

**ALASKA STATE LEGISLATURE
SENATE STATE AFFAIRS STANDING COMMITTEE**

January 30, 2014

9:02 a.m.

MEMBERS PRESENT

Senator Fred Dyson, Chair
Senator Cathy Giessel, Vice Chair
Senator John Coghill
Senator Bill Wielechowski

MEMBERS ABSENT

Senator Bert Stedman

OTHER LEGISLATORS PRESENT

COMMITTEE CALENDAR

PRESENTATION: INDIANA'S EXPERIENCE WITH CONSUMER DRIVEN HEALTH PLANS

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

MIKE BARNHILL, Deputy Commissioner
Alaska Department of Administration
Juneau, Alaska

POSITION STATEMENT: Provided an overview of Consumer Driven Health Plans.

DENNY DARROW, Deputy Director-Chief of Staff
Indiana State Personnel Department
Indianapolis, Indiana

POSITION STATEMENT: Provided an overview of Indiana's Consumer Driven Health Plans for state employees.

ACTION NARRATIVE

[9:02:34 AM](#)

CHAIR FRED DYSON called the Senate State Affairs Standing Committee meeting to order at 9:02 a.m. Present at the call to order were Senators Giessel, Coghill, Wielechowski, and Chair Dyson.

PRESENTATION: INDIANA'S EXPERIENCE WITH CONSUMER DRIVEN HEALTH PLANS

[9:02:59 AM](#)

CHAIR DYSON announced that the Alaska Department of Administration (DOA) is considering a number of things to improve the way the state delivers several kinds of benefits. One of the places DOA has looked for help is the state of Indiana. He stated that the committee will be hearing from Mr. Denny Darrow, Deputy Director-Chief of Staff, Indiana State Personnel Department. He noted from Mr. Darrow's syllabi that he was a crucial part in Indiana's recent changes to their state employee health programs. He noted that Mr. Mike Barnhill, Deputy Commissioner from the Alaska Department of Administration (DOA) will address the committee.

[9:04:30 AM](#)

MIKE BARNHILL, Deputy Commissioner, Alaska Department of Administration (DOA), Juneau, Alaska; set forth that other states can provide very helpful information and helpful models for Alaska to follow. He asserted that if Alaska has a problem then someone else has experienced the same thing at a scale that much exceeds the state's problem. He said Alaska can benefit from other states' expertise.

MR. BARNHILL disclosed that DOA had spent the last two years really focusing on healthcare and specifically on how much the state is paying for healthcare through its various programs. He addressed the current payments for retiree healthcare and for active healthcare, both the AlaskaCare plan managed by DOA and the plans that are managed by the state's union health trusts. He said the state of Alaska is spending in excess of \$700 million per year in healthcare costs. He explained that the healthcare costs are of sufficient magnitude that scrutiny is warranted. He asserted that how the state was doing healthcare can benefit by analyzing and potentially implementing other healthcare models. He said DOA had been aware of Indiana's experience with Consumer Driven Health Plans (CDHP). He noted meeting Mr. Darrow at a health administrator's conference. He said Mr. Darrow will share Indiana's experience with CDHP.

[9:06:30 AM](#)

CHAIR DYSON asked to clarify that the committee is not being asked to make any decisions or take any actions.

MR. BARNHILL answered correct.

CHAIR DYSON asked if the intent is to have the committee and the legislature begin to understand what DOA is considering.

MR. BARNHILL answered yes.

CHAIR DYSON asked what was the process that will lead from what DOA is learning and what DOA decides to implement.

MR. BARNHILL replied that the Plan Administrator (PA) is the Commissioner and the PA can make adjustments to plan design. The process is somewhat different for "actives" versus "retirees." He said the process is generally to first learn about what is out there and then have some period of notice and comment if DOA decides to make a change so that people can be apprised, ask questions, and submit comments.

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CHAIR DYSON surmised that DOA's anticipation will not require any legislative action to go forward.

MR. BARNHILL answered no.

CHAIR DYSON noted reading that DOA had lots of discussions with the "bargaining units." He asked if he is right in assuming that DOA's processes will be or is involving employee bargaining units.

MR. BARNHILL answered yes. He explained that the concept of a CDHP, formally known as a High Deductible Health Plan, has been on the radar within DOA since 2005. He said discussions have occurred but there has not been a serious move towards a CDHP. He said this year DOA intends to do more than simply talk about CDHP and see what can be done to actually standup with an optional or voluntary CDHP within the state's active plan.

CHAIR DYSON summarized that his intention is to have the committee do all that it can to let DOA get through the review process as a package. He said he wants to allow any questions that clarify and try to steer away from the debate of CDHP during the process. He asserted that his previous statement does not mean the topic will not be debated.

[9:09:40 AM](#)

DENNY DARROW, Deputy Director-Chief of Staff, Indiana State Personnel Department (ISPD), Indianapolis, Indiana; announced that it was his privilege to share with the committee the positive experience and opportunities learned from Indiana's foray into the implementation of CDHP over the past several years. He said he will set forth information for the committee to draw some differences between membership in Alaska's plan versus the state of Indiana to provide an overview of how and why Indiana attacked providing CDHP in the manner in which they were delivered.

