposed model for public school employee health insurance

- State Sponsored Catastrophic Stop Loss Coverage

- Competitive health care purchasing by local school districts through regional group-purchasing pools
- State-of-the-art programs to improve employee health
- Disclosure of hospital and physician performance on quality measures
- Efficient administrative services that leverage industry standards, competition and information technology
- Transparent health care information for purchasers and consumers

The proposed model offered in response to the HayGroup report will control short and long term health care costs through the pooling of large health care claims, competition and improving quality.

### **Bring Value to Health Care: An Alternative Model**

#### ***1. State Sponsored Catastrophic Stop Loss Coverage: Mirroring Successful Programs***

Under the proposed model, the State would provide catastrophic stop loss coverage to all school districts. This approach mirrors other successful State and Federal programs to address catastrophic insurance claims. For example, the Michigan Catastrophic Claims Association (MCCA), an unincorporated non-profit association, was created by the state Legislature in 1978. The MCCA reimburses auto no-fault insurance companies for each Personal Injury Protection (PIP) claim paid in excess of \$350,000. That means that the insured's insurance company pays the first \$350,000 of medical expenses and the MCCA reimburses costs over that amount. Similarly designed programs are provided on the federal level for consumer protections of bank deposits, catastrophic natural disaster insurance claims and large claims resulting from acts of terrorism.

In the proposed model, the State, or its agent, would be responsible for the management of the catastrophic pool. All claims that reach a pre-established dollar threshold (attachment point) for payment would be paid through the catastrophic pool. In order to ensure that individuals with catastrophic health care costs receive the necessary care, the State program would include a comprehensive case management program.

Given that the catastrophic stop loss program would have fewer required administrative functions than the HayGroup's State sponsored health plan, start-up costs would be lower. The HayGroup projected \$3 million in start-up costs are spread over a two-year period. The start-up costs for administration of the catastrophic pool are estimated to be approximately \$1.5 million during the two year implementation of the catastrophic pool.

The reduction in cost would be directly related to the level of specific stop loss provided by the State. If the State offered specific stop loss for amounts ranging from \$50,000 to \$150,000, it would have a direct effect on the cost of the local school districts underlying plan through the spreading of risk.

To protect the State program against adverse selection, districts would be required to conform to plan requirements. There are proven savings when using a PPO plan as illustrated by the recommendations of the HayGroup report. Districts could still offer employees the option of a HMO plan (s). HMO plans would be excluded from the catastrophic pool given their unique structure.

School districts would also need to be pro-active in promoting employee wellness and to provide chronic care management programs to members living with disease if they are to participate in the catastrophic pool. The school district would be required to:

- Provide every employee an incentive to complete a Health Risk Assessment.
- Submit its district's health promotion and chronic care management programs to the State for approval. These programs could be delivered through the district's health plans or provided through vendor contracts. These programs would need to meet standards (e.g., NCQA accreditation for chronic care programs) and demonstrate that proactive interventions are used to address employee health.
- Provide the local school district's long-term plan to improve the health of their employees to the State. An implementation plan would also be required.

## ***2. Group Purchasing Coalitions and Regional Pools: Fostering Competition in the Health Care Market***

Districts would be encouraged to join together in “regional purchasing pools” to achieve better pricing on medical services, including prescription drugs and dental and vision coverage. Alternatively, school districts could also participate in purchasing groups that may be active in the area. The use of health care purchasing pools is a major element of the President Bush’s health care reform agenda.

Group purchasing programs are an effective mechanism to address health care costs and quality. The deepest discounts can only be obtained when negotiating from a position of strength. When dealing with the health care system, this strength comes from the size of the group. Discounts can be found not only in provider/facility, pharmacy, laboratory, dental, vision costs but also in the fees charged for administration of the plan. Improvements in quality can also result from purchasing coalition’s holding health plans accountable for meeting performance measures. Often these performance measures reflect the quality of care, such as childhood immunization rates.

The regional purchasing pooling in the proposed model approach allows districts to seek the best cost for the product they negotiate rather than negotiating to purchase a predetermined plan as proposed by the HayGroup. Through pooling, smaller districts obtain the critical mass that is necessary to obtain “best pricing” from health care providers and health care plan administrators. Regional pools could be initiated by any one of the key stakeholders, such as the district, its unions or as a joint district-labor initiative.

