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How to Cure Pennsylvania's Health Benefits Crisis

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Summary

- Taxpayer spending on health care for Pennsylvania state employees has skyrocketed as a result of wasteful incentives and a lack of price transparency in the state's health care system.
- As public employee benefit costs continue to spiral out of control, they will crowd-out funding for vital public services.
- Cities, counties, and states across America have successfully reformed public employee health benefits by empowering workers with greater control over their health care and more price transparency.

Executive Summary

Pennsylvania's state government faces severe financial strains. A major cause of the state's growing fiscal crisis is the rising cost of state employee health benefits. Over the past 14 years, state spending on employee health care has skyrocketed, from $395 million in 2002 to $866 million in 2016, a 119 percent increase.[1] In addition, taxpayer spending on retiree health care rose from $1 billion in 2009 to $1.5 billion in 2016, a 45 percent increase.[2,3]

An underlying reason for this spending increase is employees have little incentive to control health care costs. The price of health care services can vary by tens of thousands of dollars between hospitals only a few miles away from each other, but Pennsylvania's state employees and retirees have no financial reason to seek lower-cost providers since

[1] Author's calculations made by multiplying the historical filled salaried and wage positions by the historical average per employee state paid benefit costs in fiscal year 2016, with data from "2018 Pennsylvania State Government Workforce Statistics," Pennsylvania Office of Administration, 2018, pp. 9, 19. http://www.oabis.state.pa.us/SGWS/2018/2018_SGWS_Dashboard_Charts.pdf#pagemode=bookmarks.

[2] *Comprehensive Annual Financial Report For the Fiscal Year Ended June 30, 2009*, Office of the Budget, Commonwealth of Pennsylvania, January 22, 2010, p. 113, http://www.budget.pa.gov/PublicationsAndReports/AnnualFinancialReport/Documents/june-30-2009-cafr.pdf.

[3] *Comprehensive Annual Financial Report For the Fiscal Year Ended June 30, 2016*, Office of the Budget, Commonwealth of Pennsylvania, December 15, 2016, p. 134. http://www.budget.pa.gov/PublicationsAndReports/AnnualFinancialReport/Documents/2016/june-30-2016-cafr.pdf.

the Pennsylvania Employee Benefit Trust Fund (PEBTF) charges workers low deductibles and other out-of-pocket fees. This inefficient system wastes taxpayer dollars and crowds out spending for other vital state services, creating an excuse for policymakers to raise taxes even higher.

PATIENT-CENTERED REFORMS CAN STOP THIS UNSUSTAINABLE SPENDING TRAJECTORY WHILE ENSURING WORKERS CONTINUE TO ENJOY RELIABLE ACCESS TO QUALITY MEDICAL PROFESSIONALS AND FACILITIES.

Patient-centered reforms can stop this unsustainable spending trajectory while ensuring workers continue to enjoy reliable access to quality medical professionals and facilities. Other states offer lessons instructing Pennsylvania how it can successfully transform public employees from passive beneficiaries into engaged, cost-conscious consumers.

Such reforms include:

Health Savings Accounts (HSAs): Michigan encourages state and local government employees to enroll in HSAs, which reduce spending on unnecessary treatments and procedures by imposing healthcare spending caps on public employers.

Cash Rewards: Kentucky and New Hampshire allow state employees to compare medical procedure prices between providers. When workers choose less expensive providers, the state health plan sends them cash as a reward for seeking savings.

Direct Primary Care: Union County, North Carolina and Arvada, Colorado partner with direct primary care physicians to deliver routine and preventive treatments for public employees, reducing health care spending on specialists and emergency rooms.

Reference Pricing: California encourages government workers to visit less expensive doctors and hospitals by establishing a maximum contribution limit for elective medical procedures and requiring patients to pay the difference.