MR. DARROW said the state of Indiana offers its employees and eligible dependents health plans administered by ISPD. He said authority is given by state statute to ISPD to administer and design plans for the benefit of those members and eligible employees. He said the state of Indiana currently offers three self-funded health plans to its employees. As of late 2013, enrollment in Indiana's self-funded health plans totaled 65,600 covered lives; 90.7 percent are represented by active employees and their eligible dependents, remaining enrollees are a mix of early retirees and those bridging to full retirement. He revealed that Indiana does not offer health insurance to the retiree population. He added that 5.7 percent of Indiana's healthcare membership is made up of local school corps and municipalities that have the option to choose join the state's plans. He detailed that Indiana's average age of its member population is 45 years; the average age of all employees in the population is 37 years, not different from Alaska's average age of 35 years.

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He addressed how Indiana reached its current point with CDHP and how the state decided CDHP was a logical progression to pursue. He explained that during the 2004 gubernatorial campaign, soon to be elected Mitch Daniels began talking about CDHP and Health Savings Accounts (HSA) as fundamental tools to the growth in healthcare cost. The overall philosophy was simple, by allowing consumers to have a larger financial stake when purchasing healthcare services; they will make informed choices about their healthcare and therefore spend those dollars more efficiently in the most effective manner possible.

MR. DARROW said once elected in January 2005, Governor Daniels tasked ISPD with design and implementation of the state's first CDHP; at that point in time the challenges that Indiana faced were not different from many state governments and private

corporations facing the same rapid rate of increase in healthcare costs. He detailed that in 2005, Indiana's trends were rising at unsustainable rates. He noted that the plans Indiana's offered at the time included Health Maintenance Organization (HMO), Personal Provided Organization (PPO), and several regional HMO plans.

He set forth that Indiana's employees were insulated from the true cost of healthcare. He noted that there were third party insurance payments rather than personal payments to cover the cost of healthcare, low deductibles, minimum co-pays, and first-dollar coverage plans where no premiums were paid by the employees. He added that co-pays were not subject to the deductible over time. He explained that in the design of the plans themselves, there was little or no emphasis on preventative care, prescriptions were not subject to the planned deductible, and there was no "skin in the game" for the employee. He summarized that Indiana had provided a lot of disjointed services without an overall outcome mission.

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He addressed why CDHP made sense for Indiana in 2005 as follows:

- Encouraged long-term improvement in health status of employee population & their families;
- Inspired "consumerism mindset" by instilling responsibility for efficient purchase of medical services;
- Increased personal stake in making informed health care decisions and positive behavior changes;
- Allowed for Health Savings Account (HSA) portability versus Health Reimbursement Account (HRA) where HSA can go with an employee overtime while HRA contributions stays with the employer;
- Triple-tax HSA advantages where employee savings and employer contributions are made prior to taxation, funds may be used tax-free for healthcare purposes in perpetuity, and HSA growth and investment income is not taxed.

He noted that many HSA programs offer mutual fund and other tax-free savings vehicles that allow a more meaningful way for employees to invest. He said HSA fit into ISPD's overall philosophy for employees to make their life-long decisions on how to get and receive care.

MR. DARROW said ISPD wanted to communicate to employees that HSA and CDHP was a partnership with the state of Indiana. He noted

that employees were taking more risk through higher deductibles; however the state would make contributions to HSA accounts in addition to employee contributions. He explained that HSA is a savings vehicle over time that hopefully will address two important aspects:

1. Addressing a consumerism mindset where employees have more "skin in the game." Employees will save more dollars, make wiser choices on where to get services and how services are purchased. The best and most affordable care will be offered due to the economic impact on the medical delivery system.
2. Life-long investment savings vehicle that goes with employees and grows over time.

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He said in 2005, ISPD took the rather large task of designing plans for a launch of the state's first CDHP option in 2006. He remarked that Indiana was the first state to have a foray into designing a CDHP plan and offering it to their employees. He explained that ISPD designed the CDHP plan with a standard 80/20 split coverage that included:

- Deductibles at \$2,500 for single and \$5,000 for family;
- Paid for in full by the employee's contributions;
- Employee was 100 percent responsible until he or she reached 80 percent of costs with co-insurance kicking in for the remaining 20 percent until the employee hit the out-of-pocket maximum at \$4,000 for singles and \$8,000 for families;
- Employees had the option to open an HSA that was controlled by ISPD;
- Indiana's contribution to the HSA account was 60 percent of the total deductible; \$1,500 for singles and \$3,000 for families.

He noted that Indiana faced a challenge in designing a large scale HSA due to a lack of institutions that offered commercially viable options. He said Indiana was fortunate in finding an instate bank that was willing to partner with the state that allowed ISPD to offer employees an HSA account option.

[9:18:49 AM](#)

CHAIR DYSON asked if the contribution from the state was a one-time contribution.

MR. DARROW replied that the first year offering was 60 percent of the deductible and today the state offered 45 percent of the deductible contribution to the employee HSA accounts.

CHAIR DYSON asked to clarify that every year the state puts in \$3,000 for a family in addition to the contribution on payroll deductions.

MR. DARROW answered correct. He explained that the employer and employee HSA account contributions are dictated by statutory limits set by the Internal Revenue Service (IRS).

He explained that Indiana offered employees no premiums for the first year. He specified that ISPD's intent was to offer a meaningful event for employees coming from an environment where there was not very much "skin in the game." Employees were apprehensive coming from a little or no co-pay environment to having a high deductible with first-dollar coverage responsibility. He said ISPD felt that offering the CDHP at no premium contribution with a generous HSA contribution would be a very meaningful "carrot" for employees to consider. During the first year approximately 1,400 eligible employees or 4 percent of the state's employee population enrolled in CDHP. There were two concurrent offerings as well with two PPO and one large HMO offered to employees.

[9:20:46 AM](#)

SENATOR WIELECHOWSKI asked what ISPD's offerings and deductibles looked like prior to the CDHP.