Purchasing pools, both within and outside of health care services have proven an effective mechanism to control costs. For example, the School Employers Trust (SET)-School Employers Group (SEG) is an autonomous, non-profit organization whose mission is to provide high-quality insurance programs to Michigan school districts and their employees. SEG is the dominant player in Property/Casualty insurance and Workers' Compensation insurance for the public education sector. The SEG Property/Casualty Pool now provides coverage on behalf of approximately 450 participants for nearly 3,000 separate building locations, collectively valued at \$13.5 billion. Since 1995, the SEG Property/Casualty Pool has returned over nearly \$53 million in the form of premium discounts. The SEG Worker’s Compensation program also has a track record of success. From its inception in 1977 through June 30, 2004, the Fund

returned more than \$137 million in surplus, dividends and accumulated assets returned in the form of premium discounts.

Health care purchasing coalitions, such as the AFL-CIO Employer Purchasing Coalition (AEPC), have proven effectiveness in providing quality products at a reduced cost. The AEPC is a not-for-profit corporation that was established in 1993 to assist organized labor in the group purchasing of health care services. AEPC is governed by labor, business and public sector representatives that have ensured the integrity of AEPC programs since its creation; AEPC has developed value-based purchasing programs for prescription drugs, dental and vision services. These programs not only leverage the AEPC purchasing power of nearly 200,000 covered lives, but also provide improvements in the quality of services provided to members.

The existing relationship between AEPC and Caremark, the pharmacy benefits program used by AEPC, has brought measurable results:

- In 2004, the per member per month (PMPM) trend for AEPC was 13% - significantly lower than the trend for its peer groups
- Rebate billings increased 80% over the previous year to just under \$5,000,000
- Total Caremark program savings increased 7.8% in 2004
- Caremark has saved AEPC members \$77,000,000 since 1996

AEPC continually monitors the cost and quality of the products it offers and renegotiates when conditions are appropriate. This year, an in-depth audit of the pharmacy program was conducted by an outside auditing firm at no cost to AEPC members. Monies recovered through the audit will be returned to AEPC member organizations.

As for members of AEPC, participation by school districts in purchasing coalitions for the procurement of healthcare services is an integral piece of the puzzle for saving dollars and improving quality now and in future years.

### ***3. Focusing on Employee Health: The Right Strategy for Today and the Future***

If health care costs are to be controlled in the future, strategies to address

employees' health status must be implemented in a proactive manner. These strategies must address the following:

### Health Promotion

Employees must be provided tools to assess their current health status and encouraged to seek appropriate preventive care. Health risk assessment tools should be made available to employees through multiple media, such as via the web or on paper. These health assessment tools must also be designed to address the language and culture of the employees and their family.

Programs should be implemented to encourage members to obtain necessary preventive services. Key program elements include personalized member reminders based on needed services as identified in the health risk assessment and through medical claims data. Plan benefit design should also support preventive care through limited member out-of-pocket expense for these services.

The proposed alternative model will provide the tools necessary for employees to assess and improve their personal health status. Through the collective bargaining process, school employees can negotiate affordable access to preventive care. Health promotion and preventive care will generate savings in future years.

### Chronic Care Management

Nearly 60% of all health care costs result from the treatment of chronic conditions, such as diabetes, heart disease, asthma, etc. Proactive chronic care management programs have been shown to be an effective strategy to control health care costs (short and long term), reduce employee absenteeism and improve worker productivity.

Through the proposed model, members would have access to a chronic care management program that is based on evidence-based clinical guidelines, incorporates member-specific prescription drug, laboratory tests and associated results, and leverages the latest in information technology systems. An example of a "best in class" program is that which is provided by ActiveHealth Management. Both physicians and employees are made aware of "gaps in care" such as missing services. Employees with chronic conditions are provided the support of a nurse to telephonically help them better manage their condition. The program will not only improve care but will result in cost savings. For example,

the ActiveHealth Management program reported a savings of \$8 per member per month (PMPM) in published peer review journal.<sup>9</sup>

#### ***4. Provider Performance Information: Not all Health Care Providers Are Created Equal***

Research on health care quality has clearly demonstrated the variation in both physician and hospital performance. The recent RAND study published in the New England Journal of Medicine examined thousands of patient records in 12 US cities. The researchers found that patients receive the recommended, evidence-based health care for their preventive, acute or chronic conditions only 54.9% of the time.