State Employee and Retiree Health Care Benefits

The Commonwealth of Pennsylvania established the Pennsylvania Employees Benefit Trust Fund in 1988 to provide medical benefits to all full-time state workers, dependents, and retirees, through an agreement with the American Federation of State, County and Municipal Employees (AFSCME), the largest union representing Commonwealth employees.[4] Over the next several years, the remaining unions representing Pennsylvania's public employees opted into PEBTF, with the exception of the Pennsylvania State Troopers Association. In 2016, 72,985 employees received their health benefits through PEBTF.[5]

[4] *Issues Associated with Extending Commonwealth-Subsidized Healthcare Coverage*, Commonwealth of Pennsylvania Public Employee Retirement Commission, 2006, http://www.ifo.state.pa.us/download.cfm?file=/Resources/Documents/2006_surviving_spouse_healthcare_study.pdf.

[5] *Supra* note 1, p. 9.

In recent years, the cost of Pennsylvania's health benefits has dramatically increased. In 2002, PEBTF spent $395 million on employee health care. Yet by 2016, that spending ballooned to $866 million, a 119 percent increase over 14 years.[6] In addition, taxpayer spending on retiree health care has risen from $1 billion in 2009 to $1.5 billion in 2016, a 45 percent increase.[7,8]

A major contributor to Pennsylvania's rising health care spending is the extremely generous health insurance options the state offers. PEBTF typically covers 88.7 percent of the cost of health care premiums and spends on average $11,877 per worker.[9] In contrast, the average private sector employer in Pennsylvania covers 79 percent of insurance premiums and spends only $4,861 per worker.[10]

State employees also spend far less on deductibles than private sector employees. Individuals and families under PEBTF can purchase coverage with deductibles as low as $350 and $700, respectively.[11] In the private sector in Pennsylvania, individuals on average must pay a $1,603 deductible before insurers cover most of their medical bills, according to the 2016 Medical Expenditure Panel Survey.[12] Families must pay on average a $3,030 deductible.[13]

The cost of public employee health care has also increased because Pennsylvania lacks an effective way for consumers to determine which doctors and hospitals offer the best value.[14] A database developed by the Centers for Medicare and Medicaid Services found insurers pay wildly different prices for the same procedures at different hospitals.[15] For instance, patients seeking a joint replacement will spend $62,023 at the Carlisle Regional Medical Center in Carlisle, Pennsylvania. But if they visit PinnacleHealth in Harrisburg, Pennsylvania, located just 24 miles away, they will spend only $30,259.

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6 *Supra* note 1, pp. 9, 19.

7 *Supra* note 2.

8 *Supra* note 3.

9 Conversation with Daniel Egan, press secretary of the Pennsylvania Office of Administration.

10 *Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance,* Henry J. Kaiser Foundation, 2016, https://www.kff.org/other/state-indicator/single-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