MR. DARROW answered that ISPD's offerings were all over the map. He noted deductibles varied from \$150 to \$500 with some plans having smaller deductible with very little co-pays. He asserted that ISPD felt it was important to offer a choice rather than mandating CDHP. He explained that CDHP had a learning curve for everyone involved, including ISPD. He said it really is incumbent upon ISPD as a state personnel department and state government to educate employees about what their options are and the impact on them.

SENATOR WIELECHOWSKI asked what the incentive was for the 4 percent of employees to go from a plan with a \$300 deductible to a plan with a \$3,000 deductible.

MR. DARROW replied that there were multiple reasons. He noted that the decision to change was dependent on an employee's

healthcare usage and services utilization. He said having the benefit of a cash contribution provided by the state was done to make sure that employees understood the investment meaning over time. ISPD spent a lot of time during the first year educating employees that the state's \$3,000 contribution combined with their contribution was going to help their HSA grow over time.

9:22:24 AM

SENATOR WIELECHOWSKI asked if HSA funds have to be spent within one year or the funds go away.

MR. DARROW replied no. He explained that Flexible Spending Accounts (FSA) are another vehicle provided by many governments with a "use it or lose it" provision. He detailed that an FSA contribution is made at the beginning of the year and funds have to be used prior to April 15 the following tax year. He specified that an HSA rolls over and grows over time.

He said ISPD introduced a second CDHP (CDHP-2) in 2007. Based upon employee feedback, ISPD determined that \$4,000 or \$8,000 out-of-pocket max was a big leap for people to make. ISPD offered CDHP-2 with lower deductibles and the risk perceived by employees made it a little bit easier to tolerate a slightly higher deductible than the initial offering. He specified that CDHP-2 had a 55 percent state contribution to the HSA versus 60 percent in the 2006 CDHP (CDHP-1). He said the second year's workforce marketing and education program increased enrollees from 4 percent in 2006 to 18 percent in 2007 with 6,300 subscribers. He explained that significant benefit changes precipitates a maturation period for plan administration and education for employees to develop a comfort level.

9:24:56 AM

He said employee participation doubled in 2008 from 2007 where enrollment reached 12,000 members or 35 percent of all subscribed members. He noted that the state's sole HMO plan exited the market in 2008 and that action facilitated movement to other healthcare options. In 2008 there were two PPO options, two CDHP options, and no HMO option.

CHAIR DYSON asked to clarify that the program's value ISPD put into place enticed or convinced employees to voluntarily switch plans without minimizing or taking away other choices other than the HMO provider that quit.

MR. DARROW answered yes. He explained that the HMO provider was no longer financially viable and closed the plan voluntarily.

CHAIR DYSON asked to clarify that there was no manipulation on Indiana's part to drive people into the new system.

MR. DARROW answered no. He specified that Indiana marketed the HSA on the aspect of saving for costs that are more predictable and more known. He asserted that when employees have HSA funds saved to pay for medical procedures, the burden on an individual is reduced if a catastrophic event happens. He said word-of-mouth spread, comfort level grew, education efforts increased, and membership continued to grow. The state of Indiana focused its education on maximizing the use of employees' HSA accounts, using preventative care, and cost transparency of information provided by the insurance carriers to understand what is the best price and best quality of care for the individual as well as alternative service lines. He pointed out that one of the things that consumers just are not used to doing, and it is still an evolution for the state of Indiana today, is asking their provider:

Doctor, I understand that you are recommending this particular procedure, however I am part of a consumer driven health plan. What would you recommend would be the most quality, lowest cost service that I can undertake?

He said physicians are not necessarily educated to answer questions on a cost perspective. On the quality side, physicians are very resolute, either through their network or through their practice about where the quality service should lie. He emphasized that ISPD is really trying to educate employees that making a medical procedure decision by knowing costs prior to making a choice is a long term way to affect the marketplace price point of healthcare delivery.

SENATOR GIESSEL addressed price transparency and noted that Mr. Darrow may have said the insurer provides cost options to employees and not the healthcare provider. She asked if it is the healthcare provider that is transparent about their cost.

[9:28:04 AM](#)

MR. DARROW replied that one of the long standing challenges for ISPD was to provide enough cost information to allow employees to shop for healthcare just like with any other consumer product. He detailed the cost transparency initiative as follows:

At the time, our insurance carrier, which was Anthem, their parent company being Well Point Health Carriers, did provide cost of care procedures for state of Indiana employees through their web-portal, so they could say if I'm shopping for a hip replacement, this is the average cost at this facility; it was a limited tool, it did not serve by any means the breadth and depth of information that we wanted. However, providers, and still today this is a challenge for us in Indiana, providers are limited in their knowledge about what the true cost of healthcare is for the individual, because health plans vary, insurance plans vary, the actual individual impact could be widely different based upon where the employee is provided coverage for. That being said, we have introduced transparency tools in recent years, most notably last year a significant investment in a transparency tool that is very personalized and tailored to the individual that shows the entire claims history of Indiana's experience available to the individual. So if I wanted to go online, I would search for the procedure I want to look for, I could search by doctor, by hospital; it would list the average price paid by the state of Indiana over the last three years for those services at that provider and this has really opened up an entire window of opportunity for our employees to really know the quality procedures as well as the cost of that care.

[9:29:52 AM](#)

SENATOR WIELECHOWSKI commended Mr. Darrow for his presentation.

SENATOR GIESSEL asked that it is not that Indiana is asking healthcare providers, physicians, nurse practitioners, or physician assistants to post their prices for the general population; ISPD is confining cost transparency to state employees who are beneficiaries.