The Leapfrog Group, a collaborative effort of 170 companies and organizations that buy health care, is undertaking community-based initiatives to address the safety problems that plague the health care system. Leapfrog gathers and reports hospital specific patient safety measures. The Leapfrog Group companies and other organizations encourage patients to use this information when making decisions about where to receive hospital care. The Leapfrog Group reports are founded on published research that has, for example, established the relationship between high volumes of certain surgical procedures and reduced risk of mortality.

Through the proposed model, school employees and their families would be educated about the variation in health care quality. They would be provided with tools to obtain provider performance information. Hospital performance information collected by such organizations as the Leapfrog Group, Michigan Health and Safety Council, and CMS would be distributed. Physician performance information, such as NCQA certification for diabetes and heart/stroke care, would be disseminated

The proposed model would also actively work to provide comparative provider cost information to members. With the exception of fixed dollar copays, healthcare is the only service that we purchase for which we do not know the cost in advance. Tools developed by leading national firms will be evaluated for future incorporation into the alternative delivery system.

## ***5. Efficient Administration: Leveraging Standards, Competition and Technology***

Performance standards for effecting health plan administration are essential. In industries such as automobile manufacturing, industry standards on a vast array of metrics have dramatically reduced production costs and dramatically improved quality.

A set of minimum guidelines for administrative functions will be developed and apply to all carriers offering benefits to school districts. Districts and/or regional purchasing pools would be encouraged to use administrators that meet these guidelines. Standards for efficient administration would include many key administrative functions, such as the maintenance of accurate enrollment and eligibility information. In order to ensure accurate and timely enrollment and eligibility, on-line systems must be provided by the plan administrator. Another critical administrative capability is electronic claims adjudication. Administrative savings can be realized as the percent of claims that are electronically submitted and processed without manual intervention increase.

Data from the National Business Coalition on Health eValue8 health plan performance tool can be shared with school districts and regional purchasing pools. Annually, the eValue8 evaluation tool is fielded locally by the Greater Detroit Area Health Council, the Alliance for Health and the South Central Michigan Health Alliance. This tool provides extensive comparative health plan specific performance information on many critical areas of performance, including administration. The eValue8 information not only compares Michigan plans with one another, but also with approximately 100 health plans across the county. The State could consider expanding the fielding of eValue8's administrative section to any health care plan administrator who contracts with a local school district.

If a school district's plan administrator is not currently meeting or exceeding standards for accurate enrollment and eligibility information, the district should be encouraged to require the administrator to meet such standards within a two year period or move to a new administrator. Plans and plan administrators would compete based on administrative performance for the district's business, thus moving the entire market to a higher level of performance. The benefits of competition would not be realized with the single administrator approach recommended in the HayGroup report. A single administrator, like most monopolists, would be slow to adopt breakthrough technologies and continuously

strive to become more efficient. Once the administrator had succeeded in obtaining the contract, there would be no incentive to continue to reduce costs.

## ***6. Transparency: Knowing the Price of What You Buying***

The health care industry lacks transparency on from both the “purchaser’s” (i.e., school district) and the “consumer’s” (i.e., employee/family member) perspective.

Health care purchasers, even those who are self-funded, are greatly limited as to the health care utilization and cost data that they can access. These limitations are even greater if the health plan is the dominant player in the market place. Health plans often will not provide purchasers’ data by individual hospital, on the specific services, and the cost of the services provided to their employees. Nor will plans disclose the portion of the hospital discount that is retained by the plan.

Consumers, too, are plagued by a lack of transparency in the health care system. With the exception of fixed dollar copays, healthcare is the only service that consumers purchase for which they do not know the cost in advance. Consumer cannot be expected to purchase health care based on value, cost and quality if appropriate data is not readily available.

The proposed model would advance health care transparency for purchasers and consumers. The State-sponsored catastrophic stop-loss pool would remove the mystery of stop loss premiums and commissions from the health care purchasing equation. Purchasing coalitions and regional purchasing pools traditionally embrace transparency more so than insurance carriers. The proposed model would also actively work to provide comparative provider cost information to members. Tools developed by leading national firms will be evaluated for future incorporation into the alternative delivery system.