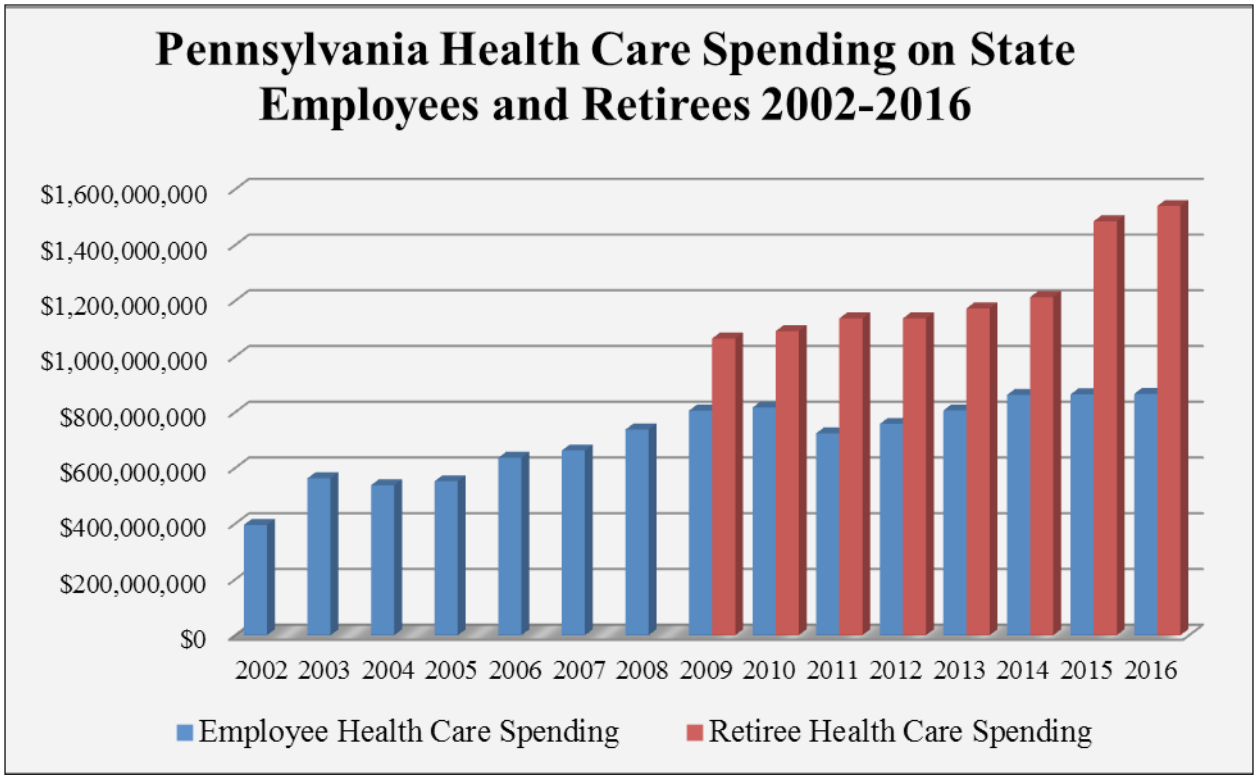
11 *Pennsylvania Employees Benefit Trust Fund Summary Plan Description*, Pennsylvania Employee Benefits Trust Fund, April 1, 2018, p. 44, https://www.pebtf.org/PDF/SPD.pdf.

12 *Average Individual Deductible per Employee Enrolled with Single Coverage in the United States,* Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2016, https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2016/tiif2.pdf.

13 *Average Family Deductible per Employee Enrolled with Family Coverage in A Health Insurance Plan That Had a Deductible in the United States in 2015,* Agency for Healthcare Research and Quality, 2015, https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2016/tiif3.pdf.

14 Sarah Kliff and Dan Keating, "One hospital charges $8,000 – another, $38,000," *The Washington Post*, May 8, 2013, https://www.washingtonpost.com/news/wonk/wp/2013/05/08/one-hospital-charges-8000-another-38000/?utm_term=.af2265b52cb5.

15 "How Much Hospitals Charge," *The Washington Post*, May 19, 2013, http://www.washingtonpost.com/wp-srv/special/national/how-much-hospitals-charge/.



Note that 2009 is the first year Pennsylvania started publishing annual retiree health care costs under Statement 45 of the Government Accounting Standards Board. *Source*: Data from the Pennsylvania Office of Administration and Office of the Budget. Chart created by The Heartland Institute.

Public Sector Compensation Crowd-Out

An adverse consequence of the rising cost of state employee health coverage in Pennsylvania is these health plans divert taxpayer dollars away from other vital public services. While research on the direct impact of state employee health benefits on other budget decisions is limited, state employee pensions demonstrate how ballooning benefits can divert funding away from core public services.