MR. DARROW answered correct. He explained that the price quotation is something that is highly protected between the insurer community and the provider community; those contractual relationships are intellectual property in some cases that are based upon the contracts. He specified that ISPD has a software tool that provides employees with password protected access to research claims history prices and procedures from the state's plan.

[9:30:59 AM](#)

CHAIR DYSON noted his cynicism about cost and healthcare systems. He addressed the challenge with ascertaining the honest cost of healthcare services due to crossed-subsidies within hospitals. He noted that hospitals are forced to take everybody that staggers into emergency rooms and cost recovery is less than 60 percent; that cost gets subsidized by other services and profoundly distorts the system. He asked how ISPD gets down to knowing that the actually costs are.

MR. DARROW replied that Chair Dyson's inquiry is a larger issue about the true cost of healthcare than what Indiana addressed in their delivered system tool. He said Indiana purchased a transparency solution called Castlight Health; they are a private third party company that provides a vehicle for ISPD to report the price paid by the state of Indiana for those services at that location, at that provider, for that procedure, over a period of three years. He remarked that Indiana is actually giving its employees a look at the actual cost paid, not only what the total cost of the procedure is, meaning the employer portion plus the employee portion, but also the employees expected procedure cost. He explained that employees can access information year-to-date deductibles, how much more has to be spent to reach co-insurance, and additional data.

CHAIR DYSON asked to verify that the service provided by Castlight Health includes non-hospital delivered services where a private standalone radiology lab's cost was clear as well as the hospital cost for the same service that might have included the cross-subsidization.

[9:33:14 AM](#)

MR. DARROW answered yes.

CHAIR DYSON remarked being outraged when he was able to walk into a physical therapist and pay \$85 an hour versus \$125 an hour when using his state insurance plan. He asserted the insurance reimbursement practice is almost a shell game. He noted that the therapist said everybody does it and the business is allowed to bill up to an amount that is 40 percent more than what is paid walking off the street.

MR. DARROW replied that Indiana shares Chair Dyson's frustration.

CHAIR DYSON asked how to solve the billing issue.

MR. DARROW replied that Indiana's CDHP cannot solve the larger issue Chair Dyson addressed. He explained that the CDHP philosophy allows individuals to make informed decisions to ask the right questions to use lower cost procedures.

CHAIR DYSON remarked that he learned in high school biology that diseases grow in the dark.

9:35:01 AM

MR. DARROW set forth that 2009 was a reaffirmation year for the state's investment and belief that CDHP was starting to make a difference. He said Indiana made the decision to begin prefunding half of the employer contribution in the HSA account at the first paycheck of the year and allocating the remaining contribution over the course of the year. He explained the reason to prefund half of the employer contribution as follows:

You may have the employee who has the catastrophic healthcare incident right at the beginning of the year and they do not have funds built up because they drew them down the previous year; this allows them a little piece of mind if you do have an out of normal event to be able to have some funds to pay for that cost out-of-pocket. The state's contribution in 2009 remained at 55 percent of the plan of the total HSA contribution. The CDHP enrollment in that year climbed to 47 percent, almost 15,500 employees.

He said Indiana was super-charged in its growth during 2010. He detailed that the previous HMO plan exit coupled with the closing of a southern region PPO plan left state employees with three options: two CDHP options and one PPO option. He explained that Indiana redesigned the current PPO in 2010 to more approximate the delivery of the consumer driven plans to include an 80/20 split as well. The state contribution to the HSA remained at 55 percent and enrollment climbed to 20,000 members, or 70 percent of the state's participation overall.

MR. DARROW addressed the advent of the Affordable Care Act (ACA) and noted that Indiana has remained largely unchanged in its plan design at the current time. Indiana is currently at 96 percent total participation in the state's CDHP plans. He said the state believes some of the things the state set out to do have evolved into positive consumer behaviors with employees making more informed decisions. He noted that Indiana currently contributes 45 percent of the total deductible in employees' HSA accounts on an annual basis.

[9:38:09 AM](#)

He said Indiana sought out third party validation in 2010 to assess the true financial impact and meaning to the state. He explained that the Governor Daniel's administration commissioned the state's actuary to do a study on the savings and impact of CDHP offerings for the first three years of the plan, 2006-2009. He reported that the total cost savings versus traditional PPO plan were evident. The annual average cost per member was \$9,444 in CDHP-1; \$5,462 in CDHP-2; and \$12,317 for the state's PPO plan.

CHAIR DYSON asked if the cost savings encompassed all of the delivered medical services or just to the state.

MR. DARROW replied that the report showed the actual cost paid by the state for offering coverage to the employees in each of the three plans. He noted that cost in the traditional PPO plan is higher with higher utilization and costs that are not as sustainable. He added that the two CDHP models showed that the state's cost of coverage was significantly less.

CHAIR DYSON asked to verify that the state's costs were less.

MR. DARROW responded yes.

[9:39:59 AM](#)

He explained that the differences between the CDHP plans and the PPO plans fell into five categories:

1. Plan Design: obviously by structuring the PPO plan like Indiana in 2010 to have more of an 80/20 split, put the plans on par and made them comparable.
2. Demographic Differences: Age, gender, and family size were noticeable between the three plans; however they were more normalized than what the state thought.
3. Health Status Differences: Early CDHP adoption individuals tended to be younger individuals rather than individuals who have been on the PPO or HMO plans for quite some time.
4. Consumerism and Behavior Change: Quite evident that was the most striking impact.
5. Consumers Making Better Decisions: Appropriate care, not necessarily avoiding care, but whether that care was appropriate and what is the right vehicle to receive that care.