### **Moving from Concept to Implementation**

1. Develop legislation authorizing the State of Michigan to accept the risk for catastrophic coverage. An actuarial study would be needed to determine such program elements as the pool’s funding requirements, the method for reimbursement from the individual districts, etc.

2. Support school districts with the necessary information to identify coalition/regional purchasing pools and/or develop a regional pool.
3. Develop/identify “best in class” health promotion and chronic condition management programs.
4. Disseminate tools to school employees and their family member that provide comparative health care provider performance information.
5. Develop standards for efficient administrative systems that leverage the latest information systems technology.
6. Formulate “transparency” standards that will move the health care industry on the direction of providing meaningful information to purchasers and consumers.

### **Proposed Model: Estimated Savings**

The savings projections for the proposed model assume that the HayGroup's estimates are accurate. Savings assumptions are identical to the HayGroup except where noted. For example, it is assumed that 75% of the lives in groups currently fully-insured would move to self-funding. As in the HayGroup report, start up costs is excluded from the savings analysis. The HayGroup projected \$3 million in start-up costs that are to be spread over a two-year period. The proposed model's start-up costs are limited to the administration of the catastrophic pool and are estimated to total approximately \$1.5 million over two years.

The estimated first year savings for the proposed model are \$156 million. This represents a savings of 7.2%, which exceeds the HayGroup projected savings of 6.7%. Table 1 details the analysis of the savings projected for the proposed model.

### **Table: Estimated Savings for the Proposed Model**

| Source of Savings                    | Year 1 Savings (%) | Assumptions   |
|--------------------------------------|--------------------|---|
| <b><i>Eligibility Management</i></b> |                    |   |
| Frequent updates                     | 0.65               | Same as HayGroup*   |
| Student Eligibility                  | 0.14               | Same as HayGroup*   |
| <b><i>Self-Funding</i></b>           |                    |   |
| Insurer gain                         | 1.16               | Assume 75% of HayGroup saving would be realized as fully insured groups move to self-funding arrangement through purchasing coalitions/pools. |
| Stop-loss premiums                   | 0.17               | Same as HayGroup*   |
| Commissions                          | 0.12               | Assume 75% of HayGroup Saving would be realized as fully insured move to self-funding through purchasing coalitions/pools.                    |
| Subsidies                            | 0.58               | Assume 75% of HayGroup Saving would be realized as fully insured move to self-funding through purchasing coalitions/pools.                    |
| <b><i>Purchasing</i></b>             |                    |   |
| Negotiated admin fees                | 0.11               | Same as HayGroup* (Option 1) since Year 1 participation in purchasing pools will be limited   |
| Provider access fees                 | 0.63               | Same as HayGroup*   |
| Pharmacy carve-out                   | 3.35               | Assume HayGroup Option 2 savings. Multiple plan designs do not significantly reduce savings from pharmacy carve-out                           |

|  |       |                          |
|--|-------|--------------------------|
| DME  | 0.20  | Same as HayGroup*        |
| Audits   | 0.10  | Same as HayGroup*        |
| Chronic Care Management                        |       | Not considered by        |
| <b>Estimated Total Savings: Proposed Model</b> | 7.20% | \$155,934,125            |
| <b>Estimated Total Savings: HayGroup</b>       | 6.70% | \$146,000,000 (HayGroup) |
| <b>Difference</b>                              | 0.50% | \$9,934,125              |

Greater savings in the first year are possible through the use of PPOs. First year savings could be as much as 8% with increased use of PPOs. Projected savings for the first year would further increase to 8.32% if, in addition to the greater use of PPOs, a chronic care management program was added.

In the second year under the proposed model, as participation by districts in purchasing coalitions and regional purchasing pools increases, savings of 8.31% are projected. Second year savings could increase to as much as 9.1% if there was greater use of PPOs. If the savings from a chronic care management program was added in conjunction with greater use of PPO plans, second year saving would further increase to approximately 9.42%. This is only slightly less than the HayGroup's savings under Option 3, which mandates school district participation in the plan.

In future years, the proposed model will continue to generate savings that exceed those projected by the HayGroup. These savings result for the proposed model's focus on member health and chronic care management, as well as competition.

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