From 2003-04 to 2017-18, the cost of Los Angeles' public employee pensions increased from 4.3 percent of the city's budget to 12 percent. As pension costs crowded out more taxpayer funding, Los Angeles was forced to divert $900 million away from health, education, and sanitation services. Spending on public health and sanitation declined 60 percent. Funding for public works fell 63 percent. And spending on cultural and recreational services declined by 80 percent.[16]

Employee benefits have also squeezed cities in Illinois. After years of underfunding pensions for police and firefighters, the city of Mattoon was forced to cut the fire department's ambulatory services.[17] Springfield's deepening pen-

[16] *Pension Math: Public Pension Spending and Service Crowd Out in California, 2003-2030,* Stanford Institute for Economic Policy Research, October 2, 2017, pp. 36–37. https://siepr.stanford.edu/sites/default/files/publications/17-023.pdf.

[17] Cole Lauterbach, "City: Mattoon Ambulances Gone after Pension Costs Crowd out Services," Illinois

sion burdens caused city officials to shutter libraries and reduce police patrols.[18]

Even without detailed studies of state budgets to show a direct diversion of funds from other programs to medical benefits for state employees, there seems little doubt that spending on other services has been shortchanged to make up for the rising cost of state employee medical benefits.

It is vital for Pennsylvania policymakers to curb the increasingly costly burden of state employee health benefits.

As they grow increasingly more expensive, the Keystone State's health care benefits will similarly divert funding away from critical social services. Since 2009, taxpayer spending on health care for employees and retirees has grown from $1.8 billion to $2.4 billion, nearly a 30 percent increase. If these costs continue to increase at their current rate, Pennsylvania's annual health care costs for state employees and retirees will exceed $3 billion by 2024.[19]

Recommendations

It is vital for Pennsylvania policymakers to curb the increasingly costly burden of state employee health benefits. In recent years, several states and localities have introduced consumer-driven incentives into public health benefit plans. They have dramatically lowered health care spending while also delivering better health outcomes for workers.

Pennsylvania lawmakers can learn from these successes and apply these proven reforms in their own state to help ensure workers enjoy quality health insurance at a price taxpayers can afford.

Health Savings Accounts

A powerful tool states can use to reduce unnecessary health care spending is a health savings account (HSA) program. HSAs are financial tax-free accounts that allow individuals and families to save for future health care expenses. Individuals who sign up for an HSA must also enroll in a high-deductible health insurance plan. Unlike typical public employee health plans—which require enrollees to pay little if any out-of-pocket expenses—HSA-linked plans expose patients to real health care costs. This gives them a strong incentive to seek less expensive providers.

In 2011, Michigan Republican Gov. Rick Snyder signed the "Publicly Funded Health Insurance Contribution Act" to restrain the grow-

News Network, July 27, 2017, https://www.ilnews.org/news/statewide/city-mattoon-ambulances-gone-after-pension-costs-crowd-out-services/article_7c6f824c-730c-11e7-b6da-27ac049d2a1b.html.

[18] Ted Dabrowski, "Springfield Pensions Hurt City Credit Rating, Residents," Illinois Policy Institute, October 29, 2016, https://www.illinoispolicy.org/springfield-pensions-hurt-city-credit-rating-residents.

[19] Author's calculations based on historical employee and retiree health care spending data.

ing cost of his state's public health benefits.[20] The act offers school districts two options to control health care spending. The first option restricts school districts from spending more than $5,500 on coverage for the average individual, $11,000 for the average couple, and $15,000 for the average family. The second option requires every school district employee to pay at least 20 percent of his or her health insurance premiums.

In response to these limits, many school district employees opted to enroll their workers in high-deductible insurance plans attached to HSAs to reduce the cost of insurance premiums. As workers utilized HSAs to get the best prices for services to meet their needs, health care spending steadily declined, from $1.69 billion in 2011 to $1.45 billion in 2015, a 14 percent reduction in health care costs over just four years, according to data from the Michigan Department of Education.[21]

> Unlike typical public employee health plans, HSA-linked plans expose patients to real health care costs.

Cash Rewards

Several states have started offering workers cash rewards as an incentive to utilize less expensive health care providers through a company called Vitals SmartShopper. SmartShopper contracts with health insurance plan providers, analyzes their claims data, and allows patients to compare prices for routine, non-emergency services. When patients choose a less expensive provider in their network, the state—that is, the taxpayer—saves money and SmartShopper sends to those cost-conscious enrollees some of the savings. The larger the savings, the larger the reward.