[9:41:06 AM](#)

MR. DARROW said the study showed that Indiana had greater use of cost effective treatments. He asserted that there is no evidence employees were avoiding care since they were paying a higher share of first-dollar coverage. He explained greater employee use in CDHP as follows:

- Generic drugs versus brand name drugs;
- Fewer hospital admissions with shorter stays than the PPO plan;
- Less frequent use of the emergency rooms, a long standing problem issue for using as a primary care vehicle;
- Use of outpatient versus inpatient procedures visits dramatically increased in CDHP versus PPO;
- Visiting primary care physicians instead of specialists when possible and appropriate seemed to be a trend that was growing in CDHP.

He summarized that under an annual cost basis, the study estimated that the state saved 10.7 percent through the CDHP adoption with approximately \$28 million in total healthcare savings from 2006 through 2009. He noted that in 2010, since the enrollment was growing close towards 70 percent participation, the study estimated that the state would annually receive \$17 million to \$23 million in savings by the adoption of CDHP on an ongoing basis.

[9:42:57 AM](#)

CHAIR DYSON called an "off the record" with Mr. Barnhill.

[9:43:14 AM](#)

CHAIR DYSON called the committee back to order.

MR. DARROW said from the employee perspective there was also savings. He pointed out that the study determined employees realized \$7 million to \$8 million in savings by making the switch from the PPO option to the CDHP options. He noted two ways the employee savings are realized as follows:

1. Payment of lower premiums.
2. More efficient use of healthcare.

MR. DARROW said the consumerism effect from reduced or more efficient utilization of healthcare also reduces an employee's out-of-pocket expenses. He explained that consumers had started

to make better decisions and utilized the most efficient way to spend healthcare dollars.

He reiterated that employee savings are significant. He revealed that as of 12/31/2013, state employees have \$59 million invested in their HSA accounts with the average employee balance of \$1,728; a balance that is growing about 5 percent per year. He said the equity accumulation that HSA participants receive from the state contributions in 2013 is estimated to be between \$5 million and \$6 million annually. The state refers to a group called "super savers" with 1238 employees having invested over \$10,000 in their HSA accounts. He pointed out that employees are really showing a determined mentality in trying to save for future healthcare expenses.

[9:45:15 AM](#)

He addressed different ways in which ISPD measures progress and success with regards to healthcare's "spend and trend" growth. He asserted that a CDHP will not slow the growth in healthcare on its surface. What CDHP can do is offer a very predictive model based on ISPD's experience about how that cost increase will portray. He noted that for many employers, having an indication about growth and projection is just as important in the planning stages as the projected future expenses. He explained that Indiana measures its expenses from multiple viewpoints and overall cost trends are measured on a Per-Member-Per-Month (PMPM) cost basis. He noted a 2008 through 2013 chart that shows PPO growth in PMPM versus the growth in the two CDHP options. He noted that the PPO growth has been priced accordingly with the appropriate price plans and premiums correlated to the health risk of the group that remains in the plan. He said the PPO plan does tend to have individuals that are higher utilizers with less discipline and the costs reflect dramatic growth as a result. He pointed out on a diagram that even as a significant employee migration from the PPO and HMO plans into the CDHP plans occurred, Indiana has experienced a very moderate and measured growth in costs from 2008 through 2013.

SENATOR COGHILL asked if there was a barrier or were employees allowed to go from the CDHP-1 to CSHP-2. He addressed the employee migration and inquired if employees wanted to settle out in a high deductible, prefer to go out, or could they go out.

MR. DARROW answered that each employee has a choice of going between one of the three plans during an annual open enrollment

period. He said other than outside of qualifying events during Indiana's open enrollment, the state markets all three plans and the prices accordingly.

[9:47:40 AM](#)

He called attention to a belief that because the employee is paying higher first-dollar cost coverage; HSA is expressly just a cost shift from the state to the employee for the additional growth in cost and the cost burden. He referenced a chart that shows why the state of Indiana chose to make HSA contributions and the impact of those contributions on the employees' out-of-pocket spending. He pointed out that the chart shows unrestrained costs in the PPO plan have increased significantly each year for the members on their out-of-pocket spending. Once the state's HSA contributions are subtracted, \$20 to \$25 per month more is being spent by the individual in a CDHP environment versus \$52.75 to \$100 more in the PPO option. He pointed out that the monthly out-of-pocket difference is another example that a much more measured, defined, and predictable growth benefits employers and employees as well.

He addressed the state's perspective on a PMPM trend and noted a graph that shows the impact CDHP has had on employer's cost of coverage over the last six years. He said the cost of coverage is very predictable and stable due to a combination of both planned design as well as consumerism taking effect. He remarked that Indiana has found out that an informed consumer making better decisions with an appropriate amount of risk and bearing the healthcare cost burden leads to a very predictable structured cost for the state to live by.

[9:49:46 AM](#)

He said Indiana is also very proud of increased preventive care by employees. He noted that significant coverage is free for the individual on preventative care. He pointed out that key utilization categories are up for the following: preventative care, Well Child visits, immunizations, appropriate mammogram screenings, cholesterol screenings, and PSA screening rates. The participation offered in Indiana's disease management programs for individuals with chronic conditions is also above the benchmark. He said ISPD believes that employees are aware that maintaining current health status is a viable way of controlling costs in the future.

[9:51:28 AM](#)

MR. DARROW addressed lessons learned and things Indiana felt were meaningful along the way for the state. He declared that

Indiana could not have achieved as wide spread adoption amongst the provider community, healthcare delivery system, and employee education without the consistent support by Governors Daniels and Pence; both men are extremely adamant in their beliefs that a more informed and stronger consumer will drive market forces appropriately in the delivery of healthcare. He continued to address ISPD's focus as follows:

We talk about positive communications. We look at the advantages and opportunities in the new plans with our employees. We don't focus on, "Yes your healthcare costs have gone up this year versus last year, but how have they truly gone up." If you look at the education and information we give today, they are starkly different conversations than they were in 2006; it was the basic conversations reeducating our employees on about what to ask your doctor, about how you should receive care. Now employees are asking about how to save and finance for their healthcare. Now employees are asking about specific preventative care and should this be covered and where should I go to get this type care; those types of conversations are much more fun to have once we have come through the learning and ramp-up phase in understanding for our employees. We believe that honest dialogue on cost, trends, and future impact are vitally necessary for the employee to understand this. From a health administrator's standpoint, from every conference you will attend, the average health literary is around 11 percent. When you add a consumer driven environment, it does put a bigger burden on the employee to understand exactly how they should act. We have very deliberate conversations about the impact on you and the impact on us. If we work together, these are some of the impacts we can have through a concerted effort between the two. I think there needs to be a commitment to execute comprehensive education amongst the employees, it is not an eleventh-hour decision to suddenly offer CDHP; it does require extensive education, learning opportunities. To our chagrin, we did not have the opportunity to get out in front of Indiana's employees as much as we want. When we first launched the plan in 2006, we learned that in 2007 as we educated folks and had more of a concerted effort amongst our staff to get out to the local facilities, locations, far reaching area of that state and really hold face-to-

face meetings and talk about it; that really began to make a difference for us.

9:54:21 AM

MR. DARROW said some of the internal challenges that Indiana faced that many organizations will face included lack of committed support from executive agencies and directors. He explained the need for appropriate education resulting from a cultural mind shift where employees go from a little or no stake to a major stake in the healthcare environment. He revealed that Indiana found it very helpful to market actively to middle managers and those that had most face-to-face contact with employees on a day-to-day basis. He specified that depending upon the adoption rate a state chooses to achieve, a state will have a slower migration to CDHP by offering plans with low deductibles, co-pays, and premiums for traditional PPO and HMO plans.

He pointed out the importance for a state's administration and leadership in allowing members to have a choice. He revealed that Indiana believed in not mandating CDHP as the only healthcare option and allowing migration to occur naturally. He noted that Indiana's employees have always had choice. He set forth that Indiana educates employees on the pros and cons from choices in relationship to out-of-pocket healthcare expenses and premiums paid for plan participation.

9:56:14 AM

SENATOR COGHILL noted that providing education, wellness choices, and multiple plans are important in healthcare. He asked if Indiana's information was web-based and showed dollars-out. He inquired how Indiana begins the healthcare conversation with employees to weed through the initial confusion.

MR. DARROW replied that ISDP starts with the unknown commodity of health savings accounts, addresses risks, and points out IRS guidelines for using an HSA in a CDHP. He said ISDP addresses the misconception that the state is not offering options beyond a contribution to an HSA. He explained that ISDP's intent is to educate employees on the dollar risk, HSA use, healthcare coverage's true cost, the state's payments, employee's out-of-pocket expenses, and the difference between a traditional plan and a CDHP. He detailed that the initial employee education is very methodical with the process starting from the HSA perspective in order to show the risks, rules, and regulations. He noted that many websites are available that provide the pros and cons for CDHP.

[9:58:17 AM](#)

SENATOR COGHILL noted the confusion and work involved in Alaska when healthcare offerings are addressed. He pointed out the difference between wellness and illness management in addition to the shift occurring in society. He asked how wellness versus illness was addressed in Indiana.

MR. DARROW replied that Indiana honestly did not have wellness conversations when CDHP was first addressed because the state's wellness offerings were little to nonexistent. He said ISPD made a real emphasis on the preventive care side by offering coverage for free. He said it pays for employees to know the risks, conditions, and costs so that plans can be made for healthcare costs over time. He revealed that ISPD is now undertaking the next evolution on the wellness side by making a significant investment in keeping employees healthy rather than managing conditions when they are sick.

SENATOR GIESSEL remarked that there is a significant difference in something Mr. Darrow said at the beginning regarding Indiana not providing healthcare coverage for retirees. She surmised that Indiana employees are thinking long term and addressing healthcare during the aging and retirement process. She pointed out that Alaska's healthcare scenario differs significantly where the state picks the tab and who really cares what it costs.

MR. DARROW confirmed that Indiana does not have a retiree plan. He noted that a retiree may use their CDHP plan as long as they follow the IRS guidelines that an individual over 65 and Medicare eligible cannot have an HSA account. He said Indiana employees are educated upon what options are available to them.

[10:00:51 AM](#)

CHAIR DYSON asked to clarify that an HSA can or cannot be persevered past retirement.

MR. DARROW answered that HSA can exist in retirement, but a Medicare eligible individual cannot make HSA contributions.

CHAIR DYSON replied that the IRS ruling seems suboptimal.

MR. DARROW explained that employees can burn-down their HSA account and use those funds to pay for expenses in perpetuity, but contributions cannot be made.

CHAIR DYSON asked would have happened to Indiana's costs if the shift was not made to CDHP.

MR. DARROW referenced a previous diagram which shows cost projections between the PPO and CDHP options. He said Indiana's cost would have continued to skyrocket unsustainably and the state would not have been able to realize the annual savings of \$17 million to \$23 million.

CHAIR DYSON asked if Indiana's system includes public school teachers.