Patients seeking a blood test could get $25 for picking a lower-cost lab. Meanwhile, patients needing back surgery could receive up to $500 for choosing to go to a low-cost surgery center instead of a costlier hospital. The procedures eligible for financial rewards include adenoidectomies, carpal tunnel surgery, colonoscopies, CT scans, hernia repair, knee arthroscopies, mammograms, and MRIs.[22]

In 2011, the New Hampshire Department of Administrative Services integrated SmartShopper into the state's Anthem Blue Cross Blue Shield plan for state employees.[23] SmartShopper rewarded the Granite State's workers for shop-

[20] Act No. 152, Publicly Funded Health Insurance Contribution Act, 96th Michigan Legislature, September 27, 2011, http://www.legislature.mi.gov/documents/2011-2012/publicact/pdf/2011-PA-0152.pdf

[21] *Financial Reports, Student Count-Attendance*, Michigan Department of Education, 2017, https://www.mischooldata.org/Other2/DataFiles/FinancialInformation/HistoricalFinancialReports.aspx.

[22] "Vitals Smart Shopper Incentive Reward Services," Anthem BlueCross Blue Shield, https://das.nh.gov/hr/documents/VitalsSmartShopperIncentiveList.pdf.

[23] Sara M. Willingham and Karen D. Hutchins, "Compass SmartShopper Program," Memo, State of New Hampshire Division of Personnel, June 28, 2010, https://das.nh.gov/hr/documents/compass%20memo.pdf.

ping for the best prices for medical care, and they demanded better value from their providers. From 2011 to 2015, SmartShopper's rewards saved taxpayers $12 million by redirecting workers to cost-effective providers.[24]

In 2014, Kentucky decided to enhance SmartShopper's incentives by offering them alongside several high-deductible health plans that include HSAs. As more employees took advantage of both initiatives, Kentucky's spending on state employee health care declined. According to *Kentucky Employees Health Plan 2017 Annual Report*, spending on medical claims for members and dependents decreased from $1.55 billion in 2013 to $1.38 billion in 2016, a reduction of 11.2 percent.[25]

SMARTSHOPPER'S REWARDS WOULD INCENTIVIZE PENNSYLVANIA PUBLIC EMPLOYEES TO SEEK MEDICAL PROVIDERS THAT OFFER LESS EXPENSIVE CARE.

Smartshopper's rewards would incentivize Pennsylvania public employees to seek medical providers that offer less expensive care. These workers currently have little reason to select less-costly services and facilities because enrollees are responsible for only a tiny share of their health care expenses. These cash incentives would encourage workers to seek cost-effective care and save taxpayers money.

Direct Primary Care

Several cities and counties have started utilizing the cost-saving health care delivery model known as direct primary care (DPC). Under this model, physicians opt out of charging for each individual procedure and instead charge a flat, low monthly fee for routine services.

According to physician advocates, private practices can save 40 to 60 percent on their overhead costs by shifting to direct pay.[26] DPC allows doctors to spend more time and resources treating patients, thereby ensuring they remain in good health and out of the hospital, which is much more expensive.

A look at DPC's record suggests how Pennsylvania can deliver significant savings to employees and taxpayers by encouraging enrollees to use DPC. In 2015, Union County in North Carolina partnered with Paladina Health, a network of DPC doctors, to offer a patient-centered primary care alternative for county employees. After just one year, workers who enrolled in this program spent 23 percent less than workers who stayed with conventional physicians. This translated into an annual savings of $3,120 for each patient.[27] Overall,

[24] "$12M Recovered in Medical Costs for State of New Hampshire," Vitals SmartShopper, 2016, p. 2, https://www.colorado.gov/pacific/sites/default/files/NH_Case_Study_Final.pdf.