MR. DARROW replied that Indiana's system does not include public school teachers. He explained that teachers' healthcare is separately negotiated by the school systems. He noted that school systems may offer joining the state's health plan if they so choose. He said a limited number of schools participate in the state's health plan.

CHAIR DYSON asked what Mr. Darrow's experience was in dealing with the public employee bargaining units.

10:02:59 AM

MR. DARROW answered that Indiana was represented by several public employee bargaining units prior to 2005. He said in 2005, Governor Daniels took office, removed the previous executive order, and the bargaining units were disassembled. He specified that employees still had the ability to make contributions to their represented units if they wished, concessions were made, and ISPD met with union representatives to address the pluses and minuses if the union wished to educate their employees. He noted that dealing with the disassembled bargaining units occurred during the initial CDHP process and ISPD was learning on the fly.

CHAIR DYSON noted that Alaska's public employee unions have medical funds that often have significant amounts of money with better healthcare plans and coverage than what the state offers. He said there is a real pushback from the bargaining units and membership asking not to be included in the state's plan. He asked if Mr. Darrow had the same experience when dealing with bargaining units in Indiana.

MR. DARROW responded that the reaction Senator Dyson noted from the bargaining unit members is a normal line of thinking. He asserted that one thing that is sure to stir conversation amongst employees is changing paychecks and benefits. He said

feedback is going to happen and feedback is welcomed. He remarked that Indiana's results speak for themselves with 96 percent of employees participating in the CDHP option. He said employees realize that CDHP is a much more viable vehicle not only for them, but for the state's sustainability over time.

CHAIR DYSON noted Governor Daniels' front-end action on bargaining units and their leverage went away.

MR. DARROW answered yes.

CHAIR DYSON added that Indiana did not have a willing participant in the discussions. He asked if there are any classes or demographic groups of employees in Indiana that CDHP is not attractive for.

[10:06:11 AM](#)

MR. DARROW answered that he did not believe so. He explained that CDHP covers all of Indiana's government, legislators, and judges. He said there are separately elected bodies of government in the plan as well that are not part of the executive branch that make up the 65,000 members. He asserted that CDHP enrollment has pretty wide diversity.

CHAIR DYSON called attention to prior discussions that addressed the Affordable Care Act (ACA) as not really impacting what Indiana is doing.

MR. DARROW responded that CDHP is a much more viable option for employees and employers to control the cost of healthcare going forward. He said there are no [ACA] stipulations which impact Indiana's administration of the state's healthcare plans.

CHAIR DYSON replied that the ACA impact on Indiana is both surprising and intriguing. He noted that Idaho's former Governor Dirk Kempthorne mentioned that 70 percent to 80 percent of his state's budget was controlled by formulas and the administration literally controlled approximately 20 percent. He remarked that Alaska is below 70 percent and the formula trend continues to increase. He surmised that Indiana has reduced healthcare cost acceleration with significantly more predictability.

MR. DARROW agreed with Chair Dyson's assumption and noted contributing factors as follows:

We were very interested in the socio-economic impact of how enrollment manifested itself over the years.

The average state employee salary in Indiana is somewhere around \$37,000. The average salary of the employees in CDHP options is actually less than the PPO plan. So the notion that more affluent, higher income individuals have a propensity to adopt the CDHP did not bear out in our example.

Secondly, the rate of growth at which we've seen in our cost had been significantly below our trend and we use a national benchmark to measure our trend, we actually have a metric to measure our performance that we post on our portal for state government that we want to be a certain percentage below that trend due to our consumer driven options. Last year, which was a very mild year weather wise, in 2012's plan year we were at negative 1.5 percent medical trend for our plans and that is almost unheard of. This year we were at 5 percent trend which is below the national average of 7.5 percent.

10:09:58 AM

SENATOR COGHILL explained that one of the things Alaska struggles with that Indiana probably does not is its provider community. He said Alaska has a small population with vast areas. He inquired how CDHP was received by Indiana's provider community. He noted Indiana's state employee enrollee numbers was a good chunk of the state's population finding services. He surmised that Indiana's hospitals and clinics are probably two different animals that would respond differently.

MR. DARROW answered that provider adoption was initially slow in 2006. He noted that having a very large scale employer adopting and marketing CDHP was an education for everyone. He addressed the adjustment challenge for providers pertained who were used to collecting co-pays at the point of transaction and service rather than when the claim is adjudicated. He noted a study launched last fall by the Robert Wood Johnson Foundation and cited the following findings:

The study showed the provider mentality in adoption towards CDHP. While 70 percent of physicians say that CDHP is a good deal and approved, 43 percent believe that they just don't understand enough on the cost side of things to be that much of a benefit to their employees. So that has really been our education from the employee side of view that you need to be one to say, "This is what I can afford to spend and this is

what my plan pays for, what's the option for me in your network and then if I can't find a viable economic option, would you write the order for me to go the out-patient clinic or the non-hospital based clinic?"

I will say from Indiana's perspective obviously we have, especially in the metro Indianapolis area, very good provider network with lots of choice for our employees that is meaningful to the marketplace. I know you are facing a far different decision in Alaska as far as the selection the state has for selecting healthcare, but over time with that consumer base growing and more informed consumers joining consumer driven plans, it has affected the marketplace. We have had our hospital based systems take a very strong, hard look at their healthcare costs and announced major restructuring just in the past year due to CDHP growth and the advent of transparency.

10:12:44 AM

SENATOR GIESSEL noted her observation as a healthcare provider that the healthcare industry is not a free market. She asserted that the steps Indiana is taking does in fact create more of a free market, which allows competition and cost transparency. She applauded what Mr. Darrow has done.