[25] "Kentucky Employees' Health Plan Seventeenth Annual Report," Kentucky Group Health Insurance Board, December 15, 2017, p 6, https://personnel.ky.gov/KGHIB/Annual%202017%20Report.pdf.

[26] Katherine Restrepo, "Direct Primary Care: Restoring the Physician-Patient Relationship," *Forbes,* October 23, 2015, https://www.forbes.com/sites/katherinerestrepo/2015/10/23/direct-primary-care-restoring-the-doctor-patient-relationship/#52bf62796bc2.

[27] Katherine Restrepo and Julie Tisdale, "Direct Primary Care For Local Governments: Helping Union

the county saved $1.28 million by offering a DPC option for its workers.[28]

Direct Primary Care has also proven to be successful in delivering cost-effective care for patients with expensive illnesses. In 2018, a three-year study was published on Denver suburb Arvada, Colorado's experience utilizing Paladina Health physicians for city workers.[29] The study's authors found the costs for medical services for chronically ill patients who opted into DPC were 34 percent less than the costs for chronically ill patients who remained in the traditional health plan. Arvada's DPC patients spent just $436 per month on medical care while non-DPC patients spent $660 per month.[30] A major driver of these savings is that patients who visited DPC doctors visited the emergency room—a very costly option—31 percent less than other patients because of their improved patient experience.

DIRECT PRIMARY CARE HAS ALSO PROVEN TO BE SUCCESSFUL IN DELIVERING COST-EFFECTIVE CARE FOR PATIENTS WITH EXPENSIVE ILLNESSES.

Pennsylvania can hold down health care costs and provide patients access to quality medical care by offering a DPC option to state workers and retirees.

The Keystone State could also hold down costs by exempting DPC providers from burdensome state insurance regulations. For example, the Pennsylvania Insurance Code defines a health maintenance organization (HMO) as "An organized system … which provides basic health services to voluntary enrolled members for a fixed prepaid fee."[31] Under this definition, the Pennsylvania Insurance Department could consider a DPC practice to be an HMO and thus subject them to expensive rules that would threaten a DPC practice's viability.

Pennsylvania lawmakers can protect these innovative practices from Pennsylvania's insurance regulations by making clear DPC is not considered insurance under state law. Currently, 23 states have enacted legislation to exempt DPCs from insurance rules to promote this cost-effective health care delivery model.[32]

County Save $1.28 Million in Health Care Claims," *Spotlight #483,* The John Locke Foundation, 2016, p. 6. https://www.johnlocke.org/app/uploads/2016/12/Spotlight-483-Direct-Primary-Care-for-Local-Government-1.pdf.

[28] *Ibid*.

[29] "Case Study: Paladina Health Delivers Results for City of Arvada," Paladina Health, 2018, https://www.heartland.org/_template-assets/documents/publications/Paladina Health_City of Arvada_Case_Study.pdf.

[30] *Ibid.*, p. 3.

[31] Part 10: Health Maintenance Organizations. Chapter 301, The Commonwealth of Pennsylvania Code, 2001, 301-2, https://www.pacode.com/secure/data/031/chapter301/031_0301.pdf.

[32] "2018 Direct Primary Care Laws," Direct Primary Care Frontier, 2018, https://www.dpcfrontier.com/states.

Reference-Based Pricing

A successful reform effort in California can also offer Pennsylvania lawmakers a lesson for how to reduce employee health care costs. After years of rising public medical expenses, the California Public Employees Retirement System (CalPers) began to offer its members an incentive to seek lower-cost health care providers through reverse deductibles, known as "reference-based pricing." Under this system, CALPers sets a maximum contribution amount it will pay for elective procedures and requires patients to pay for any remaining costs.

> Currently, 23 states have enacted legislation to exempt DPCs from insurance rules to promote this cost-effective health care delivery model.

For example, CALPers established a maximum contribution limit for knee and hip replacements of $30,000 for each service. Any worker who selects a provider that charges at or below the reference price would pay the usual coinsurance rate of 20 percent, up to a maximum of $3,000. But if patients select a facility that charges, say, $35,000, they must pay the remaining $5,000.[33]

Soon after CALPers introduced reference-based pricing, families flocked to less expensive hospitals and surgery centers. Within the first year of the program, the share of hip and knee replacements delivered by inexpensive providers increased by 28 percent.[34] This resulted in a 26 percent reduction in the average price of these procedures for a total two-year savings of $5.5 million.[35] The share of colonoscopies delivered by low-cost facilities increased by 21 percent, which reduced the procedure's prices by 28 percent, saving $7 million.[36] And the share of knee and shoulder arthroscopic procedures delivered by low-cost ambulatory surgery centers increased by 14.3 percent, which reduced the price of these procedures by 13 percent, saving $7 million.[37]

Instituting reference-based pricing in Penn-

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[33] James C. Robinson and Kimberly MacPherson, "Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and Hugh-Quality Providers," *Health Affairs*, Vol. 30, No. 9, September 1, 2012, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.1313.

[34] David Cowling, "Reference-Pricing Policy for Hip/Knee Replacements Generates Significant Savings by Encouraging Enrollees To Choose High-Value Facilities," Agency for Healthcare Research and Quality, May 21, 2014, https://innovations.ahrq.gov/profiles/reference-pricing-policy-hipknee-replacements-generates-significant-savings-encouraging.

[35] *Ibid*.

[36] James C. Robinson *et al*., "Association of Reference Payment With Consumer Choices, Insurer Spending, and Procedural Complications," *Journal of American Medical Association Internal Medicine*, September 8, 2015, pp. 1–2, 5, https://bcht.berkeley.edu/sites/default/files/assoc_ref_pay_colonosc_cons_choice_ins_spend_proc_complc_jama_9.15.pdf.

[37] James C. Robinson *et al*., "Consumer Choice Between Hospital-Based and Freestanding Facilities for Arthroscopy: Impact on Prices, Spending, and Surgical Complications," *The Journal of Bone and Joint Surgery*, September 16, 2015, http://doi.org/10.2106/JBJS.O.00240.

sylvania would deliver enormous value to Pennsylvania public employees and taxpayers. CMS' data reveal Pennsylvania hospitals charge the fifth-highest average prices in the country, behind only California, Florida, New Jersey, and Nevada.[38] Establishing a contribution limit for medical procedures would force patients to seek the most effective providers and encourage high-cost hospitals to lower their prices to remain competitive.

PENNSYLVANIA CAN IMPLEMENT CONSUMER-CENTERED REFORMS THAT WOULD REDUCE HEALTH CARE COSTS AND LEAVE MORE MONEY TO PAY FOR FUTURE HEALTH CARE EXPENSES.

Conclusion

Since its inception, the Pennsylvania Employee Benefit Trust Fund has provided Pennsylvania's public employees with a generous benefits package for all kinds of health services. But due to the rising costs of these benefits, taxpayers cannot afford them over the long term.

Fortunately, Pennsylvania can implement consumer-centered reforms that would reduce health care costs and leave more money to pay for future health care expenses. The Keystone State should encourage public employees, dependents, and retirees to utilize cost-saving innovations such as health savings accounts and direct primary care to reduce unnecessary health care spending and improve outcomes. In addition, policymakers should introduce reference-based pricing and cash rewards to incentivize beneficiaries to choose low-cost health care providers and avoid expensive facilities.

These proven reforms will enhance Pennsylvania's commitment to public employees and prevent public health care obligations from crowding-out critical public services or forcing lawmakers to raise taxes on hardworking families to keep the state afloat financially.

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[38] "Average Hospital Cost by State," *Governing the States and Localities*, 2013, http://www.governing.com/gov-data/health/average-medical-hospital-costs-by-state-map.html.

About The Heartland Institute

The Heartland Institute is an independent national nonprofit research organization founded in Chicago in 1984. It is a tax-exempt charity under Section 501(c)(3).

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