CHAIR DYSON addressed Alaska's difficulties with not having a free market for healthcare. He noted learning that medical specialists in a major Alaska city set their annual net income at \$700,000 and structure pricing accordingly. He said the state also has lots of folks saying that they cannot make a living on their services based on the reimbursement rates. He asserted that Alaska has done a fairly good job on limiting medical liability cases and awards, noting the state as being one of the better ones in the nation. He asked if medical malpractice liability exposure is an issue for Indiana.

MR. DARROW replied that Indiana has not addressed medical liability nor have been asked to. He commented that due to the availability and broader range of services that Indiana's marketplace offers, medical malpractice liability has not been something that Indiana has addressed or been asked to address.

CHAIR DYSON addressed Senator Giessel's statement that in addition to not having a "real marketplace," Alaska has a few major suppliers of services in the state who seem to be looking

for vertical integration and crowding out the other folks sometimes with the aid of government. He asked if Indiana is facing the same challenges with major suppliers.

MR. DARROW answered yes. He explained that with the advent of ACA and especially as the regulations came out in 2010, Indiana saw the increased formation of what ISPD calls Accountable Care Organizations (ACO) within the marketplace. He said larger Hospital Based Systems (HBS) bought specialists and practices that allowed HBS to charge the rate of service for their hospital rather than what the provider previously receives and the end result increases the state's costs. He asserted that the provider market dynamics is something ISPD is very concerned about and is talking to insurance carriers. He said ISPD is leaning on insurance carriers to make sure fair prices for services are negotiated and not allowing that costs are just passed along by employers.

[10:15:47 AM](#)

CHAIR DYSON noted a physician friend who found a heart medication that was approved on most third party payers and could not be covered. He explained that the physician's ethics drove him to using a far better product. He said the physician was outraged at non-knowledgeable medical experts were practically controlling treatment that the doctor could deliver. He asked if Indiana dealt with situations similar to what he previously described.

MR. DARROW replied that Indiana's philosophy is to make sure that the primary care physician is front and center in making the decision that is best for that individual. Indiana then allows its insurance carrier to negotiate for the state the best and most affordable price for that physician in the network of services offered. The advent of price transparency and putting prices out there has raised awareness in the medical community in Indiana to be more aware of about what the impact of that price is on that employee and the long term ability of that employee to pay for prices going forward. He said at least the conversation is started and most appropriately the conversation is between the health plan member and the physician. He pointed out that no one else is controlling exactly what service a health plan member should get and the physician determines what the most appropriate care for the health plan member is and then the contractor rate based upon with the health plan offers is the outcome.

[10:17:49 AM](#)

CHAIR DYSON clarified his example of a physician who prescribed a very helpful heart medication and there was no reimbursement from a third party payer with no discussion with the patient or doctor and no mechanism for the particular heart medication to be reimbursed for. He expressed his hope that his previously noted example did not happen often and noted the barrier for drug reimbursement authorization must be removed.

MR. DARROW answered that Indiana works with its insurance carrier and Pharmacy Benefits Manager (PBM). He noted that the PBM is separate for the insurance carrier. He explained that Indiana negotiates and looks at the insurance carrier and PBM to provide the best advice on what is medically appropriate care.

10:19:19 AM

SENATOR GIESSEL asked if Indiana has a "Certificate of Need" requirement for healthcare facilities.

MR. DARROW replied that he was not certain.

CHAIR DYSON asked Mr. Barnhill where DOA goes from here.

MR. BARNHILL explained that DOA is taking the first step with CDHP this year. He said DOA is using the balance of the year to investigate CDHP more thoroughly and how CDHP could be implemented within the context of Alaska's employee healthcare plan, "AlaskaCare." He said DOA is giving everyone a heads-up that the CDHP discussion is starting now. He declared that DOA will have meetings with Mr. Darrow to address CDHP transition logistics. He noted that Indiana is an entirely different context than Alaska, but the belief is the state can learn from Indiana. He explained that Alaska's costs on a PMPM basis are upwards of 50 percent higher than what Indiana experiences. He remarked that higher costs are attributed to a lack of free market dynamics happening in Alaska's healthcare market. He summarized that the CDHP process is mostly thinking, designing, and possibly deciding to implement in calendar year 2015. He noted that an important communication and education effort would occur prior to CDHP implementation.

CHAIR DYSON recalled ten years ago that he was able to insert language into the budget bill that said all future contracts have to be negotiated so that there is a HSA option. He said he is quite sure that nothing ever happened.

MR. BARNHILL replied that DOA was now paying attention.

CHAIR DYSON said he is impressed with both Indiana's CDHP system in addition to continuing to give employees several options. He remarked about the possibility of Alaska providing an employee option of continuing with their bargaining unit plan or choosing to migrate to the state's CDHP. He said the process of shifting to a CDHP option for employees is quite a hill to climb.

MR BARNHILL agreed with Chair Dyson.

CHAIR DYSON asserted that Alaska does significantly more for their retired employees. He noted that Alaska has a huge liability for retired employees. He remarked that he feels like Indiana left their retirees "out in the cold." He asked what Indiana retirees had before CDHP implementation.

[10:22:46 AM](#)

MR. DARROW replied that he cannot comment on retirees. He explained that during his tenure in Indiana, the state has never offered retiree health coverage.

CHAIR DYSON thanked Mr. Darrow for his presentation.

[10:23:13 AM](#)

There being no further business to come before the committee, Chair Dyson adjourned the Senate State Affairs Committee at 10:23 a.m.